TCAR Prior Authorization Guide

This resource provides guidance for physicians on how to submit prior authorization requests for TCAR.

Overview

Prior to Transcarotid Artery Revascularization (TCAR), we recommend the physician request a coverage decision from non-Medicare payers to ensure the procedure will be covered. Failure to gain coverage from the payer may result in non-payment to the hospital and physician.

Many payers require physician offices to submit specific patient information for prior authorization review. The information provided should document the health status of the patient and assure the reviewer that the proposed therapy is the most appropriate treatment alternative for the patient.

Keys to Success in Gaining Prior Authorization

The keys to successful prior authorization and appropriate reimbursement from a payer include:

- Identify a staff member within your practice to coordinate all prior authorization and pre-certification processes with payers and hospitals.
- Involve the patient and/or family in the prior authorization process as appropriate.
- Follow the payer's conditions for carotid artery stenting (CAS) coverage.
- Prepare a clear and concise prior authorization letter.
- Educate the payer regarding the therapy, as needed.

Medicare

Medicare does not require prior authorization for services that are considered covered benefits under Medicare. TCAR is covered under Medicare's National Coverage Determination (NCD) 20.7 for Percutaneous Transluminal Angioplasty. The Vascular Quality Initiative (VQI) TCAR Surveillance Project (TSP) is an FDA-approved post approval study; therefore, patients participating in the VQI-TSP are covered (Pub. 100-03, 20.7, B3).

Note: Some Medicare Advantage plans may require prior authorization.

Non-Medicare (e.g., Commercial, Medicaid, Veteran's Administration)

Prior authorization is often required for elective procedures. We strongly recommend pursuing prior authorizations with non-Medicare payers. Follow the process as required by each payer to obtain prior authorization and allow sufficient time for a response.

Medicaid

Prior authorization may be required. Medicaid is a highly fragmented process and many states do not provide public information on when prior authorization may be required. Contact your state authority for instructions on their process.

Types of Appeals & Process

Appeals are classified as either pre-service appeals (for services not yet provided), post-service appeals (for services already provided) or expedited appeals (for services thought to be urgent, based on either the physician's judgment). Understand the levels of appeals available for each health plan and the time frame for each level. It varies from plan to plan and state to state, but most plans and states have three levels – two internal and one external.

- **Internal appeal** is an effort to get the insurance plan to change their mind and approve your request, this may require additional information. This process has multiple steps if care has not yet been provided. Most plans will offer at least two levels of internal appeal.
    - Typically, you can only file for an external review once you have exhausted the internal appeals process.
    - In medically urgent situations, you can request an external review even if you haven't completed all the available internal appeals.

- **External appeal** is when an outside physician group referred to as a third-party or an Independent Review Organization (IRO), not connected with the insurance company, reviews all documents previously submitted, denial letters, and any additional information that supports your request, and makes an impartial decision.
    - External appeals are generally reserved for situations where you disagree with the insurance company based on medical judgment or if the insurance company claims the treatment prescribed is experimental or investigational.
    - The health insurance company is required to accept the decision made by the IRO.

Tools & Resources

Tools and resources are available to support prior authorizations, denials and appeals.

Scenario	Tools & Resources
Prior Authorization Request	• Specific payer's coverage policy • Contact the Reimbursement team for assistance researching the specific coverage policy.
	• Prior Authorization Template
Prior Authorization Denials	• Prior Authorization Denial Appeal Template
	• Peer-to-Peer Guide
Additional Resources	• FDA approval letters • CMS approval letters • TCAR Medicare Reimbursement Guide • CMS National Coverage Determination 20.7 • Bibliography • Instructions for Use (IFU)

Reimbursement Support

Contact Silk Road Medical's Reimbursement team at **reimbursement@silkroadmed.com** or 855-410-8227 option #5.

Scan the QR code with your smartphone for additional TCAR reimbursement resources.