Zimmer®
Computer-Assisted Surgery
Reimbursement Kit

Effective April 1, 2012
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### Computer-Assisted Surgery Reimbursement Kit

The **Zimmer** Computer-Assisted Surgery Reimbursement Kit is intended to provide reference material related to general guidelines for the reimbursement for optical navigation when used consistently with the product’s labeling. The Reimbursement Kit includes information regarding coverage, coding and payment as well as guidance regarding insurance verification, prior authorizations and appeals.

Zimmer offers additional reimbursement resources and tools for orthopedic products and procedures including the Zimmer Reimbursement Hotline, which provides live coding information via dedicated reimbursement specialists.

Hotline support is available 8 am to 5 pm Eastern Time, Monday through Friday at (866) 946-0444.

All Zimmer reimbursement resources are also available on our web site:

[www.reimbursement.zimmer.com](http://www.reimbursement.zimmer.com)

### Zimmer Computer-Assisted Surgery

#### Product Information

**Zimmer** Computer Assisted Surgery (CAS) also known as Surgical Navigation is defined as a surgery that is performed using a computer as a guiding and validation tool. CAS techniques combine advanced computer technology with a surgeon’s skills to help improve the outcomes of knee and hip arthroplasties. The system provides precise positional guidance when removing damaged surfaces of bones, based on a patient’s anatomy, and suggests the appropriate implant size to be used and helps to determine its correct positioning.

#### Computer Assisted Solution

When it comes to performing arthroplasties, Zimmer CAS believes that Computer Assisted Surgery should not limit your surgical flexibility. The versatile navigation system is designed to improve surgical precision and efficiency.

#### Indication for Use/Intended Use

The **ORTHOsoft**® Knee Universal system is indicated for use as a stereotaxic instrument to assist in the positioning of Total Knee Replacement components intra-operatively. It is a computer controlled image-guidance system equipped with a three-dimensional tracking sub-system. It is intended to assist the surgeon in determining reference alignment axis in relation to anatomical landmarks, and in precisely positioning the alignment instruments relative to this axis by displaying their locations.
Payer Coverage

Coverage defines what services and procedures payers will reimburse. Coverage is usually delineated in medical policies, and is payer-specific. Payers, including the Centers for Medicare and Medicaid Services (CMS), Medicare Part A Fiscal Intermediaries, Part B Carriers, Medicare Administrative Contractors (MACs) and private payers, may have different coverage policies for the same procedure. Each payer determines their own coverage policies.

Total Knee Arthroplasty (TKA) is a widely accepted procedure and it becomes an integral part of the surgical procedure that should not require special payer coverage consideration beyond that normally required for the TKA procedure itself. Coverage policies can vary by payer, and providers should contact payers directly to clarify coverage policies and medical guidelines. Similarly, prior authorization requirements for TKA or imaging services can vary by payer, so providers should also contact their payers directly for information specific to their prior authorization requirements.

Should a payer establish a non-coverage policy for TKA, it may still be possible to obtain coverage on a case-by-case basis. A clinical determination of medical necessity will be required of the healthcare professional (HCP), and might necessitate peer-to-peer discussions between the treating physician and the payer’s medical director.

A self-insured group health plan (also known as a self-funded plan) is one in which the employer assumes the financial risk for providing healthcare benefits to its employees. Self-insured group health plans come under all applicable federal laws, including the Employee Retirement Income Security Act (ERISA). Providers should contact and confirm coverage through the employer and/or the third-party administrator. Patients that are covered under a self-insured employer’s health plan might not be subject to a payer’s non-coverage policies in the same manner as that payer’s commercially-enrolled members.

While major joint replacement procedures (i.e., TKA or THA) are typically covered, many payers identify computer assisted navigation or computer assisted surgeries as experimental and/or investigational and therefore not covered. Procedures employing CAS tools may or may not be covered by your payer. Zimmer suggests that your check with your payer or do a prior authorization of the service to determine if the primary procedure will be covered even if the payer considers CAS investigational.

The Federal Employee Program (FEP) which is a part of the Federal Employees Health Benefits Program (FEHBP) may dictate that a drug, device or biological product approved by the U.S. Food and Drug Administration (FDA) may not be considered investigational and therefore, coverage eligibility may be assessed on the basis of medical necessity. Contact the FEP to confirm coverage and guidelines for TKA.

Because payer coverage requirements and navigating the authorization and appeal processes can vary among payers, the remainder of this reimbursement kit provides guidance regarding typical payer processes including insurance verification; prior-authorization and appealing denied claims. The guidance provided in this reimbursement kit might help HCPs navigate case-by-case coverage for using Zimmer Computer-Assisted Surgery in TKA.
Insurance Verification Process

Eligibility and Benefits Verification

Understanding and verifying a patient’s insurance eligibility and benefits is a critical process prior to treatment. The eligibility and benefits verification process involves the following three steps:

1. Verifying the patient’s insurance eligibility and benefits prior to treatment by contacting the payer’s provider line number that appears on the patient’s insurance card
2. Checking with the payer regarding any patient payment responsibilities, including co-payments, deductibles, co-insurance and any other out-of-pocket expenses prior to and post treatment
3. Informing the patient of their payment responsibilities at the time of appointment scheduling. This step is beneficial to both the patient and the HCP. It helps the patient decide on the course of treatment and the HCP to avoid last minute cancellations

It is important to gather and document information during the insurance verification process for future reference, especially insurer contact information, the patient’s financial responsibilities and prior-authorization approval numbers. (See Sample Insurance Verification Form on page 7 and the Insurance Verification Process Flowchart on page 8).

