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 covers TCAR under the national coverage determination (NCD) 20.7 for Percutaneous Transluminal Angioplasty (PTA) of the Carotid Artery Concurrent with Stenting,[1] which was last updated on October 11, 2023.[2] This NCD covers carotid stenting procedures for traditional Medicare and Medicare Advantage beneficiaries under the following indications:

- B3. Concurrent with Carotid Stent Placement in FDA-Approved Post-Approval Studies (e.g., Vascular Quality Initiative TCAR Surveillance Project or VQI TSP)[3]
- B4. Concurrent with Carotid Stent Placement

Traditional Medicare does not require prior authorization for procedures.

Medicare Advantage plans are managed by private insurers and must cover TCAR according to the NCD.[4] They cannot have more restrictive coverage criteria than the NCD, but they may require prior authorization or precertification. Contact the patient's Medicare Advantage plan for claims processing requirements.

Non-Medicare

Non-Medicare payers, such as private insurers, Medicaid, and the Veteran's Administration, have different coverage plans and policies. Contact the payer before the TCAR procedure to verify coverage and billing requirements for carotid artery stenting.

Prior authorization or precertification is often required for elective procedures like TCAR. Reviewing payer guidelines is essential to avoid denials, payment losses, and penalties. The hospital can contact Silk Road

[1] NCD - Percutaneous Transluminal Angioplasty (PTA) (20.7). Cms.gov. https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=201

[2] NCA - Percutaneous Transluminal Angioplasty (PTA) of the Carotid Artery Concurrent with Stenting (CAG-00085R8) - Decision Memo. Cms.gov. https://www.cms.gov/medicare-coverage-database/view/ncacal-decision-memo.aspx?proposed=N&ncaid=311

[3] Carotid Artery Stenting (CAS) Investigational Studies | CMS. Cms.gov. https://www.cms.gov/medicare/coverage/approved-facilities-trials-registries/carotid-artery-stenting-studies

[4] Medicare Managed Care Manual Chapter 4 - Benefits and Beneficiary Protections. Cms.gov. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf

Medical's Reimbursement Team at **reimbursement@silkroadmed.com** to determine coverage availability before scheduling a patient's procedure.

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). 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 its 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.

Reimbursement Support

For reimbursement assistance, please contact Silk Road Medical's Reimbursement team:

- Email: **reimbursement@silkroadmed.com**
- Phone: **(855) 410-8227, Option #5**
- Website: **https://tcar.at/reimbursement**

Scan or click the QR code to access our website and reimbursement resources or visit us at: **https://tcar.at/reimbursement**.