KIMBERLY-CLARK*
Cooled RF Systems

Reimbursement Guide

Kimberly-Clark

*Trusted Clinical Solutions**

KIMBERLY-CLARK* Pain Management Cooled RF Systems Reimbursement Guide

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Introduction

This reimbursement guide provides basic information regarding coding and coverage to assist you and your facility in obtaining reimbursement for our cooled RF procedures, which include:

- Disc Biacuplasty (TRANSDISCAL* System)
- SINERGY* System
- THORACOOL* System
- LUMBARCOOL* System

Information contained in this reimbursement guide is derived from a variety of sources as of April 2011 and is intended for general information only.

The intent of this guide is to assist providers in accurately obtaining coverage and reimbursement for healthcare services. It is not intended to increase or maximize reimbursement by any payer. Providers assume full responsibility for all claims submissions and reimbursement decisions. Each claim should be coded appropriately and supported with adequate documentation of the patient's medical record. The codes listed in the guide are examples of codes that may be appropriate for individual situations. These codes do not represent correct coding for all procedures involving our various cooled RF technologies.

DISC BIACUPLASTY

The disc biacuplasty procedure uses the KIMBERLY-CLARK* TRANSDISCAL* System. Disc biacuplasty is performed to treat patients with chronic discogenic pain and contained herniated discs through a bipolar approach using internally water-cooled radiofrequency probes to coagulate and deactivate nerves while decompressing disc material.

CPT® Codes:

22899: Unlisted procedure, spine

OR

64999: Unlisted procedure, nervous system

77003: Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures

Device Codes:

There are no specific HCPCS codes (C Code or pass-through code) for the disc biacuplasty probe kit. The miscellaneous surgical supply code, A4649, can be used to bill for the single-use probe kit; however, it is at the payer's discretion to provide additional reimbursement.

Coverage:

To support the use of an unlisted procedure code, a prior authorization from the payer is recommended.

ICD-9 Diagnosis Codes:

Following is a list of possible diagnosis codes which may support medical necessity for the disc biacuplasty procedure to treat the chronic pain caused by these medical conditions. This list is not intended to be an all-inclusive list. Other ICD-9 diagnostic codes may apply based on the patient's diagnosis. The physician must always make the final determination of the appropriate diagnosis code.

ICD-9-CM

Diagnosis Code	Description
722.51	Degeneration of thoracic or thoracolumbar intervertebral disc
722.52	Degeneration of lumbar or lumbosacral intervertebral disc
722.6	Degeneration of intervertebral disc, site unspecified
722.90	Other and unspecified disc disorder of unspecified region
722.93	Other and unspecified disc disorder of lumbar region
724.2	Lumbago
724.5	Unspecified backache
724.8	Other symptoms referable to the back
724.9	Other unspecified back disorders
739.3	Nonallopathic lesions of lumbar region, not elsewhere classified

For a complete list of coding options and descriptions, consult the current ICD-9-CM manual.

Pre-Authorization Process:

Once a candidate has been identified, medical necessity has been established, and a Waiver of Financial Liability has been signed by the patient, a pre-authorization request should be submitted to the patient's insurance carrier prior to performing the disc biacuplasty procedure.

Note: Medicare does not have a pre-authorization process. It is recommended that a potential patient who is covered by Medicare sign an ABN (Advanced Beneficiary Notice).

When submitting a pre-authorization request, the following steps should be taken:

- Place a call to the payer to verify insurance benefits and determine if a pre-authorization is required.
- Provide the payer with the patient's diagnosis and the appropriate CPT® code
- If a pre-authorization is required, documentation to support medical necessity will be required, which should be included in the letter of medical necessity (LOMN):
  - Patient's brief medical history
  - Physician's exam findings
  - Copies of pertinent reports (MRIs, CT scans, etc)
  - Alternative treatments previously tried
  - How the activities of daily life are being impacted by the medical condition
  - Duration of the diagnosis
  - Identification of the site of service (office, ASC, or hospital outpatient)

Note: Payers base their decisions on medical necessity, as well as benefits, therefore we encourage you to make a strong case for the patient's particular medical need for the disc biacuplasty procedure.

