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Prior authorization guide

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Overview

This document outlines resources available to support your efforts in obtaining prior authorization for procedures related to Medtronic devices and therapies. Click on the blue buttons below to access resources within this document as well as external resources.

Prior authorization resources

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Click here Prior authorization guidance

Click here Physician peer-to-peer guide

Click here Documentation best practices

Click here Reimbursement website

Therapy-specific supplementary resources

Click here For additional supplementary resources to assist in prior authorizations, please see our therapy-specific resource links

Contact

For additional information, contact the Medtronic Reimbursement Customer Support team by phone at 866-877-4102 or by email at: rs.healthcareeconomics@medtronic.com.

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Levels of prior authorization

There may be varying levels in the prior authorization process. If your initial request is not approved by the payer, there may be options to appeal the initial decision. Resources are available for each level of the prior authorization process.

Initial request

Review payer policy coverage requirements, and request prior authorization

Resources

- Prior authorization guidance
- Documentation best practices
- Sample prior authorization letter (see the therapy-specific documents)

Was the prior authorization approved?

Yes → ✓

No → Review the denial letter for the next level(s) of appeal

Appeal options

Consider a written appeal

Resource

- Pre-service appeal letter

Consider a peer-to-peer review

Resource

- Physician peer-to-peer guide

The order of the peer-to-peer review and the written appeal may vary by payer and/or plan.

Each payer has their own process. Additional levels of appeal may be available after exhausting the initial prior authorization, a written appeal, and/or a peer-to-peer review. Please contact the patient's payer for exact prior authorization steps.

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Prior authorization guidance

Overview

The information below depicts the general process for obtaining prior authorization from a payer. Prior authorization – sometimes called precertification, preauthorization, prior approval, or predetermination – is a utilization management process used by payers to evaluate medical necessity and determine if certain products or services will be covered. This process requires providers to obtain advanced approval that medical necessity and coverage criteria have been met before services are provided. Prior authorization may take over 2 weeks, not including the appeal process. It is recommended providers consider this when scheduling the procedure.

Note: The information provided is for consideration only. The provider is responsible for determining medical necessity and submitting appropriate codes and charges for care provided. Please contact the payer for their prior authorization requirements and process.

Payer types

Commercial, Medicaid, or other

- Coverage and prior authorization requirements can vary by plan, and within a payer based on an individual's commercial coverage
- Verification of prior authorization and prior testing requirements is strongly recommended.
- Contact the payer or state authority for instructions
- It is the provider's responsibility to document "reasonable and necessary"

Medicare Advantage

- Medicare Advantage plans are required to cover what is covered by Traditional Medicare at minimum, and are subject to the same coverage requirements, following National Coverage Determinations (NCDs) or applicable jurisdictional Local Coverage Determinations (LCDs)
- When there is an applicable NCD or LCD, Medicare Advantage plans can only require prior authorization to confirm the presence of diagnoses or other medical criteria
- Medicare Advantage plan administrators may have policies and additional requirements such as prior testing and prior authorization
- It is the provider's responsibility to document "reasonable and necessary"

Traditional Medicare

- Traditional Medicare does not require, nor does it provide, prior authorization, for any cardiac procedures
- Traditional Medicare relies on NCDs to assess coverage
- When an NCD is not available, Medicare Administrative Contractors (MACs) will look to LCDs to assess coverage
- It is the provider's responsibility to document "reasonable and necessary"

Considerations for obtaining a prior authorization

- **Coordination:** Identify a staff member to coordinate the prior authorization process (e.g., document payer interactions, track outcomes)
- **Clarification:** Determine prior authorization and coverage requirements before providing the service
- **Accuracy:** Ensure appropriate documentation is submitted and supports medical necessity and coverage criteria. Please refer to the Documentation Best Practices and Sample Prior Authorization Letter
- **Attention:** Regularly follow up with the payer to ensure a timely determination
- **Education:** If the prior authorization is denied, request the denial letter to determine the payer's rationale and appeal process
- **Escalation:** Inquire about a peer-to-peer review. Please refer to the Peer-to-peer Guide section
- **Preparation:** If appealed, be prepared with documentation addressing the denial reason. Please refer to the Sample Pre-Service Appeal Letter

Prior authorization process may include the following:

Collect information

- Patient's name, date of birth, and identification number
- Physician name and NPI
- Name, address, and NPI of the facility where the procedure will take place (site of service)
- Date of service (requesting a date range allows flexibility in scheduling and prevent the need to resubmit your prior authorization request should a procedure be rescheduled)
- Diagnosis, procedure, and corresponding hospital and physician billing codes

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Contact the payer

- Confirm patient eligibility and benefits.
- Inquire about a coverage policy for the procedure. It is not uncommon for some therapies to have silent or non-coverage policy. In these cases, prior authorization is strongly recommended.
- Determine payer requirements for prior authorization. If no prior authorization is required, inquire if a predetermination or courtesy review is available. If no, document the date of your call, who you spoke with, and call reference number if available. Note the likelihood of a claim denial if a pre-service review is not performed and there is a non-coverage policy.

