**PREDETERMINATION**

Predetermination is a process established by health plans that allows a physician to submit a treatment plan prior to surgery. The health plan reviews the treatment plan as well as the patient’s insurance benefit plan and medical policy to determine:

- if the treatment is covered
- if the patient is a covered member
- the amount of copayments/coinsurance, deductibles, and the patient’s maximum benefits.

*This process is typically used to simply verify benefits, but it can be an effective tool to use with health plans for new technologies for which you expect coverage to be an issue.*

**Predetermination Process**

*Planning Your Predetermination Benefit Strategy*

Be Proactive: Determine if the surgical procedure and technology you plan to use are covered under your patient’s benefit plan.

Predetermination reviews vary between insurance plans, with varying timelines and requirements. But in general the predetermination process, if available, allows the health plan to determine if the patient’s plan covers the surgery. If the implants are considered “new technology”, the predetermination process can provide a mechanism for the plan’s Medical Director to review it and determine if the technology is covered. If the health plan or Medical Director reviews this information and decides the technology is covered and medically necessary, you should not encounter significant problems obtaining an authorization.

Here is a list of tasks to help you develop a predetermination packet:

- Request the predetermination of benefits process or requirements from the patient’s insurance plan
- Obtain the name of a contact person
- Verify the health plan’s mailing address
- Obtain the Medical Director’s name, phone number and specifically ask the Medical Director to review your request. (See sample letter.) [Note: A Medical Director’s review may eliminate some of the difficulties you might encounter during the preauthorization process, especially if you are requesting use of a new technology. The Medical Director will often provide guidance about what additional information may be needed.]
- Obtain published studies from the Zimmer Reimbursement Hotline representative to support your request
- Be an advocate for your patient: describe how the technology can benefit this specific patient
Include surgeon’s availability, contact information and willingness to speak with the Medical Director about this matter

The Predetermination Request

*Compose a letter of medical necessity addressed to the Medical Director*

- Patient information — name, date of birth, policy number
- Details of the patient’s medical history
  - Current diagnoses, billing codes, and reason for treatment
  - Duration and degree of illness and injury
  - Summary of past failed treatments (i.e., conservative care or other surgical interventions)
  - Description of the patient’s current condition and treatment plan
    - Ability to work
    - Activities of daily living
- Proposed procedure(s), technology (medical device/implants if applicable) and rationale for treatment
- Proposed location of service and dates planned
- Summary of the clinical evidence supporting your treatment plan including comorbidities

Additional Elements to Include with Your Predetermination Request

- Published studies supporting your treatment plan
- Product information
- FDA approval letter (helpful in certain situations; e.g., new technologies)
- Copy of the patient’s insurance card
- Physician dictation regarding patient’s history and current medical condition
- Results of diagnostic tests

Once the predetermination request is complete, submit it to the health plan. If you have not received a response within 30 days, follow up with the health plan by phone.