Following is a sample letter of medical necessity for the disc biacuplasty procedure to assist you in drafting a pre-authorization request.

SAMPLE LETTER OF MEDICAL NECESSITY

[Date]

Attn: **[Contact]** *usually the medical director*
[Title]
[Name of Health Insurance Company]
[Address]
[City, State, ZIP Code]

RE: Treatment authorization request for **[Patient Name]**
[Policy Number/Group Number/Patient ID#]
[Date of Birth]

Dear **[Name of Contact]** / **[To Whom It May Concern]:**

I am writing on behalf of my patient, **[name of patient],** to document the medical necessity of performing the disc biacuplasty procedure.

[Mr./Mrs./Ms.] [Patient's last name] has been suffering from chronic discogenic pain for **[xx]** months. **[Mr./Mrs./Ms.] [Patient's last name]**'s medical history and treatment information for chronic discogenic pain is as follows:

- **List previous conservative treatment(s) done on the patient (including use of drugs such as analgesics, opioids, anti-inflammatory drugs; physiotherapy; steroid injections) and their outcome(s)**

Despite these attempts, **[Mr./Mrs./Ms.] [Patient's last name]** has received minimal relief from symptoms and is currently **[describe patient's current condition and how activities of daily life are affected].** I have included the results of tests which indicate **[list findings from CT, MRI, etc., and attach any other tests performed to confirm diagnosis].**

Due to the unsuccessful outcome(s) of previous treatment(s), I am of the medical opinion that **[Mr./Mrs./Ms.] [Patient's last name]** would benefit from a procedure called disc biacuplasty. This procedure is medically necessary to treat **[Mr./Mrs./Ms.] [Patient's last name]** for chronic discogenic pain. My recommended treatment has been successfully used in many cases.

I am recommending a procedure called intervertebral disc biacuplasty at the **[Specify Level]** levels to ablate the nociceptors and nerve fibers that are responsible for discogenic pain within the degenerated disc. The procedure involves the use of the KIMBERLY-CLARK* TRANSDISCAL* System. The TRANSDISCAL* System in combination with the KIMBERLY-CLARK* Pain Management Generator uses a bipolar approach with internally water-cooled radiofrequency probes to coagulate and deactivate nerves while decompressing disc material and aims to treat symptomatic patients with discogenic pain and contained herniated discs.

[Mr./Mrs./Ms.] [Patient's last name] quality of life is diminished as the pain severely interferes with his/her work, family and the community activities he [she] would normally be involved in.

This procedure will be performed **[Date]** at **[Facility]** pending the authorization of this request.

Please confirm this procedure will be covered for **[Mr./Mrs./Ms.] [Patient's last name]** based on medical necessity. Contact me by phone at_____or by fax _____ if you have any questions.

Thank you for your attention to this matter, and I look forward to your response.

Sincerely,

[Physician's Name]

[Physician's Practice Name]

Encl. **(relevant diagnostic test(s) and result(s), patient's pertinent medical history records etc.)**

SINERGY* SYSTEM

The SINERGY* System is designed to treat patients with chronic sacroiliac joint pain. This system utilizes an internally water-cooled radiofrequency probe to ablate the dorsal ramus of L5 and the lateral branches of the dorsal rami exiting from the posterior sacral foramen at S1, S2, and S3.

CPT® Codes:

64635: Destruction by neurolytic agent, paravertebral facet joint nerve(s); (Fluoroscopy or CT); lumbar or sacral, single facet joint

64640: Destruction by neurolytic agent; other peripheral nerve or branch

RF denervation in the sacroiliac region is commonly done at L5, S1, S2, and S3 levels. Physicians who currently perform RF denervation procedure in the sacroiliac region commonly use the following approach in coding:

RF lesion at L5/S1 facet joint: 64635

RF lesions at S1: 64640-59

RF lesions at S2: 64640-59

RF lesions at S3: 64640-59

Note: For bilateral procedures, use Modifier-50

According to the AMA, as published in the CPT Assistant, December 2009:

"To differentiate between the work when performing sacral nerve destruction of S1, S2, S3, and S4, each individually separate peripheral nerve root neurolytic block is reported as destruction of a peripheral nerve, using code 64640, Destruction by neurolytic agent; other peripheral nerve or branch. In this instance, code 64640 is reported four times. It is suggested that Modifier 59, Distinct Procedural Service, be appended as well."

