Panniculectomy, Liposuction and Lipectomy Procedures Precertification Information Request Form

Applies to:

Aetna plans

Innovation Health® plans

Health benefits and health insurance plans offered, underwritten and/or administered by the following:

Allina Health and Aetna Health Insurance Company (Allina Health | Aetna)

Banner Health and Aetna Health Insurance Company and/or Banner Health and Aetna Health Plan Inc. (Banner | Aetna)

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates (Aetna). Aetna provides certain management services on behalf of its affiliates.

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About this form
You cannot use this form to initiate a precertification request. To initiate a request, please call our Precertification Department. Or you may submit your request electronically. **Failure to complete this form and submit all medical records we are requesting may result in the delay of review or denial of coverage**.

This form replaces all other precertification information request documents and forms. This form will help you supply the right information with your precertification request. You don't have to use the form. But it will help us adjudicate your request more quickly.

How to fill out this form
As the patient's attending physician, you must complete all sections of the form. You can use this form with all Aetna health plans, including Aetna's Medicare Advantage plans. You can also use this form with health plans for which Aetna provides certain management services.

When you're done
Once you've filled out the form, submit it and all requested medical documentation to our Precertification Department by:

- We prefer you submit precertification requests electronically. Use our provider portal on Availity® to also upload clinical documentation, check statuses, and make changes to existing requests. Register today at availity.com/aetnaproviders or learn more about Availity at www.availity.com/aetnatraining.

- Email photographs (when required) to:
  - Commercial Plans: VFAXPrecert@aetna.com
  - Medicare Advantage Plans: MedicarePrecert@aetna.com

- Send your information via confidential fax to Precertification – Commercial and Medicare using FaxHub: **1-833-596-0339.**
  - The fax number above (FaxHub) is for clinical information only. Please send specific information that supports your medical necessity review. Please continue to send all other information (claims etc.) to appropriate fax numbers. Thank you.

- Mail your information to: **PO Box 14079 Lexington, KY 40512-4079**

What happens next?
Once we receive the requested documentation, we'll perform a clinical review. Then we'll make a coverage determination and let you know our decision. Your administrative reference number will be on the electronic precertification response.

How we make coverage determinations
If you request precertification for a Medicare Advantage member, we use CMS benefit policies, including national coverage determinations (NCD) and local coverage determinations (LCD) when available, to make our coverage determinations. If there isn't an available NCD or LCD to review, then we'll use the Clinical Policy Bulletin referenced below to make the determination.

For all other members, we encourage you to review **Clinical Policy Bulletin #211: Abdominoplasty, Suction Lipectomy, and Ventral Hernia Repair,** before you complete this form.

You can find the Clinical Policy Bulletins and Precertification Lists by visiting the website on the back of the member's ID card.

Questions?
If you have any questions about how to fill out the form or our precertification process, call us at:

- HMO plans: 1-800-624-0756 **(TTY:** 711**)**
- Traditional plans: 1-888-632-3862 **(TTY:** 711**)**
- Medicare plans: 1-800-624-0756 **(TTY:** 711**)**

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Section 1: Provide the following general information	
Member name:	**Reference Number:**
Member Phone Number:	
Member ID:	**Member date of birth:**
Requesting provider/facility name:	
Requesting provider/facility NPI:	
Requesting provider/facility phone number: 1- - -	
Requesting provider/facility fax number: 1- - -	
Assistant/co-surgeon name (if applicable):	**TIN:**

Section 2: Provide the following patient-specific information.

Indicate below which of the following procedure(s) best describes the coverage request:

- ☐ Panniculectomy or apronectomy
- ☐ Panniculectomy or apronectomy *specifically for minimizing the risk of hernia formation or recurrence*
- ☐ Abdominoplasty
- ☐ Suction lipectomy
- ☐ Abdominal lipectomy for the treatment of metabolic syndrome
- ☐ Lipoabdominoplasty
- ☐ Liposuction for Lipedema
- ☐ Repair of diastasis recti
- ☐ True incisional or ventral hernia repair

☐ Other, please specify

Section 3: Provide the following documentation for your panniculectomy request

Select those that apply to the patient:

- ☐ Panniculus hangs below level of pubis **(photographs required)**
- ☐ Panniculus causes chronic intertrigo consistently recurring over 3 months while receiving appropriate medical therapy or remains refractory to appropriate medical therapy over a period of 3 months
- ☐ Photographs with pannus lifted show presence of intertrigo **(photographs required)**

Current history and physical

- Office notes related to the member's condition for which treatment is proposed
- Description of proposed treatment
- Any supporting medical records documenting clinical findings, conservative management with outcome, and current plan of care. This includes the following clinical documentation
- Medical records documenting chronic intertrigo, type(s) of medical therapy and duration
- Photographs (Submit Copies of photographs rather than originals. Photographs will not be returned.)