Information that should be obtained from the insurer and documented for future reference

- Name of insurance representative, including phone number and extension
- Note date and time of call
- Patient’s health plan effective and/or termination date
- Type of health plan (HMO, PPO, POS, etc.)
- Patient’s financial responsibilities (i.e. co-payment, deductible, out-of-pocket expense)
- In- and out-of network benefits – this information is important to know because if the treating physician is an out-of-network provider and the plan does not allow out-of-network provider services, the patient may have to seek an in-network provider to perform the procedure. Not knowing this information could lead to a claim denial
- Verification of medical benefits for treatment
- Prior-authorization requirements, if any, including contact information (contact name, telephone, fax number)
- Referral requirements, if any, including telephone number and fax number to submit a signed and dated referral from the primary care physician or other referring physician
Sample Insurance Verification Form

PATIENT INFORMATION

___________________________
Patient Name

_________________________
Patient Address

_________ __________ ________
City Street Zip

_________________________
Home Phone No. Work Phone No

_____________
Social Security No Date of Birth

M______ F______

Diagnosis:

_________ __________ ________
Applicable ICD-9-CM Diagnosis code(s)

_________ __________ ________
Anticipated CPT Code(s) for Procedure(s):

PATIENT INSURANCE INFORMATION

__________________      _________      ___________
Primary Insurance Co Policy No Group No

_________________________
Primary Insurance Phone No.

_________________________
Subscriber’s name Date of Birth

_________________________
Subscriber’s Relationship to Patient

_________________________
Secondary Insurance Co Policy No Group No

_________________________
Secondary Insurance Phone No

_________________________
Subscriber’s Name Date of Birth

_________________________
Subscriber’s Relationship to Patient

Anticipated CPT Code(s) for Procedure(s):

PATIENT ELIGIBILITY AND BENEFITS INFORMATION

Effective Date of Coverage: _____________________________

Coverage Terminated? Yes ☐ No ☐ Date: ____________

Plan Type: ☐ HMO ☐ PPO ☐ POS Other: __________

In-Network Benefits: $ _______________________________

Co-Payment

$ ____________ $ ____________

Deductible Has Deductible Been Met? Yes ☐ No ☐

$ ____________ $ ____________

Co-insurance Other Out-of-Pocket Expense

Benefits for Treatment? Yes ☐ No ☐

Is a Referral Necessary? Yes ☐ No ☐

Is Prior-Authorization Required? Yes ☐ No ☐

Out-of-Network Benefits? Yes ☐ No ☐

Out-of-Network Financial Responsibilities? Yes ☐ No ☐

INSURER INFORMATION

Call Date: ____________ Time of Call: ____________

_________________________
Name of Insurance Rep Phone No / Ext

_________________________
Prior-Authorization Phone No Fax No

_________________________
Prior-Authorization Contact Name

_________________________
Prior-Authorization Approval No

_________________________
Referral Phone No Fax No

_________________________
Referral Contact Name

Notes: ___________________________________________

______________________________________________

Insurance Verification Process Flowchart

Make a copy of the front and back of the patient’s insurance card.

Call the telephone number provided on the back of the patient’s card “to verify coverage.” This is usually a 1-800 number.

Ask the eligibility and benefits insurance representative these questions:

- Does the patient have an effective health plan with the insurance carrier?
- If terminated, what is the termination date?
- Does patient have new insurance card?

**NO**

What is the effective date of coverage?

Under what type of plan is the patient covered (e.g., HMO, PPO, POS, etc.)

What is the patient’s co-payment responsibility?

Does the patient have a deductible? If yes, how much is the deductible and how much of the deductible has been met?

Does the patient have other out-of-pocket expenses? If so, how much?

Is the HCP an in-network provider?

Does the patient have out-of-network benefits?

Contact patient with results of insurance verification.

What is the prior-authorization dept. phone number? Who is my primary contact?

Does the referral have to be submitted to payer prior to rendering services?

Where do I submit the referral? (Get phone and fax number.)

**YES**

STOP

Legend

HCP & Staff Task

Questions from Insurance Verification Personnel to Payer. Note payer responses on the Insurance Verification Form (example form provided in Reimbursement Kit)

Contact patient to schedule an appointment.