Device Codes:

There are no specific HCPCS codes (C Code or pass-through code) for the SINERGY* probe kit. The miscellaneous surgical supply code, A4649, can be used to bill for the single-use probe kit; however, it is at the payer's discretion to provide additional reimbursement.

Coverage:

Coverage for RF denervation to treat sacroiliac joint pain varies significantly between payers. As a result, a prior authorization from the payer is recommended.

ICD-9 Diagnosis Codes:

Following is a list of possible diagnosis codes which may support medical necessity for the SINERGY* Procedure to treat the chronic pain caused by these medical conditions. This list is not intended to be an all-inclusive list. Other ICD-9 diagnostic codes may apply based on the patient's diagnosis. The physician must always make the final determination of the appropriate diagnosis code.

ICD-9-CM

Diagnosis Code	Description
353.1	Lumbosacral plexus lesions
353.4	Lumbosacral root lesions, not elsewhere classified
353.8	Other nerve root and plexus disorder
719.45	Pain in joint, pelvic region and thigh
719.48	Pain in joint, other specified sites
720	Ankylosing spondylitis
720.2	Sacroiliitis
724.2	Lumbago
724.3	Sciatica
724.5	Unspecified backache
724.6	Disorders of the sacrum
724.8	Other symptoms referable to the back
724.9	Other unspecified back disorders
729.2	Unspecified neuralgia, neuritis, and radiculitis
739.4	Nonallopathic lesions of sacral region, not elsewhere classified
756.12	Cogenital spondylolisthesis

For a complete list of coding options and descriptions, consult the current ICD-9-CM manual.

Pre-Authorization Process:

Once a candidate has been identified, medical necessity has been established, and a Waiver of Financial Liability has been signed by the patient, a pre-authorization request should be submitted to the patient's insurance carrier prior to performing the SINERGY* System procedure.

Note: Medicare does not have a pre-authorization process. It is recommended that a potential patient that is covered by Medicare sign an ABN (Advanced Beneficiary Notice).

When submitting a pre-authorization request, the following steps should be taken:

- Place a call to the payer to verify insurance benefits and determine if a pre-authorization is required.
- Provide the payer with the patient's diagnosis and the appropriate CPT® code
- If a pre-authorization is required, documentation to support medical necessity will be required which should be included in the letter of medical necessity (LOMN):
  - Patient's brief medical history
  - Physician's exam findings
  - Copies of pertinent reports (MRIs, CT scans, etc)
  - Alternative treatments previously tried
  - How the activities of daily life are being impacted by the medical condition
  - Duration of the diagnosis
  - Identification of the site of service (office; ASC; or hospital outpatient)

Note: Payers base their decisions on medical necessity, as well as benefits; therefore we encourage you to make a strong case for the patient's particular medical need for the sacroiliac joint neurotomy procedure.

Following is a sample letter of medical necessity for the SINERGY* System procedure to assist you in drafting a pre-authorization request.

SAMPLE LETTER OF MEDICAL NECESSITY

[Date]

Attn: **[Contact]** *usually the medical director*
[Title]
[Name of Health Insurance Company]
[Address]
[City, State, ZIP Code]

RE: Treatment authorization request for **[Patient Name]**
[Policy Number/Group Number/Patient ID#]
[Date of Birth]

Dear **[Name of Contact]** / **[To Whom It May Concern]:**

I am writing on behalf of my patient, **[name of patient],** to document the medical necessity of sacroiliac joint neurotomy procedure.

