**Physician Office Prior Authorization Support: Tool Kit**

**Prior Authorization for Lower Extremity Vascular Interventions**

This Prior Authorization Tool Kit is designed to help your office with the process of confirming coverage and submitting a prior authorization requests for your patients who would benefit from a lower extremity vascular intervention.

**The Prior Authorization Toolkit**

The “tools” enclosed in this package will assist you in identifying and providing specific information in order to prior authorize the Lower Extremity Vascular Interventions and includes the following documents:

* Checklist of applicable CPT‡ codes and information needed when submitting a prior authorization
* Sample Letter of Medical Necessity

**Submission Process**

The following is a checklist reminder of the key steps involved in the process of verifying patient information, health plan benefits and obtaining insurance pre-authorization. This information is subject to change. Please check your patient’s benefit administrator’s prior authorization requirements before submitting a prior authorization request:

* **Obtain Patient Specific Information**
  + Collect patient information including patient consent release
  + Collect benefit plan information (e.g., plan type, insurance number(s), copy of card(s), contact information)
  + Gather patient specific clinical documentation (e.g., diagnosis code(s), relevant history and physical to include member symptoms and pertinent findings due to ischemia, interventions tried, failed, and/or contraindicated services, Ankle-Brachial Index (ABI) score, details of disabilities interfering with activities of daily living, diagnostic images documenting the location and severity of the occlusion, and letter of medical necessity if required)

Please refer to the Prior Authorization Checklist for implanting physician(s) for a suggested list of documentation requirements.

* **Verify Benefits**
  + Contact your patient’s medical benefit administrator to verify benefits and patient out-of-pocket costs (e.g., co-pay, deductible and out-of-pocket maximum)
  + Verify eligibility and medical policy requirements for endovascular revascularization procedure
  + Verify physician and facility network contract status
  + Verify requirements for prior authorization through their internet portal or by phone
* **Submit Request** 
  + Go Online to the patient’s benefit administrator’s portal and submit prior authorization request with information noted above
  + Or call the benefit administrator and submit a prior authorization
  + Attach requested clinical documentation
  + Submit request and create a follow-up alert
* **Follow up** 
  + Routinely follow up
  + Document your phone calls and interactions, including date, time, and name of contact person
  + Obtain reference numbers for your calls
  + Prior authorization approval can generally take between 3-30 days If approved, document approval number
* **Appeal if Needed**
  + Request a copy of the denial in writing
  + Make sure the physician and patient want to appeal the denial
  + If an appeal is required, contact the benefit administrator to determine their appeal process
  + Attach requested documentation to appeal form and submit
  + Follow up with the benefit administrator for final prior authorization decision

**Additional Coverage Support**

Should your office need any additional reimbursement support materials or have any questions pertaining to the prior authorization process for carotid stenting patients, please contact the Abbott Vascular Reimbursement Hotline at 800-354-9997 or [questions@askabbottvascular.com](mailto:questions@askabbottvascular.com).

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