**WATCHMAN™ LEFT ATRIAL APPENDAGE CLOSURE**

**Sample Appeal Letter**

**This following sample letter must be customized** to reflect the background, medical history and diagnosis of the specific patient, and to address any special requirements of the payer.

* This letter is an example for your consideration, and may not include all the information necessary to support your appeal request.
* The clinician has responsibility for providing accurate and complete information concerning the applicable diagnosis and procedure codes, and for supporting medical necessity.
* The requesting facility is responsible for ensuring the accuracy and adequacy of all information provided.
* It is recommended that the patient’s insurance company be contacted for specific information regarding coverage criteria.
* Medicare does not preauthorize medical procedures.

**Instructions:**

1. Sections which require customization are **highlighted in yellow**. Edit these sections to reflect medical appropriateness of the WATCHMAN™ Device for the individual patient.
2. It is important to provide the most complete information to assist with the appeals process.
3. Delete the highlighted instructions for completion, so the health plan does not misinterpret the resulting submission as a form letter.
4. Questions may be directed to WATCHMAN.reimbursement@bsci.com or voicemail: (877) 786-1050 and press 2 to leave a message. Messages are monitored daily, with responses typically on the same or following business day. Pone (toll free): (877) 786-1050 and press 1 to connect with WATCHMAN Prior Authorization or Appeals support.

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[Date]

Attention: Appeals Department

Reference number: [ ]

[Insurance Company name]

[Insurance Company address]

[Fax:]

RE: Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Policy Holder Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Patient ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Policy, Group, or Claim #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date of Denial: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RE: Request for Coverage Reconsideration for the WATCHMAN™ Left Atrial Appendage Closure (LAAC) Implant**

To Whom It May Concern:

On behalf of my patient, I am appealing a denial for the surgery, hospital stay, and post-surgical care associated with the WATCHMAN™ Left Atrial Appendage Closure (LAAC) implant procedure. This letter documents the medical necessity for this therapy and provides information about the patient’s medical history and treatment, as well as a description of the procedure.

**Principal Diagnosis**

* [list ICD10 diagnosis code and diagnosis code descriptor]

**Procedure/Service (see attached physician report &/or hospital report)**

* [if physician report] **CPT code 33340**: Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, when performed, and radiological supervision and interpretation

*[Include CPT codes (93312-93320, or 93325 or 93355) for performing transesophageal echocardiography (TEE) as applicable.]*

* [if hospital report] **ICD10-PCS code 02L73DK**: Occlusion of left atrial appendage with intraluminal device, percutaneous approach. NOTE: CMS has restricted this procedure to the inpatient hospital site of service.

To support this appeal, I am providing the following:

* Patient history & physical and operative reports, supporting medical necessity of the LAAC implant procedure
* FDA approval status and CMS National Coverage Determination for this service
* Summary of clinical evidence, with associated references

Current Coverage Status:

My patient meets the coverage criteria for the WATCHMAN LAAC implant procedure as defined by the insurance policy:

[Include policy language. Specify how the patient’s clinical status aligns with the criteria]

**OR**

My patient does not have explicit coverage for the WATCHMAN LAAC implant procedure under their current insurance policy. Prior authorization is therefore being requested based the coverage criteria as defined within the CMS National Coverage Determination for LAAC (20.34), described below:

[Specify how the patient’s clinical status aligns with the criteria]

* A CHADS2 score ≥ 2 or CHA2DS2-VASc score ≥ 3
* A formal shared decision making interaction with an independent non-interventional physician using an evidence-based decision tool on oral anticoagulation in patients with NVAF prior to LAAC.
* A suitability for short-term warfarin but deemed unable to take long term oral anticoagulation

Based upon the medical necessity for my patient, I am appealing the denial and requesting that approval be granted for the WATCHMAN LAAC implant procedure and all related services as soon as possible.

* Please fax approval to my office at [fax number]
* Please contact me with any questions at [telephone number]

Physician may choose to insert additional comments regarding why this procedure is viewed as a preferable alternative to long-term anticoagulation therapy for this particular patient.

Sincerely,

**[Physician’s name]**

**[Practice name]**