# Ptosis Surgery
# 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

**Do not use this form to initiate a precertification request.** To initiate a request, submit electronically on Availity or call our Precertification Department. Submit your medical records to support the request with your electronic submission.

We've made it easy for you to authorize services and submit any requested clinical information. Just use our provider portal on Availity®. Register today at **Availity.com/aetnaproviders**. Once your account is ready, you can start submitting authorization requests right away.

- For additional information on Availity, go to **https://www.aetna.com/health-care-professionals/resource-center/availity.html**

**Requesting authorizations on Availity is a simple two-step process**

Here's how it works:

1. Submit your initial request on Availity with the Authorization (Precertification) Add transaction.
2. Then complete a short questionnaire, if asked, to give us more clinical information.
    - If you receive a pended response, then complete this form and attach it to the case electronically.

**This form will help you supply the right information with your precertification request. Failure to complete this form and submit all medical records we are requesting may result in the delay of review or denial of coverage**.

## 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:

- If your request was submitted via telephone, you can either:
    - Access our provider portal via Availity; enter the Reference number provided and attach this form and all requested medical documentation to the case or
    - Send your information by 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.
    - Email photographs (when required) to:
        - Commercial Plans: VFAXPrecert@aetna.com
        - Medicare Advantage Plans: MedicarePrecert@aetna.com
    - If you do not have fax or electronic means to submit clinical:
        - Mail your information to: **PO Box 14079**
          **Lexington, KY 40512-4079**
          (Please note mailing will add to the review response time)

## 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 #84: Ptosis Surgery,** 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**
**Typed responses are preferred. If the responses cannot be typed, they should be printed clearly.**
**If submitting request electronically, complete member name, ID and reference number only**

| | |
|---|---|
| **Member name:** | **Reference number (required):** |
| **Member ID:** | **Member date of birth:** |
| **Member phone number:** | |
| **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: Select the procedure(s) that applies to your patient**

- ☐ Blepharoplasty
  - ☐ Left ☐ Right ☐ Bilateral
- ☐ Ptosis (blepharoptosis repair)
  - ☐ Left ☐ Right ☐ Bilateral
- ☐ Brow ptosis repair
  - ☐ Left ☐ Right ☐ Bilateral
- ☐ Canthoplasty
  - ☐ Left ☐ Right ☐ Bilateral
- ☐ Ectropion repair
  - ☐ Left ☐ Right ☐ Bilateral
- ☐ Entropion repair
  - ☐ Left ☐ Right ☐ Bilateral

Has the procedure been scheduled? ☐ Yes ☐ No
If yes, what is the date of service:

**Section 3: Select the indication(s) that applies to your patient**

- ☐ Correct prosthesis difficulties in an anophthalmia socket
- ☐ Remove excess tissue of the upper eyelid causing functional visual impairment
  **Submit the following:**
  ☐ **Photographs in straight gaze*** ☐ **Visual field test with and without the eyelid or brow taped****
- ☐ Repair defects predisposing to corneal or conjunctival irritation
  - ☐ Corneal exposure
  - ☐ Ectropion (eyelid turned outward)
  - ☐ Entropion (eyelid turned inward)
  - ☐ Pseudotrichiasis (inward misdirection of eyelashes caused by entropion)
- ☐ Relieve painful symptoms of blepharospasm
- ☐ Treat peri-orbital sequelae of thyroid disease and nerve palsy
- ☐ Relieve excessive lower lid bulk
- ☐ Repair eyelid ectropion or entropion causing corneal or conjunctival injury due to ectropion, entropion or trichiasis
- ☐ Repair for laxity of the muscles of the upper eyelid causing functional visual impairment
  **Submit the following:**
  ☐ **Photographs in straight gaze*** ☐ **Visual field test with and without the eyelid or brow taped****
- ☐ Repair for laxity of the forehead muscles causing functional visual impairment
  **Submit the following:**
  ☐ **Photographs in straight gaze*** ☐ **Visual field test with and without the eyelid or brow taped****
- ☐ Other; Please Specify

| **Member ID:** | **Reference Number:** |
|---|---|

## Section 4: 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).
- ☐ 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.)

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

*Continued*

| **Member ID:** | **Reference Number:** |
|---|---|

**Section 4: Location where procedure will be performed (Continued)**

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)

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 surgery free-standing ambulatory surgical centers or office based surgical centers to perform procedure(s) planned

**Section 5: Provide the following documentation for your request**

- Current history and physical applicable to procedure
- Office notes directly related to the member's condition for which treatment is proposed
- Description of proposed treatment
- *Photographic documentation (straight gaze) of the patient's condition, taken within the past 12 months, as indicated above

  Note: Submit Copies of photographs rather than originals. Photographs will not be returned.
- **Visual field test performed within the past 12 months that includes reliability indicators with and without the eyelid or brow taped, as indicated above

**Section 6: 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 7: 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- - -