[Mr./Mrs./Ms.] [Patient's last name] has been suffering from chronic pain associated with the sacroiliac joint complex for **[xx]** months. **[Mr./Mrs./Ms.] [Patient's last name]**'s medical history and treatment information for chronic pain associated with the sacroiliac joint complex is as follows:

- **List previous conservative treatment(s) done on the patient (including use of drugs such as analgesics, opioids, anti-inflammatory drugs; physiotherapy; steroid injections) and their outcome(s)**

Despite these attempts, **[Mr./Mrs./Ms.] [Patient's last name]** has received minimal relief from symptoms and is currently **[describe patient's current condition and how activities of daily life are affected].** I have included the results of tests which indicate **[list findings from CT, MRI, etc., and attach any other tests performed to confirm diagnosis].**

Due to the unsuccessful outcome(s) of previous treatment(s), I am of the medical opinion that **[Mr./Mrs./Ms.] [Patient's last name]** would benefit from a procedure called sacroiliac joint neurotomy. This procedure is medically necessary to treat **[Mr./Mrs./Ms.] [Patient's last name]** for chronic pain associated with the sacroiliac joint complex. My recommended treatment has been successfully used in many cases.

The sacroiliac joint neurotomy procedure is performed using the KIMBERLY-CLARK* SINERGY* Pain Management System. The SINERGY* System is comprised of SINERGY* Probe, SINERGY* Introducer, Pain Management Pump Unit and Cable, Pain Management Tube kit, Dispersive Electrode and Connecting Cable. This system is used in conjunction with a Radiofrequency Generator to create radiofrequency lesions in the nervous tissue. The procedure ablates the dorsal ramus of L5 that runs along the sacral ala and the lateral branches of the dorsal rami exiting from posterior sacral foramen at S1, S2 and S3. These nerves are known to innervate the sacroiliac joint and are responsible for the pain associated with sacroiliac joint syndrome. Because of the complex, varied and diffuse innervations in the sacroiliac region, large radiofrequency lesions are required to ensure complete ablation of the nervous tissue. A cooled probe allows a sufficiently large volume of tissue to be heated without excessively heating tissue adjacent the probe tip.

In summary, sacroiliac joint neurotomy procedure using the KIMBERLY-CLARK* SINERGY* Pain Management System is necessary and reasonable for **[Mr./Mrs./Ms.] [Patient's last name]**'s medical condition. Based on the diagnostic results, I firmly believe that **[Mr./Mrs./Ms.] [Patient's last name]** is an excellent candidate for this procedure and I request you to consider a prompt approval for this procedure.

Thank you for your attention to this matter, and I look forward to your response.

Sincerely,

[Physician's Name]

[Physician's Practice Name]

Encl. (relevant diagnostic test(s) and result(s), patient's pertinent medical history records etc.

THORACOOL* SYSTEM

The THORACOOL* System is designed to treat the pain associated with thoracic Z-joint through the use of an internally water-cooled radiofrequency probe to ablate the medial branches coursing over the superolateral aspect of the transverse process of the thoracic spine.

CPT® Codes:

64633: Destruction by neurolytic agent, paravertebral facet joint nerve(s); (Fluoroscopy or CT); cervical or thoracic, single facet joint

64634: Destruction by neurolytic agent, paravertebral facet joint nerve(s); (Fluoroscopy or CT); cervical or thoracic, each additional facet joint

Thoracic medial branch neurotomy procedures are commonly performed at levels from T1 to T12. An example of coding commonly used by physicians performing thoracic medial branch neurotomy is listed below:

RF lesion at T3-4 facet joint: 64633

RF lesion at T4-5 facet joint: 64634

RF lesion at T5-6 facet joint: 64634

Note: For bilateral procedures, use Modifier-50

Device Codes:

There are no specific HCPCS codes (C Code or pass-through code) for the THORACOOL* probe kit. The miscellaneous surgical supply code, A4649, can be used to bill for the single-use probe kit; however, it is at the payer's discretion to provide additional reimbursement.

Coverage:

Coverage for RF denervation to treat thoracic facet joint pain varies significantly between payers. As a result, a prior authorization from the payer is recommended.

