{NAME OF INSURANCE PRESIDENT/CEO}

{TITLE}

{ADDRESS}

{CITY, STATE, ZIP}

{DATE}

**EXPEDITED SINGLE CASE RATE LETTER OF AGREEMENT**

**{PATIENT NAME}**

**Group#: {XXXXXX}**

**ID#: {XXXXXXX}**

Dear {EXECUTIVE NAME},

I apologize in advance if you are not the right person to send this request to, I am attempting to navigate getting treatment for my condition, and it is truly overwhelming. I am discovering that there’s a gap not only in care, but in how my condition is viewed and treated by Medicare Part B, among other entities. I am writing to you today because I am not sure where to begin so I can get the right care that I need, and I wanted to make sure a doctor saw my expedited request. I am truly hoping you can help me route this in the right direction or advise on how to proceed. As you can imagine, for a layperson, navigating the healthcare system is daunting to say the least and your help would be invaluable to restoring my health.

I am a {XX}-year old woman who has endometriosis; one of the leading gynecologic diagnoses in women with recurrent and progressive chronic pelvic pain. Endometriosis is a progressive and debilitating disease, which can cause serious organ dysfunction if left untreated or improperly treated. It is critical that I get surgery and treatment soon, as each passing day, my symptoms increase, and I cannot imagine what my life will be like if they become worse, which they already are.

I’m not sure if you are familiar with endometriosis, but it is a progressive condition where cells, similar to those that line the uterus, are found throughout the pelvis and sometimes, in distal sites outside of the pelvis like the lungs or the brain.  These cells cause pain and trigger an inflammatory reaction in the body. Endometriosis can be found in many different places, including but not limited to the bowels, the bladder, the peritoneal wall, appendix, rectum, and even the diaphragm, lung and brain. Women with endometriosis typically have a range of pelvic and abdominal pain symptoms, including dysmenorrhea, dyspareunia, heavy menstrual bleeding, non-menstrual pelvic pain, pain at ovulation, dyschezia and dysuria, as well as chronic fatigue ([Kennedy *et al*., 2005](https://urldefense.proofpoint.com/v2/url?u=http-3A__humrep.oxfordjournals.org_content_28_6_1552.full-23ref-2D55&d=DQMFaQ&c=hNAZrKxPkhfPADjr9wUJ4I9GS8ZQPNEcFQu4kKjVcNw&r=oUrE-5PMwF5Hhp5P3eVtgkIdPwnUCMFP36Y9s1jLZK0&m=g-B_TFbDkuQZrqShjzJp6K4WYEe8m-mTUTkhZJcAjq4&s=9X_Lc3MCfsMyVaIvrjwce0duvTi5PP57VW00tEzLkAU&e=); [Nnoaham *et al*., 2011](https://urldefense.proofpoint.com/v2/url?u=http-3A__humrep.oxfordjournals.org_content_28_6_1552.full-23ref-2D75&d=DQMFaQ&c=hNAZrKxPkhfPADjr9wUJ4I9GS8ZQPNEcFQu4kKjVcNw&r=oUrE-5PMwF5Hhp5P3eVtgkIdPwnUCMFP36Y9s1jLZK0&m=g-B_TFbDkuQZrqShjzJp6K4WYEe8m-mTUTkhZJcAjq4&s=BTivYzKLCG5sz5a3nQeFZYfdEnEhlRjlB_YijeUHkOs&e=)).

I wanted to reach out to you personally, because the increase in endocrine disruptors contributing to rising numbers of endometriosis, (*Journal of Endocrinology and Metabolism*, Trasande, et al, April 2016), deepening clinical knowledge about the disease, changing diagnostic standards and standards of care based on clinical evidence, and increased media attention mean that this will most likely be the first of many of these types of Letters of Agreement/Single Case Rate requests you will receive in the coming decade. There is a clinician and patient activist movement growing as more is learned about endometriosis and how safe, accepted and medically necessary excision surgery is. As an executive at a world-class insurance company who cares about your members, I know you would want to be aware of, and on the front lines of this healthcare trend.

