

Insurance Reimbursement Suggestions

Contact your insurance carrier and request a **pre-determination of benefits**. If you are informed the treatment is not covered, then contact your referring physician, either PCP or ENT and ask for a **Letter of Medical Necessity** for your insurance carrier. This letter should state the medical necessity of obtaining the Neuromonics Tinnitus Treatment in order to treat your condition. Your insurance carrier should be **asked how they determine medical necessity, and what documentation is needed in your case**. Ask your insurance carrier if there is coverage for **Durable Medical Equipment (DME) on your particular policy**. Also be prepared to do the following:

- Provide copy of Neuromonics Tinnitus Treatment Device Overview (attached).
- Provide copy of Peer Reviewed Clinical trial (attached).
- Provide a copy of your Audiogram.
- Provide a copy of a Neuromonics Tinnitus Treatment brochure.

APPEALS PROCESS

If you are denied coverage initially, do not be discouraged. There is an appeals process that is a standard part of the reimbursement protocols established by insurance companies. You can specifically ask your carrier the steps involved in their appeals process. **If you are denied follow the following steps:**

Step 1: Contact the payer and obtain the following information:

- **Specific information the payer requires for appeal submission.**
- **Deadline for submitting the appeal.**
- **Specific contact information (name of person, telephone and fax number) and address of the person to whom the appeal should be sent.**

Step 2: Prepare a letter appealing the decision (ask your audiologist or physician if they have one available). The letter should address all of the issues raised in the denial letter. Be sure to reiterate the medical necessity of the Tinnitus Treatment and Device (A sample letter is attached).

Step 3: Assemble all required documents requested by the payer to determine Medical Necessity. Make copies and send the originals according to the payer's directions. In order to track the documents it is recommended they be sent certified mail, overnight mail, or in any manner that allows for tracking.

Step 4: One week after sending the appeal package, contact the payer to determine the status of your appeal. Continue to periodically contact the payer until you have received a definite answer.

Step 5: Review times for appeals varies from carrier to carrier. Payers should be able to provide an approximate time for appeal. Note: Some payers allow appeals to be expedited directly to the Medical Director while others require a more formal process. Each payer should be queried for their requirements.

Do not be discouraged if your first appeal is denied as well, that does not mean the issue is dead. Contact the payer and ask the procedure for appealing a second, third, or even fourth time. Be sure to maintain records of who is spoken to, when and what you are advised to do. It is not uncommon to have coverage initiated after additional appeals are made to the carrier. Attached you will find a sample appeals letter.

For assistance contact Curtis Amann, Mid-Atlantic Territory Manager, Neuromonics. 703-731-3231