Submit the request

- Determine the payer's prior authorization submission method: fax, phone, payer portal, email, or mail. Track submission method for future prior authorization requests.
- Gather and submit all supporting materials such as the information gathered for the 'collect information' step, any payer required prior authorization forms, and supporting medical documentation (e.g., prescription, letter of medical necessity, medical records.)

Follow-up

- You may contact the payer within a few days of submission to verify receipt of the prior authorization request. Continue to follow up routinely until a determination has been made. If available, obtain the pending prior authorization number.
- Prior authorization can take over 2 weeks, not including the appeal process.
- Document payer interactions and track outcomes and time to determination.

Verify outcome and eligibility

- If the prior authorization is approved, obtain the prior authorization number and request the approval letter. Re-verify the patient's eligibility to ensure they are still covered.
- If the prior authorization is denied, request the denial letter to determine the payer's rationale and appeal process. Only continue to the next step if the prior authorization is denied.

- If the prior authorization is denied, the payer may allow a peer-to-peer review. Please contact the payer to inquire about this option.
- **Generally, this must be requested within a few hours to days upon notification of a denied prior authorization**, and in some cases, could result in approval.

Appeal

- Review the denial letter for the payer's rationale and information regarding their appeal process.
- Prepare an appeal, addressing the denial reason and including any new supporting medical documentation.
- Submit the appeal within the timeframe listed in the denial letter. Time frames can vary based on the payer; generally: 180 days for commercial payers, 60 days for Medicare Advantage payers, and 30-45 days for Medicaid payers. Appeal determinations can take up to 30+ days.
- There is only one first level appeal available. This can either be submitted by a patient or provider. Patients may contact their employer for assistance.

Subsequent appeal(s)

- The appeal denial letter will provide information on additional appeal rights.
- Generally, commercial payers offer a second appeal (within 60 days) followed by an external review (within 120 days). An external review, also referred to as an independent medical review, is a final appeal submitted to a third-party review organization.
- For Medicare Advantage plans, the first appeal will automatically be sent to an Independent Review Entity (IRE) for a second appeal; providers can submit additional information to the IRE within 10 days. If the second appeal is denied, you may request review by the Office of Medicare Hearing and Appeals. This will involve a hearing before an Administrative Law Judge. For additional appeal rights, please contact the payer or CMS.

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Prior authorization letter guidance

Overview

When obtaining a prior authorization, you may want to consider drafting a pre-service letter, or letter of medical necessity (LMN), to assist in obtaining a prior authorization for a Medtronic device and/or therapy. These letters must be customized to the patient and payer. As the requesting provider, it is your responsibility to ensure the accuracy of all information provided. This information is for your consideration and may not include all the information necessary to support your request. Use of these instructions does not guarantee authorization or eventual payment. It is important to contact the patient's insurance for prior authorization timeline(s), submission process, and requirements.

Click here — For a therapy- or device-specific letter, please reference our therapy-specific resources

What to consider including in your letter

- Include patient-specific information such as patient's name, date of birth, and policy identification number; procedure and diagnosis codes; and the intended date of service
- Summarize your intention to request a prior authorization for this procedure and outline why this procedure is medically necessary and aligns with the practice guidelines, or the payer's policy.
- Provide a brief summary of the therapy/device and its indication
- Include any relevant medical policy information specific to the patient, the indication, and the payer, if applicable
- Explain the clinical rationale leading to the decision to perform this procedure. You may include:
    - Patient's relevant medical history including
        - Diagnosis, date of diagnosis, and any diagnostic tests
        - Current clinical presentation: symptoms, severity, impact on quality of life and activities of daily living, etc.
        - Any significant risk factors, comorbidities, or other relevant medical history (e.g., hospitalizations, compliance with other therapies or treatments)
    - Outcomes and limitations of previous treatments (e.g., surgeries, interventions)
    - Reasons for the procedure including why alternative treatments or therapies did not work or would not be successful
- Providers may include their professional expertise and experience with this procedure

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Peer to peer guidance

Overview

A peer-to-peer (P2P) review provides physicians the opportunity to discuss a denied prior authorization with the insurance company's Medical Director. This guide is intended to support peer-to-peer discussions for a Medtronic device and/or therapy. Use of this guide does not guarantee authorization or eventual payment.

Considerations:

- A P2P review is a scheduled phone call, typically brief, that must be arranged by the requesting physician or designated person from the requesting physician's office within the timeframe set by the payer. **Many payers require the call to be completed within 24-48 hours following a denied prior authorization.** Confirm the exact guidelines and instructions with the payer to avoid missing a level of appeal.
- A P2P review should occur prior to submitting a written appeal (or in accordance with the payer's peer-to-peer guidelines).
- A determination is usually made at the conclusion of the call. In some cases, a P2P review may result in an approved prior authorization.
- A P2P may not be available for all health plans.
- For a list of supplemental resources that are available to support your peer-to-peer discussion, please refer to the Resource Table of Contents.