STOP

STOP
Prior-Authorization Process

Medicare

The Medicare program does not provide prior authorization, prior approval or a predetermination of benefits for any services. General coverage guidelines for many services can be found using the Medicare Coverage Database. The database is maintained by CMS and is located on their web site at [http://www.cms.hhs.gov/mcd/overview.asp](http://www.cms.hhs.gov/mcd/overview.asp) In the absence of a local or national coverage determination, the local Medicare Administrative Contractor (MAC) or carrier will determine whether coverage is available for a service on a case-by-case basis.

An HMO Medicare Advantage program most likely will require prior-authorization of specified services, such as TKA. Please verify prior-authorization guidelines with the payer.

Private Payer

The requirements of private payers for prior-authorization vary. Certain payers may require healthcare professionals to submit specific patient information for medical review. It is important to become familiar with each payer’s prior-authorization guidelines. (See Prior-Authorization Process Flowchart on page 10).

Prior-authorization means that the insurer has given approval for a patient to receive treatment, a test or surgical procedure before it has actually occurred. A prior-authorization approval does not guarantee payment.

To prior-authorize a procedure before services are rendered, provide the following information to the payer’s prior-authorization department:

- Diagnosis code(s)
- Procedure (CPT*) code(s)
- Description of the procedure
- Product-specific description, if required
- Any additional information requested by the prior-authorization department related to the patient’s condition and procedural clinical evidence

A written prior-authorization request may be required by the payer. (See Appendix A: Sample Letter of Prior Authorization and Medical Necessity). This requirement may vary by payer. Some insurers may require the submission of their own prior-authorization request form or a letter from the treating physician (See Appendix B: Sample Letter of Medical Necessity). The prior-authorization request should include the following detailed information about the patient’s medical condition and the reason for the patient to undergo treatment:

- The patient’s medical condition with exact diagnosis and symptoms associated with the disease
- The medical necessity for the treatment and what health problems may occur if the patient does not undergo the procedure
- What other treatments or services the patient has already had, if any, and why these alternative treatments did not alleviate the symptoms
- A description of the treatment
- Why the procedure is the most appropriate treatment for the patient’s condition

Typically, most payers will respond with a decision within 30 days. The health plan is required to provide a clinical reason for their decision, and whether they are approving or denying the request. If the prior-authorization is approved, document the approval number in the patient’s chart should any questions or reimbursement issues arise at a later date.

Workers’ Compensation

Workers’ compensation insurance provides compensation for employees who are injured during the course of employment. It provides reimbursement for medical expenses. Workers’ compensation benefits are administered on a state level, typically with oversight by a state governing board overseeing varying public/private combinations of workers compensation systems, and under the jurisdiction of a state’s Department of Labor.

Workers’ compensation prior-authorization rules are state-specific. Please contact your local workers’ compensation carrier for a list of services that require prior-authorization as well as state-specific instructions.

Prior-Authorization Process Flowchart

HCP prescribes treatment.

**Conduct Verification of Eligibility & Benefits**
See Insurance Verification Process

Is the patient eligible?

**NO**

STOP

**YES**

**Prior-Authorization Process**
- Contact prior-authorization department.
- Complete written prior-authorization request form or prior-authorization letter (sample letter provided in Reimbursement Kit).
- Provide the following to the prior-authorization department: diagnosis code(s), CPT* Code(s), description of procedure, product specific description.
- Provide any additional information requested by the prior-authorization department or utilization review nurse.
- Record contact information of the insurance representative including: name, telephone, extension, fax number, and note date and time of call.

Is the prior-authorization approved?

**NO**

Appeal prior-authorization denial?

**STOP**

**YES**

HCP treats patient.

HCP submits claim to payer.

Is payment received?

**NO**

Proceed to payment appeals process.

**YES**

STOP

**Appeal Level 1**
- Obtain copy of denial letter from payer or patient (letter contains instructions and contact information).
- Contact payer for clarification of instructions if necessary or if denial can simply be corrected by providing information over telephone.
- Speak to utilization review nurse and/or medical director to address reason for denial, if possible.
- Provide the following documentation to the appeals department:
  - Letter of Medical Necessity (sample letter provided in Reimbursement Kit)
  - Clinical notes
  - Description of procedure
  - Product-specific description and clinical information
- See payer communication process

Is Appeal Level 1 approved?

**NO**

Appeal prior-authorization denial?

**STOP**

**YES**

Payer Communication Process
- Follow up with payer contact 10-15 days into the process to check status.
- Follow up with payer contact 20-30 days into the process to check status.
- Continue follow-up until final determination. Most payers will respond with a decision within 30 days.

**Appeal Level 2**
- Obtain copy of denial letter from the payer or patient.
- HCP may request peer-to-peer telephone conversation with payer medical director. Call the number on denial letter for instructions.
- Provide the following documentation to the payer appeals department:
  - Letter of Medical Necessity (submit additional clinical data documenting patient’s condition and necessity for treatment not previously mentioned to previous correspondence to payer)
  - Additional clinical notes to clarify why treatment is best option for patient
  - Additional clinical data to clarify treatment
- See payer communication process

Is Appeal Level 2 approved?