The good news is I have found a provider who can deliver skilled scientific and precise identification and removal of endometriosis and adhesions, and is willing to do the treatment at an in-network hospital. This is where the serious gap in care comes in – his surgical fees reflect his skill in this sub-specialty which requires advanced skill and training in identification of the disease, as well as surgical skill akin to advanced cancer surgery. However, Medicare Part B currently doesn’t recognize these skills in terms of compensation – and this is where the patient, me, gets trapped in a care gap – while my symptoms worsen.

Until this care gap is resolved, I am requesting in good faith that {NAME OF INSURANCE COMPANY} create a Single Case Rate Letter of Agreement with Dr. Andrew Cook at Vital Health Endometriosis Center for my medically necessary treatment so I can traverse the road back to health.

**What is endometriosis excision surgery?**

Wide excision removes endometrial cells by cutting them away from the surrounding tissue with scissors, a very fine heat gun or a laser beam, similar to an advanced cancer biopsy, ensuring no endometrial cells are left behind. The tissue is then sent to pathology for confirmation of endometriosis. Since endometriosis cells are on delicate organs like the bowel, bladder, ovary, rectum or peritoneum, this surgery requires significant training of the surgeon, not only in removing the endometriosis from extremely delicate organs, but identifying it as well, since endometriosis can appear as red, blue, white, yellow, clear or brown**.**

**Excision is extremely different than cauterization/coagulation/fulguration/ablation of endometriosis cells on multiple levels**. **Cauterization/coagulation/fulguration/ablation** **does not** **remove the endometriosis cells**, it can damage underlying tissue, it takes very little time or expertise to do, and it is palliative at best as outcomes for cauterization show little long-term symptom and pain relief. Wide excision surgery, **performed by a high-volume wide excision surgeon with advanced surgical skill in identification of the disease**, is the gold standard in removing in endometriosis of all stages (see attached clinical documentation). It is safe, clinically sound, and proven effective for long-term patient outcomes.

However, as documented in increasing amounts of articles in the press as well as, increasing treatment failures among patients, there is a serious access to care problem for endometriosis patients, as Medicare Part B does not recognize excision as a specialty.

Because of this structural problem, lack of training available to doctors, and outdated treatment protocols, women who suffer from this debilitating disease wait on average seven years to even receive a diagnosis. [Sixty-three percent of general ob/gyn practitioners feel uncomfortable diagnosing and treating patients with endometriosis](http://acogpresident.org/?p=1443), and as many as half are unfamiliar with the three main symptoms of the disease. The longer the diagnosis, the more crippling this condition becomes rendering patients unable to work or perform basic everyday functions.

**Clinically proven patient outcomes**

“Complete excision of endometriosis, including vaginal resection, offers a significant improvement in sexual functioning, quality of life, and pelvic pain, including in those symptomatic patients with deeply infiltrating endometriosis nodules in the posterior fornix of the vagina. As well, the technique offers good results in terms of reduced bladder morbidity and bowel symptoms. However, in that this kind of surgery requires advanced skills and anatomical knowledge, again, it should be performed only in selected reference centers.”

*APGO Educational Series on Women’s Health Issues Diagnosis & Management of Endometriosis: Pathophysiology to Practice*, https://www.apgo.org/binary/EndometriosisCMEMonograph.pdf

**The World Endometriosis Forum,** the international clinical organization that advances evidence-based standards and innovations for education, advocacy, clinical care, and research in endometriosis and related disorders, recommends excision surgery at a high-volume practice for optimal outcomes.

**"Consensus on current management of endometriosis, Neil P. Johnson, Lone Hummelshoj, for the World Endometriosis Society Montpellier Consortium"**

Previously the term ‘centre of excellence’ has been used ([D'Hooghe and Hummelshoj, 2006](https://urldefense.proofpoint.com/v2/url?u=http-3A__humrep.oxfordjournals.org_content_early_2013_03_25_humrep.det050.full-23ref-2D27&d=DQMFaQ&c=hNAZrKxPkhfPADjr9wUJ4I9GS8ZQPNEcFQu4kKjVcNw&r=oUrE-5PMwF5Hhp5P3eVtgkIdPwnUCMFP36Y9s1jLZK0&m=g-B_TFbDkuQZrqShjzJp6K4WYEe8m-mTUTkhZJcAjq4&s=WR7iW0rgciyRgvVGBMVQ0MmPmwe1ShvF3Fyq7oyLZhA&e=)) but we now agree that ‘centre (or network) of expertise’ is more appropriate. It was accepted that a centre/network of expertise would take differing forms in different settings, such centres/networks should ideally comprise a multi-disciplinary team approach with specialists who have undergone specific training in endometriosis, advanced surgeons with a high caseload of managing deep endometriosis (also known as deep infiltrating endometriosis, DIE), ready access to an endometriosis organization with substantial input on behalf of women and a track record of commitment to collaborative management and research.."

