INBONE®

Total Ankle System

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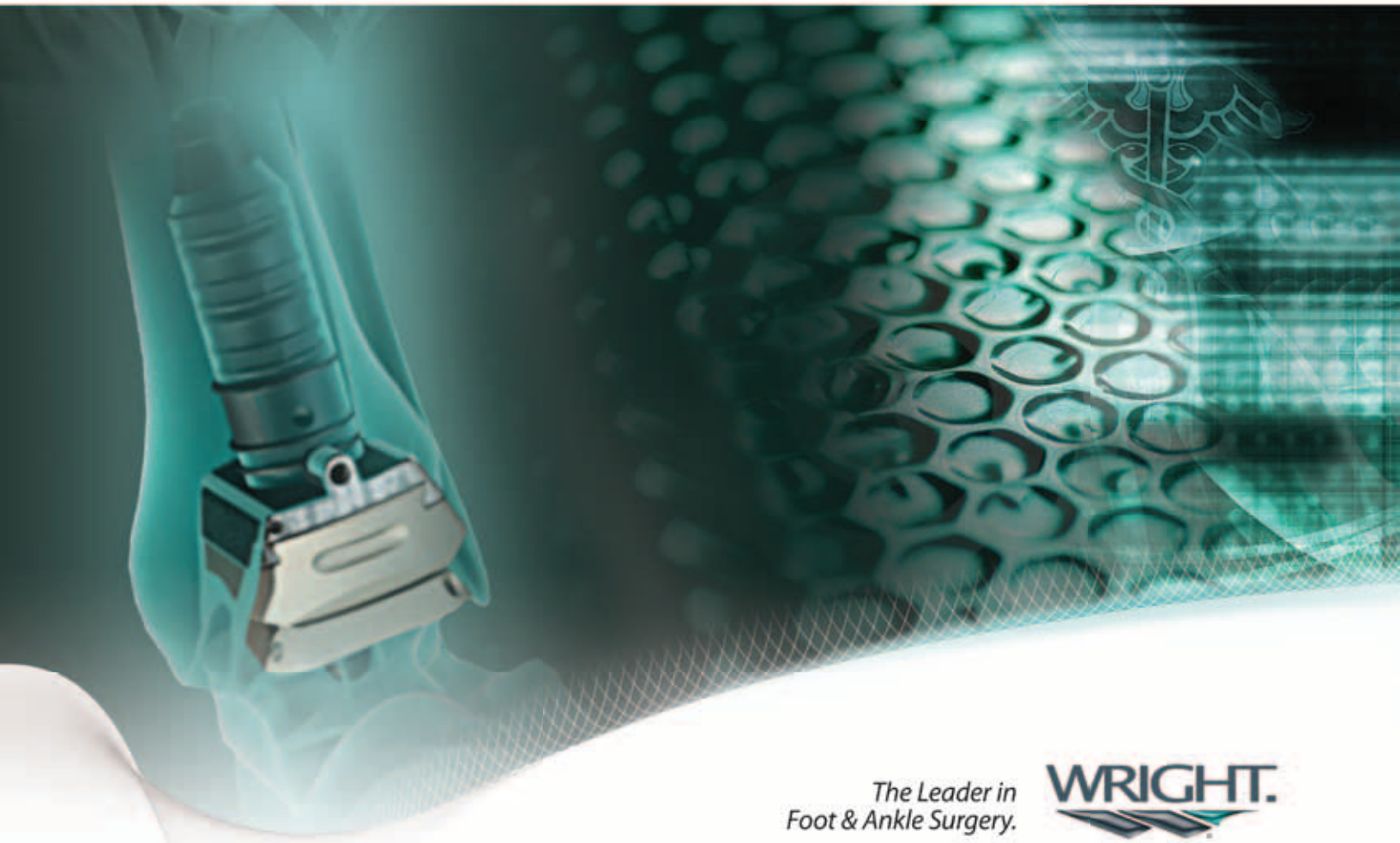
REIMBURSEMENT GUIDE



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For further information, visit
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INBONE® Total Ankle

*2013 Reimbursement Codes**

The following codes are representative of possible services or diagnoses that may be associated with use of Wright products. This is not a complete listing of possible codes. Not all of the codes are necessarily to be used together. Some codes may be considered a component of another ('bundled'). Final determination of the correct coding for services performed are made by the claims submitter/provider ONLY.