ICD-9 Diagnosis Codes:

Following is a list of possible diagnosis codes which may support medical necessity for RF denervation of thoracic facet nerves to treat the chronic pain caused by these medical conditions. This list is not intended to be an all-inclusive list. Other ICD-9 diagnostic codes may apply based on the patient's diagnosis. The physician must always make the final determination of the appropriate diagnosis code.

ICD-9-CM

Diagnosis Code	Description
353.3	Thoracic root lesions, not elsewhere classified
353.5	Neuralgic amyotrophy
353.8	Other nerve root and plexus disorder
720.0	Ankylosing spondylitis
720.1	Spinal enthesopathy
721.2	Thoracic spondylosis without myelopathy
721.6	Ankylosing vertebral hyperostosis
721.7	Traumatic spondylopathy
722.82	Postlaminectomy syndrome, thoracic region
724.1	Pain in thoracic spine
724.4	Thoracic or lumbosacral neuritis or radiculitis, unspecified
724.8	Other symptoms referable to the back
729.2	Unspecified neuralgia, neuritis, and radiculitis

For a complete list of coding options and descriptions, consult the current ICD-9-CM manual.

Pre-Authorization Process:

Once a candidate has been identified, medical necessity has been established, and a Waiver of Financial Liability has been signed by the patient, a pre-authorization request should be submitted to the patient's insurance carrier prior to performing the THORACOOL* System procedure.

Note: Medicare does not have a pre-authorization process. It is recommended that a potential patient that is covered by Medicare sign an ABN (Advanced Beneficiary Notice).

When submitting a pre-authorization request, the following steps should be taken:

- Place a call to the payer to verify insurance benefits and determine if a pre-authorization is required.
- Provide the payer with the patient's diagnosis and the appropriate CPT® code
- If a pre-authorization is required, documentation to support medical necessity will be required which should be included in the letter of medical necessity (LOMN):
  - Patient's brief medical history
  - Physician's exam findings
  - Copies of pertinent reports (MRIs, CT scans, etc)
  - Alternative treatments previously tried
  - How the activities of daily life are being impacted by the medical condition
  - Duration of the diagnosis
  - Identification of the site of service (office; ASC; or hospital outpatient)

Note: Payers base their decisions on medical necessity, as well as benefits, therefore we encourage you to make a strong case for the patient's particular medical need for the thoracic medial branch neurotomy procedure.

Following is a sample letter of medical necessity for the THORACOOL* system procedure to assist you in drafting a pre-authorization request.

SAMPLE LETTER OF MEDICAL NECESSITY

[Date]

[Payer Address]

Re: **[Insert patient name and subscriber number]**

Dear **[Medical Director]:**

Please consider this letter a request for preauthorization of benefits to treat my patient, **[insert patient name],** who suffers from **[insert patient ICD-10-CA diagnosis code and description of procedure].** It is my clinical judgment that **[Mr./Ms. insert patient last name]** is an ideal candidate for radiofrequency (RF) denervation in the thoracic region utilizing the KIMBERLY-CLARK* THORACOOL* Pain Management System, and prior to scheduling this procedure I am seeking preauthorization and predetermination of benefits for my patient.

Patient History

[Mr./Ms. insert patient name] presented to me with complaints of **[insert *detailed* patient history with description of patient's current condition including diagnosis, length of time problem has existed, current/ongoing complaints, and level of impairment. Describe functional impairments, and how the patient's condition has impacted his/her activities of daily life.]**

Previous interventional treatment efforts include: **[indicate procedures, medications, and/or therapies attempted – include outcome of each treatment].** Despite these treatments and therapies, **[Mr./Ms. insert patient name]** has experienced no significant relief from **[insert specific symptoms here].**

A problem-focused history and exam was performed as well as **[indicate scans, MRIs, X-rays, nerve blocks etc].** The findings of these test results confirm my diagnosis of **[insert patient diagnosis code]** and support my request for treatment.