There is***unanimous consensus***over the recommendation ***to*** ***excise lesions where possible***, especially deep endometriotic lesions, which is felt by most surgeons to give a more thorough removal of disease ([Koninckx *et al*., 2012](https://urldefense.proofpoint.com/v2/url?u=http-3A__humrep.oxfordjournals.org_content_28_6_1552.full-23ref-2D59&d=DQMFaQ&c=hNAZrKxPkhfPADjr9wUJ4I9GS8ZQPNEcFQu4kKjVcNw&r=oUrE-5PMwF5Hhp5P3eVtgkIdPwnUCMFP36Y9s1jLZK0&m=g-B_TFbDkuQZrqShjzJp6K4WYEe8m-mTUTkhZJcAjq4&s=eCZtmgxANB8rzaWzPzWwQKg6L45YU50MsA7YQHoGpnE&e=)).

**First (excisional) operations tend to produce a better response than subsequent surgical procedures,** with pain improvements at six months in the region of 83% for first excisional procedures versus 53% for second procedures ([Abbott *et al*., 2004](https://urldefense.proofpoint.com/v2/url?u=http-3A__humrep.oxfordjournals.org_content_28_6_1552.full-23ref-2D1&d=DQMFaQ&c=hNAZrKxPkhfPADjr9wUJ4I9GS8ZQPNEcFQu4kKjVcNw&r=oUrE-5PMwF5Hhp5P3eVtgkIdPwnUCMFP36Y9s1jLZK0&m=g-B_TFbDkuQZrqShjzJp6K4WYEe8m-mTUTkhZJcAjq4&s=uwrggYE9kEYGCOD3ATMKHchi-DeWxxyG1p9dZD0_0aY&e=)).

**The Difference in Outcome (and Future Surgeries) is Surgical Skill**

There is a big difference in the ability to remove all endometriosis between a surgeon who does 15-25 major endometriosis excision cases a month, and those who are general gynecological surgeons, laparoscopic gynecological surgeons, or regular ob-gyn’s. The challenge is that deep, superficial and microscopic disease is technically much more difficult to identify. To remove it requires significantly more skill by the surgeon, which is why it is crucial who actually does the surgery.

While endometriosis is one of the most common gynecological diseases, with one in ten women presenting with it, there is growing clinical evidence that the way it is routinely treated by OB-GYNs in general practice, or gynecological surgeons is ineffective and palliative at best, and causes damage at worst. There is a stark difference between the surgical care and treatment being offered by those who dedicate their practice to managing this disease at a center of excellence devoted to the disease, and by those who treat the condition as one of a large array of common gynecologic disorders, as a general surgeon, general ob/gyn, or laproscopic surgeon. Lack of medical school training available, the fact that excision is not a recognized specialty, and the Medicare Part B ruling all create a massive gap in care for patients who are suffering debilitating symptoms from this condition.

**Vital Health Endometriosis Center**

Vital Health Endometriosis Center fulfills all the requirements of a center of excellence for endometriosis care. Especially for those who have had failed previous surgeries and palliative hormonal treatments, like myself, this is crucial to restoring me to health.

Dr. Andrew Cook has undergone extensive specialty surgical training in excision, and is a highly regarded specialist in identification and excision removal of endometriosis (see attached CV).