**NO**

Appeal prior-authorization denial?

**STOP**

**YES**

**Appeal Level 3**
- Obtain copy of denial letter from the payer or patient.
- Appeal Level 3 typically includes a review from an external medical director.
- Request a peer-to-peer telephone conversation with the external medical director. Call phone number on the denial letter for further instructions.
- May require additional clinical data not previously submitted to clarify procedure.
- May require additional clinical notes not previously submitted to clarify patient’s condition and medical necessity.
- See payer communications process.

Is Appeal Level 3 approved?

**NO**

STOP

**YES**

Patient Action:
If all levels of prior-authorization appeals have been denied by the payer, the patient has options in order to obtain treatment:
- The patient may choose to pay out-of-pocket for the procedure
- If the patient is insured under a self-funded (self-funded) health plan, the patient may seek authorization through the employer
- Patient contacts Department of Labor
- Patient contacts State Insurance Commissioner

Coding Guidance for Zimmer Computer-Assisted Surgery

The following section contains coding guidance for Zimmer Computer-Assisted Surgery. The coding guidance is intended to illustrate the CPT codes, ICD-9 procedure codes, MS-DRG assignment and HCPCS codes commonly used to describe procedures associated with total knee arthroplasty. This guidance is not intended to be all-inclusive and the listed codes may not be applicable in all cases.

Please note that the following reference pages do not contain payment information. Individual payment rates will vary by payer contract. Contact your payers for actual payment rates.

Common Physician Procedure Codes for Knee Arthroplasty Surgical Procedures

<table>
<thead>
<tr>
<th>CPT* Code</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>27447</td>
<td>Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (TKA)</td>
</tr>
</tbody>
</table>

The following procedure codes may apply to Computer-assisted surgery

<table>
<thead>
<tr>
<th>CPT* Code</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>20985</td>
<td>Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>0054T</td>
<td>Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on fluoroscopic images (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>0055T</td>
<td>Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on CT/MRI images (List separately in addition to code for primary procedure)</td>
</tr>
</tbody>
</table>

* Current Procedural Terminology (CPT) is copyright 2011 American Medical Association. All rights reserved.
Common INPATIENT Hospital Billing Codes for Knee and Hip Arthroplasty Surgical Procedures

The following ICD-9 procedure codes describe procedures associated with total knee arthroplasty procedures.

<table>
<thead>
<tr>
<th>ICD-9-CM Procedure Codes</th>
<th>Code Description</th>
<th>Common Medicare MS-DRG Assignment</th>
</tr>
</thead>
<tbody>
<tr>
<td>00.31</td>
<td>Computer assisted surgery with CT/CTA</td>
<td></td>
</tr>
<tr>
<td>00.32</td>
<td>Computer assisted surgery with MR/MRA</td>
<td></td>
</tr>
<tr>
<td>00.33</td>
<td>Computer assisted surgery with fluoroscopy</td>
<td></td>
</tr>
<tr>
<td>00.34</td>
<td>Imageless computer assisted surgery</td>
<td></td>
</tr>
<tr>
<td>00.35</td>
<td>Computer assisted surgery with multiple datasets</td>
<td>Additional procedures that might be coded along with the above procedures, if applicable</td>
</tr>
<tr>
<td>00.39</td>
<td>Other computer assisted surgery</td>
<td></td>
</tr>
</tbody>
</table>
Payment for Non-Covered Services

Medicare and some private payers will allow the HCP to seek and collect payment from beneficiaries for non-covered services as long as the HCP first obtains the beneficiary’s written consent (See Sample Medicare Advance Beneficiary Notice on page 14 and Sample Consent to Pay for Non-Covered Services on page 15). Obtaining this consent helps protect the HCP’s right to collect and bill the patient for services rendered when it is unknown whether or not the payer will provide coverage for the procedure. The consent must be signed and dated by the patient or legal guardian prior to the provision of the specific procedure(s) in question.

The consent must include in writing:

- The name of the procedure(s) and/or supplies requested for treatment
- An estimate of the charges for the procedure(s)
- A statement of reason why the healthcare professional believes the procedure(s) may not be covered
- A statement indicating that if the planned procedure(s) are not covered by the payer, the patient/member agrees to be responsible for the charges

If the HCP does not obtain written consent, the HCP must accept full financial liability for the cost of care. General agreements to pay, such as those signed by patients at the time of an office visit, are not considered written consent. A copy of the signed written consent form must be retained in the patient’s medical records should questions arise at a later date.
Sample Medicare Advanced Beneficiary Notice

CMS implemented the use of the revised Advance Beneficiary Notice of Non-Coverage (ABN) (Form CMS-R-131) on March 3, 2008. This form replaces the General Use ABN (CMS-R-131-G). The form and notice instructions are posted on the CMS Beneficiary Notice Initiative web page. The form was revised on June 20, 2011 with the latest version of the ABN (with the release date of 3/2011 printed in lower left hand corner) [http://www.cms.gov/BNI/02_ABN.asp](http://www.cms.gov/BNI/02_ABN.asp)

<table>
<thead>
<tr>
<th>A. Notifier:</th>
<th>B. Patient Name:</th>
<th>C. Identification Number:</th>
</tr>
</thead>
</table>

**Advance Beneficiary Notice of Noncoverage (ABN)**

**NOTE:** If Medicare doesn’t pay for D. ________ below, you may have to pay.
Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. ________ below.