Proposed Treatment

I am recommending a radiofrequency denervation procedure for the ablation of medial branch nerves in the thoracic region. The procedure involves the use of the KIMBERLY-CLARK* THORACOOL* Pain Management System to create targeted lesions at the medial branches of the thoracic dorsal rami. These nerves are known to innervate the thoracic zygapophysial joints (z-joints) and are associated with thoracic z-joint pain. Because of the varied innervations in the thoracic region, large radiofrequency lesions are required to ensure complete ablation of the nervous tissue. Cooled RF technology utilized by the THORACOOL* Pain Management System allows a large volume of tissue to be heated (without excessively heating tissue adjacent to the probe tip) compared to conventional radiofrequency electrodes.

This procedure will be performed on [indicate anticipated date of procedure] at **[indicate site of service and name of facility where the procedure will be performed – physician office, outpatient hospital].** Please confirm if there are any restrictions on performing this procedure in this setting.

Please confirm this procedure will be covered for **[insert patient name]** based on medical necessity. Please contact me at **[insert phone number]** if you have any questions.

Sincerely,

[Doctor signature]

Dr. **[doctor name]**

LUMBARCOOL* SYSTEM

The LUMBARCOOL* System is designed to treat the pain associated with lumbar Z-joint pain through the use of an internally water-cooled radiofrequency probe to ablate the medial branches coursing over the base of the superior articular process of the lumbar spine.

CPT® Codes:

64635: Destruction by neurolytic agent, paravertebral facet joint nerve(s); (Fluoroscopy or CT); lumbar or sacral, single facet joint

64636: Destruction by neurolytic agent, paravertebral facet joint nerve(s); (Fluoroscopy or CT); lumbar or sacral, each additional facet joint

Lumbosacral medial branch neurotomy procedures are commonly performed at levels from L1 to L5. An example of coding commonly used by physicians performing lumbar medial branch neurotomy is listed below:

RF lesion at L3-4 facet joint: 64635

RF lesion at L4-5 facet joint: 64636

RF lesion at L5/S1 facet joint: 64636

Note: For bilateral procedures, use Modifier-50

Device Codes:

There are no specific HCPCS codes (C Code or pass-through code) for the LumbarCool probe kit. The miscellaneous surgical supply code, A4649, can be used can be used to bill for the single-use probe kit; however, it is at the payer's discretion to provide additional reimbursement.

Coverage:

Most commercial payers and Medicare provide coverage for RF denervation to treat lumbar facet joint pain. Requirements and limitations will vary between payers. Please check with the patient's insurance for their specific coverage policy on RF denervation for lumbar facet nerves.

ICD-9 Diagnosis Codes:

Following is a list of possible diagnosis codes which may support medical necessity for RF denervation of lumbar facet nerves to treat the chronic pain caused by these medical conditions. This list is not intended to be an all-inclusive list. Other ICD-9 diagnostic codes may apply based on the patient's diagnosis. The physician must always make the final determination of the appropriate diagnosis code.

ICD-9-CM

Diagnosis Code	Description
353.1	Lumbosacral plexus lesions
353.4	Lumbosacral root lesions, not elsewhere classified
353.8	Other nerve root and plexus disorder
355.0	Lesion of sciatic nerve
719.45	Pain in joint, pelvic region and thigh
719.48	Pain in joint, other specified sites
720.1	Spinal enthesopathy
721.3	Lumbosacral spondylosis without myelopathy
721.6	Ankylosing vertebral hyperostosis
721.7	Traumatic spondylopathy
722.83	Postlaminectomy syndrome, lumbar region
722.93	Other and unspecified disc disorder, lumbar region
724.02	Spinal stenosis of the lumbar region
724.2	Lumbago
724.3	Sciatica
724.4	Thoracic or lumbosacral neuritis or radiculitis, unspecified
724.5	Unspecified backache
724.6	Disorders of the sacrum
724.8	Other symptoms referable to the back
724.9	Other unspecified back disorders
729.2	Unspecified neuralgia, neuritis, and radiculitis
739.3	Nonallopathic lesion of lumbar region, not elsewhere classified
739.4	Nonallopathic lesion of sacral region, not elsewhere classified
756.12	Congenital spondylolisthesis

For a complete list of coding options and descriptions, consult the current ICD-9-CM manual.