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Member name:	Reference Number:
Member ID:	Member date of birth:

Section 4: Liposuction for lipedema

☐ Yes ☐ No Member has pain and disability from lipedema and
☐ Yes ☐ No Member has failed 3 months or more of conservative therapy that included compression or manual therapy and:
☐ Yes ☐ No Member has pain and hypersensitivity to touch in lipedema affected areas and:
☐ Yes ☐ No Member has history of easy bruising or bruising without apparent cause in lipedema affected areas and:
☐ Yes ☐ No Member has a relative lack of effect on lipedema affected areas with weight loss and:
☐ Yes ☐ No Member has no reduction in swelling with limb elevation

Physical Exam requirements:

☐ Disproportional fat distribution
☐ Thickened subcutaneous fat in the affected extremity bilaterally and symmetrically
☐ Tenderness and nodularity of fat deposits in lipedema affected areas (dimpled or orange-peel texture)
☐ Stemmer sign negative (Stemmer's sign is negative when a fold of skin can be pinched and lifted at the base of the second toe or at the base of the middle finger) {unless the member has comorbid lymphedema}
☐ Absence of pitting edema (no "pitting" when finger or thumb pressure is applied to the area of fat-unless the member has comorbid lymphedema)
☐ Evidence of "cuffing" (tissue enlargement ends abruptly at ankles or wrists, with sparing of hands and feet, also called "braceleting" or "inverse shouldering")

Section 5: Location where procedure will be performed

Will the procedure be performed:

☐ Inpatient ☐ Outpatient

If procedure to be performed outpatient indicate the setting:

☐ Outpatient hospital
☐ Ambulatory Surgical Center (free standing)
☐ Office

If request is for Outpatient hospital check any/all that apply:

☐ Less than 12 years of age
☐ American Society of Anesthesiologists (ASA) Physical Status classification III or higher
☐ Danger of airway compromise
☐ Morbid obesity (BMI > 35 with comorbidities or BMI > 40)
☐ Pregnant
☐ Advanced liver disease
☐ Poorly controlled diabetes (hemoglobin A1C > 7)
☐ End stage renal disease (ESRD) with hyperkalemia ☐ or undergoing dialysis ☐
☐ Active substance use related disorders (Includes alcohol dependence and/or current use of high dose opioids).

Continued

Member name:	**Reference Number:**
Member ID:	**Member date of birth:**

Section 5: Location where procedure will be performed (Continued)

High risk cardiac status:

- ☐ Myocardial infarction in last 90 days
- ☐ Ongoing symptoms from previous MI
- ☐ Significant heart valve disease
- ☐ Symptomatic cardiac arrhythmia
- ☐ Hypertension resistant to 3 or more medications
- ☐ Uncompensated chronic heart failure

Coronary artery disease (CAD) or peripheral vascular disease (PVD) with:

- ☐ Ongoing ischemia or recent MI/angioplasty PCI
- ☐ Drug Eluting Stent (DES) Bare Metal Stent placed in last year
- ☐ Angioplasty in last 90 days
- ☐ Current use of Aspirin or prescription anticoagulants

Comorbid neurological or neuromuscular condition

- ☐ Stroke/cerebrovascular accident (CVA)
- ☐ Mini stroke/transient ischemic attack (TIA)
- ☐ Uncontrolled epilepsy
- ☐ Cerebral palsy
- ☐ Multiple Sclerosis
- ☐ Amyotrophic lateral sclerosis
- ☐ Traumatic brain injury with significant cognitive or behavioral issues
- ☐ Muscular dystrophy

Respiratory conditions:

- ☐ Moderate to severe obstructive sleep apnea

Unstable respiratory status:

- ☐ Poorly controlled asthma (FEV1 < 80% despite medical management)
  - ☐ COPD or
  - ☐ Ventilator dependent patient

Bleeding or clotting disorders or conditions:

- ☐ Requiring replacement factor, blood products or special infusion products to correct a coagulation defect
- ☐ Thrombocytopenia (platelet <100,000/microL)
- ☐ Anticipated need for blood or blood product transfusion
- ☐ Sickle cell disease
- ☐ History of Disseminated Intravascular Coagulation (DIC)
- ☐ Personal or family history of complication of anesthesia
- ☐ History of solid organ transplant requiring anti-rejection medication(s)
- ☐ Other unstable or severe systemic diseases, intellectual disabilities or mental health conditions that would be best managed in an outpatient hospital setting
- ☐ This will be a prolonged surgery (>3 hrs.)

Do any of the following apply when procedure(s) to be performed at **outpatient hospital setting**:

- ☐ The required operative equipment is not available at a participating free-standing ambulatory surgical center or office based surgical center

  List specific equipment not available:

- ☐ There are no participating general or specialty free-standing ambulatory surgical centers or office based surgical centers that allow procedure(s) planned

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Member name:	**Reference Number:**
Member ID:	**Member date of birth:**

Section 6: Provide the following documentation for your liposuction or lipectomy request

- Current history and physical
- Office notes related to the member's condition for which treatment is proposed
- Description of proposed treatment
- Any supporting medical records documenting clinical findings, conservative management with outcome, and current plan of care
- Photographs documenting lipedema

Section 7: Read this important information

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Section 8: Sign the form

Just remember: You can't use this form to initiate a precertification request. To initiate a request, you may submit your request electronically or call our Precertification Department.

Signature of person completing form:

Date: / /

Contact name of office personnel to call with questions:

Telephone number: 1- - -