**WATCHMAN FLX™ LEFT ATRIAL APPENDAGE CLOSURE DEVICE**

**Medicare Advantage Plan 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 FLX**™** LAAC 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](mailto:WATCHMAN.reimbursement@bsci.com) or to your local Boston Scientific Health Economics and Market Access Manager.

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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 a Medicare Advantage Patient for WATCHMAN FLX™ Left Atrial Appendage Closure (LAAC) Device Implant**

To Whom It May Concern:

On behalf of my patient, I am appealing the pre-authorization denial for the **inpatient hospitalization** and post-surgical care associated with the WATCHMAN FLX**™** LAAC 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. The WATCHMAN FLX LAAC procedure is on the CMS Inpatient-only List. Medicare Advantage plans must cover all services that Original Medicare covers; CMS recently finalized a rule that specifically includes site of service in that definition.

**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.

To support this appeal, I am providing the following:

**CMS has restricted this procedure to the inpatient** **hospital site of service.** Procedures on the Inpatient Only list and coverage must be provided which is consistent with Medicare FFS policy **effective as of January 1, 2024.**  In addition, CMS implements important utilization management policy and coverage ​criteria protections to ensure Medicare Advantage enrollees receive the same access to medically ​necessary care that they would receive in Traditional Fee for Service Medicare. [2024 Medicare Advantage and Part D Final Rule (CMS-4201-F) | CMS](https://www.cms.gov/newsroom/fact-sheets/2024-medicare-advantage-and-part-d-final-rule-cms-4201-f)

* CMS National Coverage Determination:

<https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=281>

* Patient history, physical, operative reports and supporting medical necessity of the LAAC implant procedure
* XXX (Insert payer name) has a positive coverage policy for the WATCHMAN FLX™ therapy and our patient meets the medical necessity criteria XXX (insert Medical Policy Link)
* Link to FDA Approval. The FDA approved the WATCHMAN FLX™ LAAC Device on July 21, 2020. To access the WATCHMAN FLX™ LAAC Device approval document, visit the FDA website at: <https://www.accessdata.fda.gov/cdrh_docs/pdf13/P130013S035A.pdf>
* A summary of clinical evidence, with associated references

<https://www.watchman.com/content/dam/watchman/downloads/download-center/reimbursement/WATCHMAN_Coverage_Clinical_Evidence_Summary.pdf>

Current Coverage Status:

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

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

**OR**

* 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.
* Suitability for short-term warfarin but deemed unable to take long term oral anticoagulation

Physician may choose to insert additional comments regarding why this procedure an alternative to long-term anticoagulation therapy for this patient. (HAS-BLED score, calculated stroke risk, previous events etc.)

Based upon the medical necessity for my patient and Medicare Advantage insurance policy I am requesting an **expedited internal appeal.** CMS require that when MA plans evaluate whether services are medically necessary, the decision must be based on the opinion of a physician or other health care professional of the “appropriate expertise”. I am appealing the denial of my patient’s inpatient hospital authorization and requesting that approval be granted for the WATCHMAN FLX™ LAAC 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]

Sincerely,

**[Physician’s name]**

**[Practice name]**