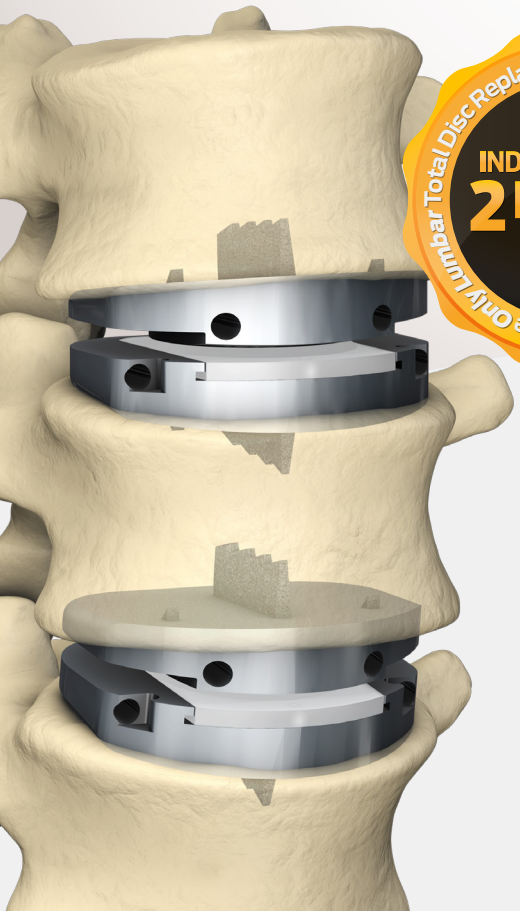
CENTINEL SPINE®

PATIENT ADVOCACY GUIDE



The Only Lumbar Total Disc Replacement with 2-Level Indications in the US

INDICATED FOR 2 LEVELS

prodisc® L

Total Disc Replacement

WHY SELF ADVOCACY MATTERS

Advocating for your own medical care is often necessary when any new or innovative procedure is prescribed by your physician. The following information may be helpful when you ask yourself why you may need to take the pre-authorization process into you own hands.

As the policy holder you have the right to appeal any negative decision made by your insurance company. You may ask your insurance company to conduct a full and fair review of its decision through multiple levels of appeals.

PROCESS

STEP 1 Pre-Authorization

Your surgeon will verify benefits and submit the procedure code and relevant clinical information about your case to your insurance company. If the procedure is denied at this level it triggers your ability start the appeal process.

STEP 2 Peer-to-Peer

This is the next level in the process and is an opportunity for your surgeon to have a one-on-one discussion with a person from the insurance company to discuss details of your specific case and talk through the medical necessity of the procedure.

STEP 3 1st & 2nd Level Appeal

If the procedure is denied at the Peer-to-Peer level, there is an opportunity for your surgeon to speak with a Medical Director at the insurance company who did not review the initial submission. Typically this is a deeper conversation and will include someone from the insurance company with expertise in the specific field of medicine that your surgeon is practicing (ie: a spine surgeon will speak with a spine surgeon).

STEP 4 External Appeal

If the procedure is denied once all appeals have been exhausted, you have the right to pursue an external appeal with an independent medical expert outside of the insurance company. This process requires that an experienced spine surgeon review the clinical data of your case independently from the insurance company. The goal is to continue to move through the entire appeal process until you get a positive resolution or force the decision to an external appeal.

RESOURCES

Centinel Spine has partnered with Musculoskeletal Clinical Regulatory Advisers (MCRA), a company that has over 50 years of combined patient access experience in the orthopedic/spine industry. MCRA may be used to provide guidance through the appeals process and may be able to work with your surgeon's office to facilitate each step of the way. This does not take away the value of you being an advocate for your care and both pathways should be used together to ensure the best chance for an approval. If your surgeon is not able to work with MCRA, they can work with you individually to guide you through the process as you self-advocate for the procedure.

MCRA

Contact MCRA at:
(800) 264-4623 or centinelspine@mcra.com

IMPORTANT SUGGESTIONS

The following tips and suggestions may make the difference between an approval and a denial:

Don't take 'no' for an answer.

If your pre-authorization is denied by your insurance company, this is the starting point not the ending point. Insurance companies count on the fact that a large percentage of subscribers will receive a denial and either **1)** forget about it, **2)** intend to file an appeal but not follow through, or **3)** incorrectly file the appeal paperwork. In any case, if you don't follow up for any reason, the denial will stand.

Appeal a Denial from Your Insurance Company.