<table>
<thead>
<tr>
<th>D.</th>
<th>E. Reason Medicare May Not Pay:</th>
<th>F. Estimated Cost</th>
</tr>
</thead>
</table>

**WHAT YOU NEED TO DO NOW:**
- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. ________ listed above.
  **Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

**G. OPTIONS:** Check only one box. We cannot choose a box for you.

- **OPTION 1.** I want the D. ________ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn’t pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
- **OPTION 2.** I want the D. ________ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.
- **OPTION 3.** I don’t want the D. ________ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

**H. Additional Information:**

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

<table>
<thead>
<tr>
<th>I. Signature:</th>
<th>J. Date:</th>
</tr>
</thead>
</table>

According to the Department of Education Act of 1994, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1150.

Form CMS-R-131 (03/11) Form Approved OMB No. 0938-0566
**Sample Consent Form for Commercial Patients**

This sample consent form may be used as a guideline when developing a consent form for patients with commercial insurance. Please consult your legal counsel for appropriate language and advice.

---

**Sample Consent to Pay for Non-Covered Services**

I, ______________________ (Patient’s Name), understand that the services and/or supplies listed below may not be considered eligible for benefits (e.g., services and/or supplies may be determined to be not medically necessary, non-covered or investigational) by ______________________________ (Health Insurance). I understand that my health insurance coverage has certain restrictions and limitations, such as prior-authorization requirements and non-covered service and/or supplies guidelines. By signing this form I understand that I am agreeing to pay for the services identified below if my insurer denies payment because the services are not medically necessary.

<table>
<thead>
<tr>
<th>Procedures/Services and/or Supplies Requested:</th>
<th>_________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason(s) Why Procedures/Services and/or Supplies May be Not be Covered:</td>
<td>__________________</td>
</tr>
<tr>
<td>Condition/Diagnosis:</td>
<td>_________________________________</td>
</tr>
<tr>
<td>Approximate Cost of Care:</td>
<td>__________ Date of Service:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient’s Printed Name</th>
<th>Member’s Insurance ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>______________________</td>
<td>____________________________</td>
</tr>
<tr>
<td>Patient’s Signature Date</td>
<td></td>
</tr>
<tr>
<td>______________________</td>
<td></td>
</tr>
<tr>
<td>Beneficiary or Legal Guardian Date</td>
<td></td>
</tr>
<tr>
<td>______________________</td>
<td></td>
</tr>
<tr>
<td>Witness’ Printed Name</td>
<td>Date</td>
</tr>
<tr>
<td>______________________</td>
<td></td>
</tr>
<tr>
<td>Witness’ Signature</td>
<td>__________________</td>
</tr>
</tbody>
</table>

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**Appealing Denials**

An appeal is a request for review of a denied claim or service. Claims may be denied for many reasons, including the result of health plan errors, inaccurate patient or claim information submission, and/or inaccurate coding or health plan coverage policy. Prior-authorization is typically denied because the payer could not determine the medical necessity and appropriateness of the proposed treatment, level of care assessment and/or appropriate treatment setting or the services are deemed experimental or investigational.

The reason for the denial can be found in the denial letter and/or the explanation of benefits (EOB). If a claim or service is denied, an appeal may be filed with the insurance carrier. (See Appeals Process Flowchart on page 18).

Depending on the payer, the level of appeal may be categorized as reconsideration, redetermination, grievance or an appeal. Each payer may have differing administrative requirements for each of these depending on their own definitions. Because payers have different appeal processes, we suggest contacting the payer directly to verify their appeal requirements.

Some payers have specific forms, phone numbers and addresses that must be used to submit an appeal. Please contact your payer to see if there is a specific appeal process that should be followed. Payer-specific guidelines for appeals may also be found online. If the payer has a standard appeal form, fill it out and submit it with all other supporting documentation that proves the need for coverage.

The following are some suggested questions to ask the insurance representative regarding their specific appeals process:

- Does the appeal request have to be completed by the HCP or the patient?
- Is there a particular form that needs to be completed?
- Can this form be faxed or mailed?
- If faxed, what is the fax number? If mailed, what is the appropriate address?
- Is a letter of medical necessity required?
- What is the time limit for requesting an appeal?
- When requesting a review of the denied claim or service, the request must meet the following requirements:
  - The request must be in writing
  - Include reasons why the denial is incorrect
  - Include any new and relevant information not previously submitted, such as the procedure dictation notes
  - Must be requested within the period of time allotted by the payer’s guidelines. Please be advised that the appeal guidelines and timeframes are provided in the letter of denial. If the denial letter is not readily available, contact the payer’s appeal department for instructions
If the payer does not have a required appeal form, submit an appeal letter (See Appendix C: Sample Prior- Authorization Appeal Letter and Appendix D: Sample Appeal Claims Denial Letter). The appeal letter should be tailored to the reason for the denial and may include a corrected claim, product information, patient medical information, clinical data, and/or economic data along with other supporting documentation.