HCPCS Level II

HCPCS Code	Description
C1776	Joint device, implantable
L8699	Prosthetic implant, not otherwise specified

CPT® Code

In 2008, fracture management codes were revised with removal of the terms "with or without" and "or external" and insertion of the phrase "includes internal fixation, when performed" to indicate that when external fixation is performed in addition to the listed procedures, it is reported separately.

Procedure coding and reporting of internal fixation are to be used only when internal fixation is not already listed as part of the basic procedure.

CPT Code	Description	RVU Fac	RVU Ofc	ASC	APC
27702	Arthroplasty, ankle; with implant (total ankle)	28.91	N/A	In-pt only	In-pt only

ICD-9 Diagnostic Code

ICD-9 Diagnosis Code	Description
715.17	Osteoarthrosis, localized, primary, ankle and foot
715.27	Osteoarthrosis, localized, secondary, ankle and foot
716.17	Traumatic arthropathy, ankle and foot
V43.66	Joint, ankle, replaced by other means

Inpatient Hospital Data

MS-DRG Code	Description
469	Major joint replacement or reattachment of lower extremity w/MCC
470	Major joint replacement or reattachment of lower extremity w/o MCC

ICD-9 Procedure Code	Description
81.56	Total ankle replacement

* Medicare Physician Fee Schedule (MPFS) facility and non-facility relative value amounts published in the January 2013 revised relative value file, linked at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files-Items/RVU13AR.html. Hospital Outpatient Prospective Payment System payment rates published in the January 2013 HOPPS addenda update, linked http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates-Items/January-2013-addendum-B.html. Ambulatory Surgical Center payment rates published in the January 2013 ASC addenda update, linked at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html.

INBONE® Total Ankle Procedures

Pre-Certification and Appeal Guide

Total ankle joint procedures have been performed utilizing various types of implants for over twenty years. As with all health care procedures, total ankle joint replacements are subject to the terms, conditions and stipulations of the individual health insurance plan covering the patient. The following information outlines guidance to assist patients and providers of health care services supply insurance carriers with the information to make appropriate coverage determinations. Applying these guidelines may assist in obtaining, but never guarantee, coverage and payment for services.

Pre-Certification/Prior-Authorization/Pre-Determination

These processes are a cost containment feature of many group medical policies whereby the insured must contact the insurer prior to a hospitalization or surgery to receive authorization for the service. Under some health plans, individuals are required to receive advance authorization of particular medical services. Such advance authorization is called "pre-authorization" or "pre-certification." Depending on the type of plan the patient has, the provider (physician, hospital, etc.) may request this authorization or the patient may be required to do so.

As with all surgical procedures, an inquiry to the patient's insurance plan should be made to determine the individual requirements for benefit coverage. Requirements may vary from plan to plan and may include pre-determination and/or prior authorization processes. Remember, this process DOES NOT guarantee payment. All payers, including Medicare, reserve the right to make a determination regarding payment at the time the claim is received and processed.

Steps for the Prior Authorization Process

1. **Collect Information**
   - Patient name
   - Patient birth date
   - Insured name and birth date
   - Insured ID Number
   - Employer of Insured
   - Facility/Clinic where surgery will take place
   - Identify all ICD-9 diagnosis and CPT® codes (e.g. 27702 for total ankle with implant)
2. **Contact Insurer**
   - Verify benefits and eligibility
   - Verify coverage for the total ankle arthroplasty (total ankle)
   - Determine insurer's requirements for prior authorization

Verbal authorization may be given based on the above information. Make note of any authorization number so this may be reflected on the claim. Request a written authorization as this is preferred.

Pre-Certification/Prior-Authorization

You may need to provide the following documentation:

- A Letter of Medical Necessity
- Patient records
- The insurer may want more information on the total ankle procedure. Provide a clinical summary and journal articles.
- State why this patient is not a candidate for ankle fusion.

3. **Send Requested Information**
   - Gather the requested material, and fax or mail it to the person or department responsible for the prior authorization decisions. If additional educational materials on the procedure are needed, please contact your Sales Representative.
4. **Follow up**
   - Continue to follow up with the insurer until a coverage decision has been made. Asking the patient to get involved is very helpful, as they are the insured.
5. **Re-Verify Eligibility**
   - When prior authorization is granted, re-verify the patient's eligibility to ensure that the patient is still covered under that particular insurer.
6. **Appeal**
   - The most effective appeals are those that involve both the physician and the patient.
   - If authorization is denied, an appeal should be submitted immediately.
   - Determine the insurance company's requirements for an appeal.
   - Obtain the patient's authorization to appeal on their behalf if necessary.
   - Follow the guidelines contained in "Elements of an Effective Appeal."