**Cost Savings + Improved Patient Outcomes = Win - Win**

The key difference in getting treated by a doctor who has specific training, and decades of experience in, accurately spotting and removing endometriosis, is both the outcome for the patient, and the cost savings to the insurer. **Endometriosis is a progressive disease – so early surgical intervention by an excision expert is crucial to patient care.** An endometriosis expert can identify superficial, microscopic and other iterations of endometriosis that are usually missed by other surgeons, and remove them in a way that has positive, clinically proven, long-term outcomes that fulguration, cauterization or ablation do not have as these modalities have all been proven to leave behind cells and require many additional surgeries. Surgery with a surgeon who has the skill to identify and remove the endometriosis, will avoid multiple further surgeries, which represents a very significant cost savings since it is common for us endometriosis patients to have anywhere from four to ten ineffective surgeries before we see an endometriosis expert who can accurately identify and remove the endometriosis.

I have undergone {HOW MANY YEARS} of chronic pelvic pain, had numerous in-network failed treatments, been offered only palliative options, and I experience progressive, debilitating chronic pain that does not allow me to function normally.

*(Include below statement if you suffer from migraines)*

{Migraines are a common symptom of endometriosis (“Increased frequency of migraine among women with endometriosis”, *Human Reproduction*, December 2004.)}

The situation is urgent.

**The surgery with Dr. Andrew Cook is a medically necessary one as my disease is progressive, debilitating and can cause organ dysfunction of bowels, bladder and other pelvic organs if left in my body.** No one in the {NAME OF INSURER} network is a high-volume, wide excision surgeon who has the advanced training and skill necessary to remove the endometriosis cells from my body.

I am requesting a good faith expedited approval for the following medically necessary surgical costs (*hospital, anesthesia and pathology are all* *in-network*):

* **Expedited Single Case Rate Letter of Agreement for Treatment and surgery by Dr. Andrew Cook at the El Camino Hospital on {DATE OF SURGERY}**

**Proposed Single Case Rate Letter of Agreement Schedule**

**Dr. Andrew Cook and Assistant Surgeon**

**Total: $XX,XXX**

CBT CODES {GET YOUR CBT CODES FROM YOUR DOCTOR}

Example:

12345 Excision of endometriosis $X,XXX

{THERE WILL BE MANY CPT CODES HERE, LIST THEM ALL}

*Please note the following:*

* Removal of endometriosis via excision is time-consuming, and requires a high level of skill similar to an advanced cancer surgeon. Fulguration/ablation takes much less skill and time but does not yield positive long-term outcomes. Currently Medicare Part B currently does not distinguish between fulguration/ablation and excision; therefore, the fees above reflect more accurately the value of the identification of endometriosis and surgical skill necessary to remove it completely.
* Surgery performed at an in-network hospital.
* Pathology lab is in-network.
* Anesthesia is in-network.

**Attachments:**

* My failed In-network treatments
* My current pain and symptoms chart
* Clinical evidence regarding excision surgery
* Dr. Cook’s CV
* Letter from primary doctor
* Letter from Dr. Cook

**My Failed Treatments**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Treatment** | **Date + Location** | **Provider** | **In-network** | **Outcome** | **Notes** |
| Diagnosis Lap Surgery | *1-15-2008* | *Dr. Smith* | *Yes* | *Confirmed endometriosis, limited pain relief* | *Pain relief for about 6 months* |
| Hormones |  |  |  |  |  |
| Birth Control |  |  |  |  |  |
| Diet change |  |  |  |  |  |
| Pain Management |  |  |  |  |  |
| Acupuncture |  |  |  |  |  |
| Chiropractor |  |  |  |  |  |

**My Current Pain Chart - {DATE}**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **TYPE** | **WHERE** | **TYPE OF PAIN** | **SCALE (1-10)** | **HOW OFTEN?** |
| **Pain with pooping** | *Lower left quadrant* | *binding* | *9* | *Every time etc…* |
| **Pain with peeing** |  |  |  |  |
| **Pain when bladder is full** |  |  |  |  |
| **Pain during Ob/Gyn exam** |  |  |  |  |
| **Pain after sex** |  |  |  |  |
| **Pain during sex** |  |  |  |  |
| **Lower back pain** |  |  |  |  |
| **Left flank pain** |  |  |  |  |
| **Migraines** |  |  |  |  |
| **Fatigue** |  |  |  |  |
| **Bloating** |  |  |  |  |
| **Heavy bleeding** |  |  |  |  |
| **Nausea/**  **Vomiting** |  |  |  |  |