CMS defines medical necessity as those services that are reasonable and necessary for the diagnosis or treatment of an illness or injury. The term medical necessity is usually used to determine whether or not a procedure or service is covered by CMS. The appropriate diagnosis, treatment and follow-up care plan, as determined and prescribed by the HCP, should fit the patient’s specific diagnosis. To establish medical necessity, the physician must clearly describe the condition(s) that justify the medical service provided.

The more complete and detailed an appeal is, the more successful it is likely to be. That is, the specificity of the medical necessity information and the documentation provided are keys to the success of the appeal. It is critical to the appeal process that the HCP attach any medical documentation that may support the medical necessity of the services being provided.

The supporting medical documentation listed below are examples of the types of information that may be submitted in order to support the claim for payment or a service for approval:

- Physician’s order
- Medical history
- Physician’s notes/nurse’s notes
- Procedure dictation notes
- Test results
- X-ray reports
- Consultation reports
- Plan of treatment
- Referrals
- Product information
- Specific reasons the physician believes that the use of Zimmer Computer-Assisted surgery is medically necessary
- Relevant clinical data
- List of conservative or alternative treatments that failed
- Discharge notes

If the claim or service is denied by the insurer's internal department and the intent is to continue the process of either obtaining a prior-authorization or appealing a denied claim, state-specific and payer-specific guidelines must be followed to elevate the appeal to a higher level. The type of insurance determines whether federal or state laws apply to the appeal process. If the plan is self-funded through an employer group then the Employee Retirement and Income Security Act (ERISA) applies and the Department of Labor has jurisdiction. If it is commercial insurance, state law applies and the state Division of Insurance (DOI) has jurisdiction.
Appealing Denials Process Flowchart

1. **HCP Receives Claim or Service Denial From Payer**
   - **Appeal Denial?**
     - **YES**
       - **Appeal Level 1 (Internal Review)**
         - Timelines to appeal are payer-specific. Contact the payer to confirm the timing requirements to file an appeal.
         - Obtain Explanation of Benefits (EOB) showing payment denial from payer or patient, or prior-authorization denial letter. (Both the EOB and the denial letter contain the reason(s) for the denial.)
         - Call payer appeals department for further instructions or clarification, if necessary.
         - Provide the following documentation to the appeals department.
           - Letter of Medical Necessity
           - Procedure Dictation Notes and Clinical Notes
           - Description of Procedure
           - Appropriate Coding
         - See payer communication process.
     - **NO**
       - **STOP**
   - **NO**
     - **Payment Received**
       - **YES**
         - **STOP**
       - **NO**
         - **Is Appeal Level 1 approved?**
           - **YES**
             - **Appeal Level 2 (Internal Review)**
               - Request copy of denial letter.
               - If necessary, contact payer appeals department for further instructions or clarification.
               - Request instructions for a peer-to-peer conversation with medical director.
               - Provide additional medical notes not previously submitted to demonstrate medical necessity (if available).
               - Provide additional clinical data not previously submitted for clarification (if available).
               - Timeline varies by payer.
               - See payer communication process.
           - **NO**
             - **STOP**
         - **NO**
           - **Is Appeal Level 2 approved?**
             - **YES**
               - **Appeal Level 3 (External Review)**
                 - Request copy of denial letter.
                 - Contact the payer appeals department for instructions for an external appeal. These instructions will vary by payer.
                 - Request instructions for a peer-to-peer conversation with medical director.
                 - Provide additional clinical notes and data not previously submitted as requested by medical director.
                 - Timeline and authorization varies by payer.
                 - See payer communication process.
             - **NO**
               - **STOP**
         - **NO**
           - **Is Appeal Level 3 approved?**
             - **YES**
               - **STOP**
             - **NO**
               - **STOP**

2. **Payer Communication Process**
   - Follow up with payer contact 10-15 days into the process to check status.
   - Follow up with payer contact 20-30 days into the process to check status.
   - Continue follow-up until final determination.

3. **Payment Received Is Appeal Level 1 approved?**
   - **YES**
     - **STOP**
   - **NO**
     - **Appeal payment denial?**
       - **YES**
         - **STOP**
       - **NO**
         - **Appeal payment denial?**
           - **YES**
             - **STOP**
           - **NO**
             - **STOP**

4. **Legend**
   - **HCP & Staff Task**
   - **Patient Task**

**Patient Action:**
If all levels of payment appeals have been denied by the payer, the patient has two options to continue the appeal process:

- **ERISA, if eligible:** The employee Retirement Income Security Act (ERISA). A plan member becomes eligible for ERISA because employee benefits are provided through a private employer. The patient contacts Department of Labor.
- **Patient contacts insurance commissioner in the state that he or she resides.**
Frequently Asked Questions

1. How do I know if a service or procedure will be covered by the patient’s insurance carrier?
   Answer: Coverage policies vary by payer. Payers may make medical policies available to HCPs to articulate which procedures are covered. Contact the payer directly with questions regarding medical policies or guidelines for computer-assisted total knee arthroplasty.