If you receive a rejection from your health plan and you believe the procedure is medically necessary, ***you have the right to appeal the denial***. It's what you expected, but it's never the last word. Now, that is not to say that you always win–but it should take more than one denial for you to accept that you are not entitled to have a medical service. Persistence and determination are a large part of what it takes to win.

Insurance companies must give you a reason why they are denying a claim. Most often this reason is that **1)** the treatment is experimental or investigational, **2)** the treatment is not medically necessary, or **3)** the treatment is not the standard of care.

Show the progression of the situation and how options have been exhausted.

Base your appeals on the phrases "medical necessity" and "medically necessary."

1. Clearly describe the impact of your condition and the need for the prescribed treatment.
2. Describe what will happen if what you're asking for ***doesn't*** happen.
3. Be sure to tell the insurance company what you have tried already, and what has failed.
4. Show how your diagnosis and treatment history has brought you to this place (or how the alternative is not preferable).
5. Provide complete information but try to be brief.
6. Be sure to include diagnosis codes and treatment codes if they are available (your medical professional will provide these).

Use the rejection letter as the foundation for your appeal.

Take the rejection letter you received and read it carefully. Don't just react with "it says no" and throw it away. It is important; because the insurance company must tell you why they are rejecting your claim (usually one of those three reasons mentioned above). ***This is the key to your appeal***. You must address this issue. The insurance company is telling you the basis for the denial, you need to fight based on that. Be thorough but don't get off track.

Be organized. Take notes. Document everything.

No matter what surgery or treatment you are appealing, ***you must be organized, take notes and document everything.***

1. Keep copies of your lab results, operative notes, and copies of all communication to/from your insurance company.
2. Include a fully documented medical history, which you can get from your doctor.
3. Take notes on conversations (including dates and full name of the person you spoke with) at the insurance company or doctor's office.
4. It may not be enough to prove your case, but if you can say "I spoke with (first and last name) on (date)" it lends credence to the fact that a conversation took place.

FREQUENTLY ASKED QUESTIONS

What is a pre-authorization and why do I need one?

A pre-authorization is an approval that health plans require members to obtain before receiving certain types of care so they can confirm medical necessity.

How long is the pre-authorization process?

A pre-authorization can take 3-15 days for the health plan to make an initial determination on your procedure. If your procedure is denied, you have the right to ask for a reconsideration of the decision. The appeal process can take an additional 30-60 days for a determination.

What can I do to help?

- If you have an HR department, contact them and have them assist you with your health plan.
- Contact your health plan.
- Write a letter describing how your pain has affected your life.

Would it help if I called my employer?

You should contact your HR department and have them contact the health plan on your behalf.

Should I coordinate my communication that I do on my own with the same person that my Surgeon's office has spoken with?

Yes. Your case will be stronger if you and your surgeon are able to work together as a team to present your case.

How do I appeal the health plan's denial of my case?

- Find the reason for the denial by reading the pre-authorization denial letter.
- Determine the insurer's appeal process (varies by insurer).
- Submit formal appeal with necessary timeframe as detailed in the appeals process.
- Keep notes, including names of individuals spoken to.
- If the health plan continues to deny the procedure, you may request an external appeal (the process varies by state law), in which an independent third-party will review the case and make a final decision.

What should I write in the letter?

In your own words, describe your symptoms, pain, activities you are no longer able to participate in because of your pain, conservative treatments you have taken that have or have not improved your condition, and why you believe the procedure is the best option for you.

What if I don't agree with the determination made by my health plan?

If the procedure is denied, you have the right to ask for a reconsideration of the decision.

Why was my procedure denied?

There are several reasons a health plan may deny your procedure. Examples include benefits and coverage, medical necessity, missing clinical information.

TIMELINE EXPECTATIONS

INITIATE PRE-AUTHORIZATION
Verify benefits and submit clinical information and literature on device

1-15 Days

PEER-TO-PEER
Opportunity for the treating physician to discuss the medical necessity of the case with a Medical Director at the health plan

1-3 Days

1ST LEVEL APPEAL
Expedited/Standard - Opportunity to request a Medical Director that did not review the initial submission

3-30 Days

2ND LEVEL APPEAL
Expedited/Standard - Opportunity to request a Medical Director that did not review the initial submission, as well as the peer-to-peer

3-30 Days

EXTERNAL APPEAL
Following appeal denial at all available internal levels, the patients should pursue an External Appeal with the applicable State Department of Insurance

5-45 Days

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