Pre-Authorization Process:

Once a candidate has been identified, medical necessity has been established, and a Waiver of Financial Liability has been signed by the patient, a pre-authorization request may be required by the patient's insurance carrier.

Note: Medicare does not have a pre-authorization process. It is recommended that a potential patient that is covered by Medicare sign an ABN (Advanced Beneficiary Notice).

When submitting a pre-authorization request, the following steps should be taken:

- Place a call to the payer to verify insurance benefits and determine if a pre-authorization is required.
- Provide the payer with the patient's diagnosis and the appropriate CPT® code
- If a pre-authorization is required, documentation to support medical necessity will be required which should be included in the letter of medical necessity (LOMN):
  - Patient's brief medical history
  - Physician's exam findings
  - Copies of pertinent reports (MRIs, CT scans, etc)
  - Alternative treatments previously tried
  - How the activities of daily life are being impacted by the medical condition
  - Duration of the diagnosis
  - Identification of the site of service (office; ASC; or hospital outpatient)

Note: Payers base their decisions on medical necessity, as well as benefits, therefore we encourage you to make a strong case for the patient's particular medical need for the lumbar medial branch neurotomy procedure.

APPEALS

Facilities and physicians may encounter denied, pended, or underpaid claims for numerous reasons. Claims are usually pended or denied for four primary reasons:

- Administrative errors made by claims processors
- Clerical errors made on claim forms
- A determination by the payer that the procedure is not medically necessary
- Patient not responding to payer's request for information

Appealing Denied Claims:

If a claim is denied, we recommend careful review of the Explanation of Benefits (EOB) for an explanation or reason for the denial. If the EOB does not clearly explain the reason, immediately contact the payer and request an explanation of the denied claim. In those cases where a clerical error was made on the claim form, simply confirm the appropriate codes to use and resubmit a corrected claim form.

In other cases, payers may deny claims based on their determination of:

- A lack of medical necessity
- A diagnosis code does not match with the CPT® code
- A determination that the technology is considered investigational

In these cases, you should contact the payer and offer to provide additional information about the procedure (disc biacuplasty; SInergy* System; THORACOOL* System; or LUMBARCOOL* System). You should ask the claims processor to specify what additional materials are required to reverse the original coverage determination.

Underpaid Claims:

If you feel your claim has been underpaid, contact the claims office identified on the patient's EOB, and request a review of your claim. Claims may be underpaid for various reasons including:

- Low contractual agreement
- Incorrect coding of the actual procedure(s) performed
- Lack or misuse of appropriate modifier
- Lack of supporting documentation

Each payer has its own review process, but in most cases, you will be asked to submit your request in writing. Once you determine what the process is, inquire as to where the request should be sent and to whom it should be directed.

Claim Reversals:

According to a recent Medicare report, the following were listed as the top reasons claims were reversed at the appeal level:

- In 45% of the cases reversed, additional information, more detailed documentation of the patient's condition, or proper diagnosis coding was supplied at the appeal level
- In 18% of the cases reversed, a Unique Identification Number (UPIN) was submitted or corrected at the appeal level
- In 18% of the cases reversed, a request for modifier change or addition to the claim was requested.

To avoid the frustration of claim denials and appeal processing, we suggest checking to be sure that the claim form contains all the required information. Claim submitters should verify that the correct UPIN number, procedure code and diagnosis have been indicated on the claim. Incomplete or insufficient documentation of a patient's medical condition could result in claim denial.

SAMPLE APPEAL LETTER

[Date]

Attn: **[Contact]** usually the medical director
[Title]
[Name of Health Insurance Company]
[Address]
[City, State, ZIP Code]

RE: Denial of **[Specify Procedure]** procedure
[Patient Name]
[Policy Number/Group Number/Patient ID#]
[Date of Birth]

Dear **[Name of Contact]:**

I am writing to appeal, **[name of insurance company]**'s recent denial of benefits for my patient, **[Patient Name]** for treatment of **[insert diagnosis]** utilizing a procedure called **[Specify Procedure].** The denial states the procedure is investigational and I strongly dispute those findings. My recommended treatment, **[Specify Procedure]** has been successfully used in many cases.