2. Will Medicare provide a prior-authorization for procedures using Zimmer Computer-Assisted surgery for total knee arthroplasty?
   Answer: The Medicare program does not give prior-authorization, prior approval or a predetermination of benefits for any services. General coverage guidelines for many services can be found using the Medicare Coverage Database. The Medicare coverage guidelines are posted on the CMS web site.

3. If I get a prior-authorization approval, will I get paid for the procedure?
   Answer: Prior-authorization means that the insurer has given approval for a patient to receive a treatment, test or surgical procedure before it has actually occurred. The intent is to determine medical necessity and appropriateness of the proposed treatment and the appropriate treatment setting. A prior-authorization approval does not guarantee payment.

4. Does the physician have to demonstrate medical necessity when appealing a denied claim or service?
   Answer: Yes – It is strongly recommended that the physician demonstrate medical necessity when requesting an appeal of a denied claim or service. To establish medical necessity, the physician must clearly describe the condition(s) that justify why the medical procedure should be provided. The more complete and detailed description provided by the physician increases the probability of overturning the denied claim or service.

5. Can I collect payment from a patient for non-covered services?
   Answer: Medicare and some private payers will allow the HCP to seek and collect payment from beneficiaries for non-covered services as long as the HCP first obtains the member’s written consent prior to undergoing the specific procedure in question.

6. What is the patient’s financial responsibility for procedures using Zimmer Computer-Assisted Surgery for total knee arthroplasty?
   Answer: In order to determine the patient’s financial responsibilities, contact the patient’s insurance plan by calling the number on the patient’s insurance card to verify co-payment, deductible, and any other out-of-pocket expenses.

7. Why do I need to know if the patient has out-of-network benefits?
   Answer: It is important to know if a patient has out-of-network benefits because if the treating physician is an out-of-network provider and the plan does not allow out-of-network provider services, the services may be denied. In such cases the patient will need to find an in-network provider to perform the services.
Frequently Asked Questions (continued)

8. Can I appeal a denied prior-authorization request?  
Answer: Yes – a denial for a prior-authorization request can be appealed. It is important to address the reason for denial in the prior-authorization appeal letter. The reason for the denial is found in the prior-authorization denial letter. Contact the payer for specific appeal instructions.

9. How do I know the reason why a claim has been denied?  
Answer: The claims denial letter contains the reason(s) for the denial as well as instructions for the appeal. The denial code(s) can be found on the explanation of benefits. The explanation of benefits does not contain instructions for appeal. Contact the payer for specific instructions to appeal the claim.

10. I have exhausted all of my options for appealing a denial. Are there any other steps available to continue the process of obtaining an approval for coverage?  
Answer: There are state-specific and payer-specific guidelines that must be followed to elevate the appeal to a higher a level. The type of insurance determines whether federal or state laws apply to the appeal process. If the plan is self-funded through an employer group then the Employee Retirement and Income Security Act (ERISA) applies. If it is commercial insurance, state law applies and the state Division of Insurance (DOI) has jurisdiction.
Sample Letters

The information provided in the letters submitted to the payer must be appropriate and applicable to the specific service or claim being requested or appealed.

Appendix A

Sample Letter of Prior-Authorization Request and Medical Necessity

(Date)
(Contact Name)
(Title)
(Insurance Company Name)
(Address)
(City, ST Zip Code)

Re: (Patient’s Name)
Date of Birth:
Group Number:
Subscriber/Policy Number:

Dear (Contact Name):

This letter is written on behalf of (Patient’s Name) to document the medical necessity of (Procedure Name) for the treatment of (Patient’s Diagnosis). This letter provides information about the patient’s medical history and treatment.

(Insert information regarding the patient’s condition and history. Include information on treatments that have been tried and failed. Describe the anticipated outcome without treatment and the medical benefit of treatment based on clinical points supported in the clinical research and/or medical literature).

Zimmer Computer Assisted Surgery (CAS) also known as Surgical Navigation is defined as a surgery that is performed using a computer as a guiding and validation tool. CAS techniques combine advanced computer technology with a surgeon's skills to help improve the outcomes of knee and hip replacement surgery. The system provides precise positional guidance when removing damaged surfaces of bones, based on a patient's anatomy, and suggests the appropriate implant size to be used and helps to determine its correct positioning.

In summary, (Procedure Name) is medically necessary and appropriate to treat (Patient’s Name) at this stage in (his or her) course of care. I am enclosing documentation supporting the medical necessity for the course of treatment for this patient. I urge you to provide coverage at this time. Please contact me at (Physician’s Telephone Number) if you require additional information or would like to discuss the case in greater detail.