Appeal Process

Should a denial at the pre-determination, prior authorization or processed claim level occur, an appeal should be submitted as soon as possible. The following information is provided as guidance to affect positive coverage decisions. For total ankle procedures, attaching clinical article references or hard-copies will be beneficial to the reviewer:

Elements of an Effective Appeal Letter

The appeals process is the way that health plans review medical necessity denials. It can be time consuming to appeal, but do not give up or the denial stands. There is always a chance the denial will be overturned.

To present an effective appeal, remember these four basic steps:

1) Read and understand the health plan's denial letter.

2) Write a letter that addresses the points raised by the health plan's denial letter.

3) Include any attachments that support the points raised in the appeal.

Many health plans now require that the appeal be submitted by the patient or the insured only. However, it is possible to receive an "Authorization to Appeal" from the patient so that you may submit the appeal on behalf of the patient. Some plans provide a special form for this.

4) The health plan must receive an appeal letter before the filing deadline. Send the appeal letter by certified mail, return receipt requested in order to receive proof of a timely delivery

Step One
Find the information you need in the denial letter.

Most denial letters follow a similar pattern. They are filled with language that is legally required to appear in them. To help cut through the red tape, here is a description of language that might be found in a letter of denial.

Claim Information: This typically includes the patient's name, the service requested, a number used by the health plan to identify the patient or case, the provider, and dates of service or requested procedure/treatment.

Introduction: It will explain the request was denied.

Medically Necessary: Often health plans include this definition. This is generally not the specific reason for denial. Keep looking for something that specifically applies to this case.

Right to Request Information: Keep in mind to request a copy of the criteria that they used to make the decision.

Description of the Appeals Process: This section provides a long explanation of what the next level of rights will be.

IMPORTANT: This is where the time frame parameters to submit an appeal and the address where to mail it appear. This section also outlines the External Review Program and the possible rights under ERISA, a Federal law. These are rights that may be pursued after all appeal rights with the health plan have been exhausted.

Reason for Denial: This is the reason for the letter. This can appear at the end, middle or beginning of the letter. It is usually only a paragraph or two that can be identified by referencing the patient's specific condition and health records and the health plan's comparison of that to their medical criteria or policy. It is usually plugged into a template and may sound different than the rest of the letter. This section explains the questions or hesitations the health plan has about the case that you will need to answer in the appeal.

Step Two
Write an appeal letter that addresses the issues in the health plan's denial letter.

To most effectively write an appeal letter, follow these steps:

A: Make sure the deadline has been met. Do not wait too long, or the appeal right will be forfeited.

B: Gather all the paperwork that is needed to write the letter.
For example:
- Denial letter
- EOBs (Explanation of Benefits)
- Health plan handbooks and contracts
- Receipts and bills
- Supporting published materials that may be utilized to support the procedure/product.
- The health plan's medical policy that applies to the issue

C: Review the denial letter again. Try to figure out if the plan missed something important. Did the plan review all the information provided? Was the recommended treatment not covered by the plan? The issues raised by the health plan must be addressed in the letter.

D: Start writing. The letter should have an introduction that clearly states what you want, a body that explains why you want it and an ending that again tells the plan what is expected as the outcome.

STATE CLEARLY THE REQUEST:

1) Name the service or procedure for which coverage is requested.

2) Be specific about the outcome or decision being requested. Do not expect the plan to look up information. Provide them all they need in the letter.

3) Be sure to put the policy holder name, policy number and phone number on each page of the letter.

STATE THE WHY:

If the health plan states in their Corporate Medical Policy that A, B, C and D must be tried first, then make sure A, B, C and D have been tried. Next, tell the health plan what has been tried and whether or not it helped. Support the description with medical records to show how A, B, C and D have been tried. Leaving out important information may delay a response or even result in a denial.

1) Tell the plan your patient's medical history before and after the start of the disease. The health plan needs to know how the disease affects the patient's daily life. Describe how the disease affects the patient's ability to stand, sit or walk for a long period or to lift or carry weight. Don't forget to include any other physical limitations that the patient may have.

2) List any exams and lab tests that were done to identify the disease.

3) Don't forget to tell the health plan about treatments that you have recommended and/or the results of any treatments that have been tried. Make sure you outline to the health plan any improvements that have been noted since treatment began.