[Patient Name] has been thoroughly evaluated and has been diagnosed with **[insert diagnosis].** Enclosed with this letter is the original documentation submitted and I request that you review the information again with particular attention to the patient's history of **[insert diagnosis]** which has been ongoing since **[include date of onset].** Numerous conservative attempts at treatment have been tried and failed, such as **[include medical history, treatments tried, include conservative treatments and length of time].**

Despite these attempts, **[Patient Name]** has received no relief from symptoms and is currently **[describe patient's current condition and how activities of daily life are affected].** I have included the results of tests which indicate **[list findings from CT, MRI, etc., and any other tests performed to confirm diagnosis].**

Based on these findings and our previous attempts at conservative treatments, I believe it is medically necessary to move forward and schedule **[Patient Name]** for this procedure. I firmly believe that **[Patient Name]** is an excellent candidate for **[Specify Procedure].** I request your immediate reconsideration of coverage for this procedure.

Thank you for your attention to this matter, and I look forward to your response. Please contact me if you have additional questions.

Sincerely,

[Physician's Name]

[Physician's Practice Name]

DEVICE MANAGEMENT SERVICES

Kimberly-Clark has entered into an agreement with Implantable Provider Group (IPG) to provide device management services which can eliminate the financial risks and authorization connected with reimbursement for our devices (cooled RF probe kits).

IPG will:

- Purchase the device from Kimberly-Clark and supply it to the facility at no charge
- IPG authorizes, bills, and collects for the device directly with the payer
- The facility bills for their customary facility and surgical fees
- The physician continues to bill for their normal professional fees

Call 1-866-753-0046

Steps:

For each new facility/account:

- Fill out the New Account Form for both the facility and physician and fax to IPG (first time only) at 866-753-0194

For each new patient:

- Before a procedure is scheduled, initiate authorization for procedure with insurance company, if required
- At the same time, contact IPG of the planned procedure date (need at least two week notice prior to procedure date) and send all patient information to IPG
  - New Patient Form/ Demographic & insurance information
  - Relevant medical history and progress notes with diagnosis
  - Rx (Equipment Order Form) signed by physician
  - LOMN
  - Copy of the Psych Evaluation, if available
  - Procedure authorization once available
  - Patient Authorization & Assignment Form – signed and dated prior to procedure

IPG will then work with the insurance company on obtaining device approval. Once IPG obtains approval for the device, IPG will fax/email notification to you and the office.

Note: If utilizing the services of IPG, do not proceed with the procedure without IPG authorization for the device

The Kimberly-Clark Advantage*

Clinical Education
Radiofrequency Lesioning Workshops
Pain Management Procedural Training

Knowledgeable Customer Support
Peer-to-peer In-service Training
On-site Clinical Support
Product Technical Support
Unsurpassed Customer Service
Reimbursement Consulting

Expert Sales Force
Certified Sales Representatives
On-site Trained in Hospitals and Other Clinical Settings

Infection prevention website:
www.HAIwatch.com

Tools & Best Practices
Tray Customization Tools
ROI Analysis Tool
Best Practices / Industry Guidelines
Physician Referral / Community Outreach Program

Clinical Research
Manufacturer-Directed Clinical Research

Commitment to Excellence

At Kimberly-Clark, we deliver innovative healthcare solutions that you can depend on to meet the demands of your fast-paced world, supported by in-service training, clinical research and accredited education. Whenever your needs involve infection prevention, digestive health or pain management, with Kimberly-Clark solutions, you'll have one less worry.


Protection & Infection Prevention


Surgical Solutions


VAP Solutions


Digestive Health


Pain Management

For more information, please call 1-800-KCHELPS (1-800-524-3577) in the United States or visit our website at www.kchealthcare.com.

H1247-11-01 February 2012

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*Trusted Clinical Solutions**