Sincerely,

(Physician’s Signature)
(Practice Name)
Enclosures
Appendix B

Sample Letter of Medical Necessity

(Date)

(Contact Name)

(Title)

(Insurance Company Name)

(Address)

(City, ST Zip Code)

Re: (Patient’s Name)

Date of Birth:

Group Number:

Subscriber/Policy Number:

Dear (Contact Name):

This letter is written on behalf of (Patient’s Name) to document the medical necessity of (Procedure Name) for the treatment of (Patient’s Diagnosis). This letter provides information about the patient’s medical history and treatment.

(Insert information regarding the patient’s condition and history. Include information on treatments that have been tried and failed. Describe the anticipated outcome without treatment and the medical benefit of treatment based on clinical points supported in the clinical research and/or medical literature).

Zimmer Computer Assisted Surgery (CAS) also known as Surgical Navigation is defined as a surgery that is performed using a computer as a guiding and validation tool. CAS techniques combine advanced computer technology with a surgeon’s skills to help improve the outcomes of knee and hip replacement surgery. The system provides precise positional guidance when removing damaged surfaces of bones, based on a patient’s anatomy, and suggests the appropriate implant size to be used and helps to determine its correct positioning.

In summary, (Procedure Name) is medically necessary and appropriate to treat (Patient’s Name) at this stage in (his or her) course of care. I am enclosing documentation supporting the medical necessity for the course of treatment for this patient. I urge you to provide coverage at this time. Please contact me at (Physician’s Telephone Number) if you require additional information or would like to discuss the case in greater detail.

Sincerely,

(Physician’s Signature)

(Practice Name)

Enclosures
Appendix C

Sample Prior-Authorization Appeal Letter

(Date)

(Contact Name)

(Title)

(Insurance Company Name)

(Address)

(City, ST Zip Code)

Re: (Patient’s Name)

Date of Birth:

Group Number:

Subscriber/Policy Number:

Dear (Contact Name):

Please accept this letter as my request to appeal to (Insurance Company Name)'s prior-authorization denial for (State the name of the specific procedure denied). It is my understanding based on your letter of denial dated (Insert Date) that this procedure has been denied because (Quote the specific reason for the denial stated in the denial letter).

I believe that (Procedure Name) is a medically necessary treatment for this patient with (Patient’s Condition). This letter provides information about the patient’s medical history and diagnosis, and my rationale for this course of treatment.

The history and clinical course for (Patient’s name) are as follows: (Insert information concerning the patient’s condition, medical history and clinical course prior to treatment with denied therapy. Include the physician’s rationale for selected therapy).

Zimmer Computer Assisted Surgery (CAS) also known as Surgical Navigation is defined as a surgery that is performed using a computer as a guiding and validation tool. CAS techniques combine advanced computer technology with a surgeon’s skills to help improve the outcomes of knee and hip replacement surgery. The system provides precise positional guidance when removing damaged surfaces of bones, based on a patient’s anatomy, and suggests the appropriate implant size to be used and helps to determine its correct positioning.

I urge you to grant prior-authorization for (Patient’s Name) for the treatment of (Diagnosis) with (Procedure Name) promptly. Please feel free to contact me at (Physician’s Telephone Number), if you require additional information.

Sincerely,

(Physician’s Signature)

(Practice Name)
Appendix D

Sample Prior-Authorization Appeal Letter

(Date)

(Contact Name)

(Title)

(Insurance Company Name)

(Address)

(City, ST Zip Code)

Re: (Patient’s Name)

Date of Birth:

Group Number:

Subscriber/Policy Number:

Dear (Contact Name):

Please accept this letter as my request to appeal to (Insurance Company Name)’s prior-authorization denial for (State the name of the specific procedure denied). It is my understanding based on your letter of denial dated (Insert Date) that this procedure has been denied because (Quote the specific reason for the denial stated in the denial letter).

I believe that (Procedure Name) is a medically necessary treatment for this patient with (Patient’s Condition). This letter provides information about the patient’s medical history and diagnosis, and my rationale for this course of treatment.

The history and clinical course for (Patient’s name) are as follows: (Insert information concerning the patient’s condition, medical history and clinical course prior to treatment with denied therapy. Include the physician’s rational for selected therapy).

Zimmer Computer Assisted Surgery (CAS) also known as Surgical Navigation is defined as a surgery that is performed using a computer as a guiding and validation tool. CAS techniques combine advanced computer technology with a surgeon’s skills to help improve the outcomes of knee and hip replacement surgery. The system provides precise positional guidance when removing damaged surfaces of bones, based on a patient’s anatomy, and suggests the appropriate implant size to be used and helps to determine its correct positioning.

I urge you to grant prior-authorization for (Patient’s Name) for the treatment of (Diagnosis) with (Procedure Name) promptly. Please feel free to contact me at (Physician’s Telephone Number), if you require additional information.

Sincerely,

(Physician’s Signature)

(Practice Name)
Disclaimer

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