Abbott

HEALTH ECONOMICS & REIMBURSEMENT

Prior Authorization & Appeal Tool Kit Instructions

This Prior Authorization and Appeal Tool Kit is designed to help your office with the process of confirming coverage and submitting a prior authorization request for your patients. ***Please do not include this form in your submission to the payer.***

THE PRIOR AUTHORIZATION AND APPEAL TOOLKIT

The "tools" enclosed in this package will assist you in identifying and providing specific information in order to prior authorize or appeal claims and includes the following documents:

- Checklists to guide you on the coding and documentation requirements.
- Sample Letter of Medical Necessity
- Sample Letter of Appeal

SUBMISSION PROCESS

The following is a checklist reminder of the key steps involved in the process of verifying patient information, health plan benefits, obtaining insurance pre-authorization, and submitting appeals of non-coverage decisions. This information is subject to change. Please check your patient's benefit administrator's prior authorization and appeal 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 atrial fibrillation, interventions tried, failed, and/or contraindicated services, $CHADS_2$ or CHA_2DS_2-VASc score, details of disabilities interfering with activities of daily living, diagnostic images, 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 out-of-pocket costs (e.g., co-pay, deductible and out-of-pocket maximum)
  - ☐ Verify eligibility and medical policy requirements
  - ☐ Verify physician and facility network contract status
  - ☐ Verify payer requirements for prior authorization through internet portal or by phone

- **SUBMIT REQUEST**
  - ☐ Access the patient's benefit administrator's portal or call the benefit administrator and submit prior authorization request with information noted above
  - ☐ Submit letter of medical necessity if necessary
  - ☐ 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 appeal process
  - Attach requested documentation to appeal form and submit
  - Follow up with the benefit administrator for final coverage decision

ADDITIONAL COVERAGE SUPPORT

Should your office need any additional reimbursement support materials or have any questions pertaining to the prior authorization process for your patients, please contact the Abbott Reimbursement Hotline at (855) 569-6430 or hce@abbott.com.

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