4) In a sentence or two explain what will happen if the patient does not have the treatment or procedure.

5) If possible, to the exact page of the member handbook or contract, or the health plan's medical policy that applies to the patient.

6) Many times treatment that is costly in the short-term may cost the plan less over time, and the plan may not save money in the long run by not authorizing treatment. If this is the case, also outline this information in the appeal.

7) Discuss any experience with same or similar treatments with other patients. Expound upon the physician's personal experience in the field and with the specific treatment.

AT THE END OF THE LETTER IN ONE BRIEF SENTENCE TELL THE HEALTH PLAN AGAIN WHAT IS EXPECTED THAT THE PLAN WILL DO.

Remember – It is important to demonstrate why the patient needs the medical service. Do not rely on the health plan to ask for or find information themselves.

Many health plans will allow you to attend or participate in the Level II appeal hearing either in person or via teleconference. You should consider presenting your appeal in person or via telephone as another way to present your position.

Step Three

Choose attachments that support the points raised in the appeal.

When writing an appeal letter to a health plan, it isn't enough to just send in a letter telling the plan that the treatment should be covered. The health plan uses evidence-based Corporate Medical Policies and/or clinical guidelines and policies to make decisions. It is important to use similar information to provide a reason why the plan should cover the treatment.

Health insurance benefits are generally restricted to treatments which have been proven to be similar to or better than conventional treatments currently being used by the medical community. Even when scientific evidence shows the value of a treatment (e.g., it prevents or lessens the disease at least as effectively as the current recognized standard of care), health plans may not agree to pay for it. Any treatment the safety of which has not been recognized by the general medical community may be considered experimental and/or investigational (unproven) and will likely not be covered by the health plan.

The health plan does not have to pay for all treatments or procedures that a medical provider recommends. Plans will only pay for treatment as outlined in the insurance contract/benefit booklet.

To provide the health plan with documentation that supports the appeal letter, attach well researched medical information.

Here are some types of information that may be beneficial in the appeal:

Doctors' Opinions – Elaborate on personal experience and whether or not the treatment is considered the 'standard of care.'

Medical Journal Articles - Include articles about specific conditions or treatments that support the letter. These articles must be peer-reviewed scientific studies that meet nationally recognized standards. These articles should have been reviewed by experts who are not part of the editorial staff or those who get paid by companies that benefit from the study results. Sources can be found in the National Institute of Health's National Library of Medicine or The Cochrane Library. Information can also be located on-line at http://medlineplus.gov/or www.WebMD.com.

Treatment Studies or Clinical Trials - Include studies that measure the results of the type of treatment that is sought. When a health plan considers a request for a treatment that is new or requires the latest technology, "randomized" or "controlled" studies are often important to the coverage decision. "Randomized" trials compare groups of people who receive specific treatment to groups who do not. An "Observational" study, on the other hand, only looks at people who received the treatment. Observational studies may be less convincing sources of information for the plan to consider.

Medical Guidelines - Government agencies, specific medical specialty organizations and other specialty groups sometime develop "consensus statements" or "treatment guidelines" that may provide valuable information to support the appeal. Also, the health plan may have medical policies to determine how a particular condition can be most effectively treated. Ask the health plan for a copy.

Medical Reference Books – it may be helpful to include information from a standard medical reference book, such as The American Hospital Formulary Service-Drug Information, The AMA Drug Evaluations, The ADA Accepted Dental Therapeutics, or The US Pharmacopoeia Drug Information.

State and Federal Laws - Do not forget to include any state and federal laws that may require the health plan to provide certain services.

Photos - A picture can often show what words can not. If possible, include copies of photos or videos to show the effects of the disease for the specific patient.

Step Four

Send the appeal letter before the deadline by certified mail, return receipt requested.

1) Pay close attention to all deadlines listed in the denial letter. If the appeal falls outside of the time frame, the right to appeal has been lost.

2) When submitting the letter to the health plan, send it certified mail, return receipt requested. Make sure you keep the green receipt to verify that the health plan received the appeal letter.

3) Always send copies of all the paperwork and keep originals in a safe place.

What if the claim is still denied?

Throughout this process, it is important to remember that even if the plan denies the initial appeal, there typically is a level two appeal where a request to present your case to a new group of professionals who are not employed by plan is available.

Even if again the appeal is denied at level two and the health plan's internal appeals process has been exhausted, there still may be entitlement to an external or independent review through the State Department of Insurance.

Disclaimer

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