**Sample Template Letter for an Appeal Request**

**(For Medicare Advantage Plans Only)**

**This template is designed to assist providers in obtaining coverage and establishing medical necessity for the *VertiflexTM Procedure†*. This template is not intended to replace any Medical judgment; it is merely to assist with the structure of a coverage request. There are several places in red within this template that encourage patient-specific information.**

**Please review this letter once you have personalized it to the specific patient and eliminate all red fonts and template-related directions, including this document title and section**.

(Insert Physician Letterhead)

Date

Insurance Name: Medicare Advantage Plan, XXX

Attn: Appeal Department

Street Address

City, State, Zip

Patient Name:

ID Number: #

Group Number: #

Date of Birth: XX/XX/XXXX

**Procedure Code**: 22869, +22870 (if two-level procedure) Insertion of a lumbar interspinous process stabilization device without decompression or fusion

**Principal Diagnosis**: Enter patient principal diagnosis

To Whom It May Concern:

I am writing on behalf of my patient, Patient Name, to request an appeal review in response to a preauthorization denial for the posterior interspinous decompression spacer procedure to treat lumbar spinal stenosis with neurogenic claudication. The denial rationale indicates Insert Rationale.

My patient specifically has a Medicare Advantage Plan offered by Insurance Company Name.

My patient chose the option of a Medicare Advantage Plan rather than a Traditional Medicare Plan,

due to the benefits that this plan offers in alignment with Traditional Medicare Plan benefits.

In support of my patient’s choice, I strongly believe that coverage should be provided under my patient’s Medicare Advantage Plan, which is based on the guidelines that they **must** comply with Original Medicare regulations and follow Medicare coverage in the respective region. By not providing coverage, this plan is out of compliance with Medicare’s guidelines. This does not allow Medicare Advantage Plan patients access to the same benefits as Original Medicare beneficiaries. According to **[Medicare Managed Care Manual Chapter 4 - Benefits and Beneficiary Protections](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf) -** *(Page 6)*: **10.2 – Basic Rule** (Rev. 121, Issued: 04-22-16, Effective: 04-22-16, Implementation: 04-22-16): “An MAO offering an MA plan must provide enrollees in that plan with all Part A and Part B original Medicare services, if the enrollee is entitled to benefits under both parts, and Part B services if the enrollee is a grandfathered “Part B only” enrollee. The MAO fulfills its obligation of providing original Medicare benefits by furnishing the benefits directly, through arrangements, or by paying for the benefits on behalf of enrollees.”

Medicare did not issue a National Coverage Determination (NCD). The Medicare Administrative Contractor, Insert MAC, for the state in which I practice, Insert State, did not issue a Local Coverage Determination (LCD) for Interspinous Spacers. Medicare does not create such policies for every procedure that is considered by Medicare as a covered benefit because specific criteria may not be needed to outline medical necessity. While some Medicare Advantage Plans base their guidelines to follow Original Medicare on an official NCD or LCD, it is important that an absence of either does not equate to non-coverage for a procedure. Medicare has been known to cover the interspinous decompression spacer procedure. Medicare does not create LCD’s for every procedure that is considered by Medicare as a covered benefit because specific criteria may not be needed to outline medical necessity.

To date, there has been no notification from Medicare regarding the need to create a specific policy for this procedure. First Coast Service Options (FCSO) was the only MAC that created an LCD. But effective April 4, 2020, FCSO retired [#L34006](https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34006&ver=17&Date=&DocID=L34006+&bc=iAAAAAgAAAAA&) and the accompanying Local Coverage Article (LCA) [#A57777](https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=57777&ver=4&SearchType=Advanced&CoverageSelection=Local&ArticleType=BC&s=12&AdvSearchName=4&KeyWord=Interspinous&KeyWordLookUp=Doc&KeyWordSearchType=Exact&Date=04042020&kq=true&bc=EAAAABAAAAAA&) outlining coverage for this procedure (please see attached). Furthermore,  FCSO published a new LCA, [#A58066](https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=58066&ver=2&Cntrctr=368&ContrVer=1&CntrctrSelected=368*1&DocType=All&s=12&bc=AAgAAAEAAAAA&), stating: “based on review of the following local coverage determinations (LCDs) and billing and coding articles, it was determined that they are no longer required and therefore, are being retired.” FCSO has also been known to continue coverage for Medicare beneficiaries after the April updates.

