Quick Tips for Obtaining Insurance Coverage

Obtaining insurance coverage for implantable hearing solutions can present challenges. There are some best practices you can implement to help maneuver through the insurance web successfully. Always remember to speak to the specific health insurance plan to determine how the health plan will cover implantable hearing devices. When requesting coverage for a Cochlear Implant or Baha® system, here are some quick tips on requesting insurance approvals, managing denials, and advocating policy change.

Understand the Health Plan

How do I know what to ask the health plan to determine coverage for a cochlear implant or Baha System?

Each health plan will cover specific procedures and treatments based on the type of insurance plan a patient has chosen. All of the covered services are outlined in the health plan benefit handbook or summary of benefits. In addition to determining coverage, it's important to determine the out of pocket responsibilities for the patient as well. Cochlear has a resource available to help ask some common questions to a health plan when trying to obtain coverage. The Insurance Interview Worksheet will help guide your conversation with the health plan.

What is the difference between Pre-certification and Pre-authorization?

Always determine if a prior authorization or precertification are required for the Cochlear Implant or Baha surgery and obtain them in writing, when possible.

Pre-Certification confirms eligibility and collects information before inpatient admissions and select ambulatory procedures and services and includes:	**Pre-Authorization** is a process used to confirm the procedure is:
• Notification – process of documenting coverage requests • Coverage Determination – review of plan documents and submitted clinical information to determine whether the health plans clinical guidelines and criteria are met for coverage	• Medically necessary • Covered for the proposed care • Covered for the proposed length of stay • Scheduled for review

Otologic Management Services (OMS) is a service available to provide support to candidates and healthcare providers seeking to obtain necessary insurance approval and to support appeals where coverage has been denied for Cochlear's Nucleus® Cochlear Implants or Baha Systems for medically qualified candidates. OMS can assist with obtaining an optional process called **predetermination**. This is the process that allows a provider to request services to determine coverage prior to surgery. The health plan will review the patient health benefits and medical policies to determine if the treatment will be covered.

OMS Contact Information
Phone: (800) 633-4667 option 4
Email: OMS@Cochlear.com

Why is it important to submit a prior authorization or predetermination?

Each health plan has its own set of medical policies and prior authorization requirements. These serve as a guideline to help determine what services will be covered under each health plan. It is important to submit a prior authorization or predetermination to ensure the health plan has an opportunity to review the patient's specific health plan benefits and make sure a given patient's condition aligns with the medical policy's clinical requirements. The health plan will review the patient's specific medical history, their medical policy, and their specific benefits plan to determine if the recommended treatment should be covered. This process also offers providers an opportunity for professionals to make a case for coverage exceptions when a patient's needs and clinical needs do not align with the plan's specific coverage criteria and the professional believes the proposed intervention to be the best treatment option. The process can also prompt plans to consider changes in health plan policy especially if they routinely receive similar requests. If you think the policy should be changed, ask for details of the plan's process to do so and continue to push for individual patient exceptions through the prior authorization/pre-determination process.

What should you do if you get a denial?

Sometimes, health plans will deny coverage for implantable hearing solutions for a variety of reasons such as:

- Health Plan exclusion
- Determined not medically necessary based on diagnosis and medical documentation provided
- Physician is requesting a procedure using technology that the health plan considers to be experimental or investigational procedure
- Health Plan misunderstands the technology and denies the implant system stating it is a hearing aid.

When this happens, be sure to initiate the appeal. The appeal process will vary by health plan but typically the process is outlined in the benefit handbook. As a provider, you can contribute to your patient appeal process by providing your clinical expertise. Providers should request a peer-to-peer review when available and always be sure to appeal to all levels available. Many health plans will offer 3 levels of appeals. Once you determine the denial reason and understand the appeal options, be sure to provide supporting documentation such as:

- Clinical history of the patient should include:
    - Causes of patient hearing loss
    - Length of patient's hearing loss
    - Severity of hearing loss
    - Specific treatments tried and failed
- FDA letter
- Appeal letter to address why technology is beneficial to patient and medically necessary
- Scientific evidence supporting the use of the technology and its applicability to your clinical recommendations for the patient's treatment plan.

Cochlear has **sample appeal letters** to help with crafting your appeal response. Be sure to write the letters specific to each patient and health plan denial. Cochlear also has a variety of clinical articles to support clinical effectiveness of cochlear implants and Baha systems and are available when requested.

In some cases, the patient may be able to speak to their employer about offering coverage for a cochlear implant or Baha system. If employer is self-funded, the human resources department may be willing to remove the exclusions of the implantable hearing solutions or make an exception for the patient. Cochlear Funding resource provides other funding options when all levels of appeals have been exhausted.

Is there a difference between a medical benefit and medical necessity?

Yes, it's important to understand the difference between medical necessity and medical benefit. Medical necessity is something a provider decided is necessary for a patient based upon the accepted standards of medical practice.

A medical benefit is something the insurance plan or the health plan employer has agreed to cover as long as the treatment meets medical necessity. In some cases, providers might decide a procedure or treatment would be beneficial to a patient but is not covered by a health plan.

How are health plan medical policies developed?

Health plans develop medical policies to assist with the administration of the health benefits. The policies serve as a guideline for determining whether health services are covered, medically necessary, and fall within the health plan benefit category of covered services. Medical policies are regularly reviewed by the health plan and updated as needed. Health plans have a medical policy review process where they will review new clinical evidence about the clinical effectiveness of a procedure or technology. During the review process providers have the opportunity to review draft polices and provide comments, feedback or pertinent references to assist with the development or updating of medical policies.

Additional Cochlear Resources:

Cochlear Americas has three geographically-based hearing implant reimbursement experts available to assist you with coding, payment, payer coverage, contracting, and other reimbursement related challenges. They are responsible for driving initiatives in their territories to remove barriers to patient access.

(Central) Anne Anthony phone: (214) 282-7214 or email: aanthony@cochlear.com
(East) Keith Latiolais phone: (901) 481-6158 or email: klatiolais@cochlear.com
(West) Joan Sunderland phone: (503) 618-0192 or email: jsunderland@cochlear.com

A more detailed description of the reimbursement support offered by Cochlear's Regional Reimbursement team and a territory map can be found on the Reimbursement Support page of Cochlear's US Professional Resources Website. Please do not hesitate to reach out to the Reimbursement Manager associated with your geography for reimbursement assistance or for questions related to this article. Cochlear offers coding assistance through the Coding Support Line accessible by calling 1-800-587-6910 between the hours of 8 AM – 3 PM Mountain time zone or via email at

codingsupport@cochlear.com. For pre-surgical insurance support, OMS is available to assist with pre-authorizations and appeals and can be reached at 1-800-633-4667 option 4.