Talking points

Before the call, take time to review the denial reason, payer's coverage policy, and patient documentation. The information provided below is for your consideration in preparation for a P2P review of a Medtronic device and/or therapy.

Peer to peer review may include the following:

State your request and why you disagree with the denial

Even if the denial is a result of a payer's non-coverage policy, the goal of the peer-to-peer review is to request a one-time patient exception for coverage of a Medtronic device and/or therapy based on medical necessity.

Describe the device / procedure, as the Medical Director may not be familiar

You may choose to utilize the FDA approved indications for use of the device and/or procedure to provide a synopsis of the intended therapy.

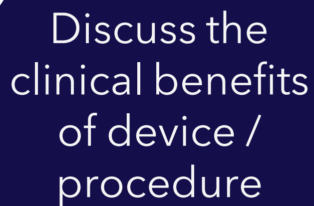
Explain the medical necessity of this device / procedure for your patient

Provide overview of the patient's relevant medical history:

- Diagnosis, date of diagnosis, any diagnostic testing
- Current clinical presentation: symptoms, severity, impact on quality of life and activities of daily living, etc.
- Any significant risk factors, comorbidities, or other relevant history (e.g., hospitalizations)

Discuss outcomes and limitations of previous treatments (e.g., surgical interventions.)

Describe reason for the procedure including why the Medtronic device and/or therapy is recommended over other clinical care.



Leverage clinical evidence to substantiate the clinical benefit the patient may achieve by using this technology. Focus on guidelines, safety, efficacy, and patient selection.

Some clinical evidence may be found in the bibliography for the device/therapy.

Share your experience with this device / procedure

Procedure volume and clinical outcomes for patients who receive this treatment/therapy.

Describe any other key factors supporting your request

Clinical evidence for the device and/or therapy use and the procedure/device in general.

Payers that have covered this device/procedure for your patients.

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Pre-service appeal letter guidance

Overview

If a prior authorization is denied prior to services being rendered, a pre-service appeal letter may assist in appealing a prior authorization denial for a Medtronic device and/or therapy. These letters must be customized to the patient and payer. As the requesting provider, it is your responsibility to ensure the accuracy of all information provided. This information is for your consideration and may not include all the information necessary to support your request. Use of these instructions does not guarantee authorization or eventual payment. Each payer has their own pre-service appeal process. Please contact the patient's payer for exact steps.

Click here

For a therapy- or device-specific letter, please reference our therapy-specific resources

What to consider including in your letter

- Begin your letter with the patient's name, date of birth, and policy identification number; procedure and diagnosis codes; and the intended date of service
- Summarize your intention to appeal a prior authorization denial and outline why this procedure is medically necessary and aligns with practice guidelines, clinical evidence, and/or the payer's policy.
- Provide a brief summary of the proposed treatment or therapy, and its indication
- Explain the clinical rationale leading to the decision to use the proposed treatment or therapy. You may include:
    - The prior authorization denial reason and why you disagree (Note: Even if the denial is a result of the payer's non-coverage policy, the goal for the appeal is to request a one-time patient exception for coverage based on medical necessity)
    - Patient's relevant medical history
        - ❖ Consider including the relevant clinical information that was included in your original prior authorization letter.
        - ❖ Goal/Clinical benefit of the proposed treatment or therapy for this patient
    - Your experience with the outcomes of the proposed treatment or therapy
    - Other key factors supporting your request (e.g., clinical studies, payers that cover the proposed treatment or therapy, practice guidelines)
- Close the letter with your contact information

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Documentation best practices

Overview

Patient medical record documentation should support medical necessity of the procedure being performed. Some payers have coverage policies which include medical necessity requirements. This guide is to assist providers in documenting for medical necessity.

Patient documentation checklist

The following is a list of information payers commonly require when reviewing for medical necessity.

- Diagnosis, date of diagnosis, and any diagnostic testing
- Current clinical presentation: symptoms, severity, impact on quality of life and activities of daily living
- Significant risk factors, comorbidities, or other relevant history (e.g., hospitalization)
- Outcomes and limitations of previous treatments (e.g., surgeries, interventions.)
- FDA-approved or FDA-cleared indication for the device/procedure
- Diagnosis and procedure codes

Product links

For product/therapy-specific information and resources, please click on the links below:

LINQ family of insertable cardiac monitors

Micra™ leadless pacemakers

Other therapies coming soon…

Contact

For additional information, contact the Medtronic Reimbursement Customer Support team:

By email at rs.healthcareeconomics@medtronic.com.

By phone at 866-877-4102

Or visit our reimbursement website at www.Medtronic.com/crhfreimbursement

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