Furthermore, to provide verification that Traditional Medicare through the Medicare Administrative Contractor provides coverage and reimburses for the Vertiflex Procedure, please see the attached redacted Medicare remittance(s) from my practice and the respective local carrier’s fee schedule. Traditional Medicare coverage is clearly evident showing the code(s) and allowable amounts that were paid in a timely manner through the local Medicare carrier.

Patient Name has suffered from this condition for Insert Years of Months and has greatly impacted his/her quality of life. This condition results in the narrowing of the spine causing cramping, pain, tingling and weakness in the back, buttocks and legs. (Describe impact to patient quality of life and/or activities of daily living) I highly recommend this minimally invasive procedure when conservative treatment has failed and as a safer alternative to a laminectomy or spinal fusion procedure.

This procedure provides decompression of the spine using an implant that is placed via a small incision, under local anesthesia. The implant then holds the space open, preserving the space in the spine necessary to lift the pressure off the nerves and lower back. There is no removal of the bone or muscle and soft tissue dissection. I plan to provide this procedure on an outpatient bases specifically in the Hospital OR Ambulatory Surgery Center. This interspinous spacer (Vertiflex™) received FDA Approval in 2015, based on a randomized controlled trial (RCT). At 5 years, outcomes were reported with 66% Back Pain Improvement (VAS), 75% Leg Pain Improvement (VAS), 85% Opioid Reduction, and 90% Patient Satisfaction (ZCQps). (Nunley 2017)

Patient Name has failed than X months of conservative approaches to treatment at this time. Failed conservative treatment approaches include: (List failed treatment approaches). My patient demonstrates to be a good candidate because: (List reasons patient is a good candidate, which may include no radiographic evidence of instability, no remarkable scoliosis or severe osteoporosis).

(Please include the patient’s specific case to demonstrate medical necessity of this procedure. Please list any concurrent co-morbidities the patient may have). According to a recent study specific to treating LSS patients with concurrent medical comorbidities, “similar to other minimally invasive techniques it has specific advantages over more open spinal surgical procedures, including shorter procedure time, the possibility to be performed under local anesthesia, minimal or no muscle disruption or blood loss and less risks of nerve damage or cerebrospinal fluid leaks.” (Hartman 2019). Included with this letter is the clinical documentation which supports these clinical findings and medical necessity for the procedure.

Please add any experiences and outcomes you have had from treating previous patients with similar history.

This treatment is considered safe and effective, as supported by its clinical benefits to patients, continued medical professional adoption, and strong clinical evidence with numerous peer-reviewed studies. I hope for a favorable outcome to approve this preauthorization request and provide the necessary coverage that my patient should be entitled to, based on enrollment with this Medicare Advantage Plan through your company.

Please contact me at any time for any questions or if you need additional information.

Thank you for your time and consideration in reviewing this request.

Sincerely,

Physician Signature

Physician Name

Facility Name

Phone

E-Mail

†Superion® Indirect Decompression System

**REFERENCES**

FDA, *Premarket Approval P140004.* 2015.

Hartman J, Granville M, Jacobson R E (August 12, 2019). *The Use of Vertiflex® Interspinous Spacer*

*Device in Patients With Lumbar Spinal Stenosis and Concurrent Medical Comorbidities. Cureus 11(8):*

*e5374. DOI 10.7759/cureus.5374.* <https://pubmed.ncbi.nlm.nih.gov/31616607/>

Nunley, P.D., et al., *Five-year durability of stand-alone interspinous process decompression for lumbar spinal stenosis.* Clin Interv Aging, 2017. 12: p. 1409-1417. <https://www.ncbi.nlm.nih.gov/m/pubmed/28919727/>

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