Varicose Vein Treatment
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)

Sutter Health and Aetna Administrative Services LLC (Sutter Health | Aetna)

Texas Health + Aetna Health Plan Inc. and Texas Health + Aetna Health Insurance Company (Texas Health Aetna)

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About this form

You can't use this form to initiate a precertification request. To initiate a request, you have to call our Precertification Department. Or you can submit your request electronically. **Failure to complete this form and submit all of the medical records we are requesting may result in the delay of review.**

Effective **May 23, 2018**, this form replaces all other Varicose Vein Treatment 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:

- **(Preferred)** Upload your information electronically on our secure provider website on NaviNet® at **connect.navinet.net**.
    - Complete a Precertification Inquiry transaction for the patient.
    - When the inquiry is successful, click the "Add Attachment" link in the upper right corner of the screen.
    - Upload your document(s) and click "Attach." The window will close and you will return to Precert Inquiry screen.

- Email requests that require photographs to:
    - Commercial Plans: **VFAXPrecert@aetna.com**
    - Medicare Advantage Plans: MedicarePrecert@aetna.com

- Send your information via confidential fax to:
    - Precertification – Commercial Plans: **859-455-8650**
    - Precertification - Medicare Advantage Standard Organization Determination: **859-455-8650**
    - Precertification - Medicare Advantage (expedited only): **860-754-5468**

- 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 #50: Varicose Veins,** 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**
- Traditional plans: **1-888-632-3862**

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Section 1: Provide the following general information	
Member name:	**Administrative reference number (required):**
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.

Select any of the following the patient has experienced:

☐ Incompetence (i.e., reflux) at the saphenofemoral junction (SFJ) or saphenopopliteal junction (SPJ) documented by Doppler of duplex ultrasound scanning?
- Left leg: ☐ SFJ ☐ SPJ
- Right leg: ☐ SFJ ☐ SPJ

☐ Intractable ulceration secondary to venous stasis

☐ More than one episode of minor hemorrhage from a ruptured superficial varicosity

☐ Single significant hemorrhage from a ruptured superficial varicosity
- Was a blood transfusion required? ☐ Yes ☐ No

☐ Recurrent superficial thrombophlebitis

☐ Severe and persistent pain and swelling interfering with activities of daily living and requiring chronic analgesic medication

Junctional reflux duration in the saphenofemoral or saphenopopliteal vein to be treated _____ ms

Measurement of the vein size (in millimeters) immediately below the saphenofemoral junction? _____ mm

Measurement of the vein size (in millimeters) immediately below the saphenopopliteal junction? _____ mm

Has the patient had any of the following procedures in the same anatomical location on the same leg? (check all that apply; indicate date(s) of each treatment)

☐ Great saphenous vein or small saphenous vein ligation / division / stripping
- ☐ Left leg date(s) _____ ☐ Right leg date(s) _____

☐ Radiofrequency endovenous occlusion (VNUS procedure)
- ☐ Left leg date(s) _____ ☐ Right leg date(s) _____

☐ Endovenous laser ablation of the saphenous vein (ELAS) - also known as endovenous laser treatment (EVLT)
- ☐ Left leg date(s) _____ ☐ Right leg date(s) _____

☐ Sclerotherapy (liquid or foam)
- ☐ Left leg date(s) _____ ☐ Right leg date(s) _____

☐ Ambulatory phlebectomy or transilluminated powered phlebectomy (TriVex System)
- ☐ Left leg date(s) _____ ☐ Right leg date(s) _____

☐ Other (please specify procedure):
- ☐ Left leg date(s) _____ ☐ Right leg date(s) _____

Section 2 Continued: Provide the following patient-specific information

Has the patient used any of the following for conservative management? (check all that apply)

☐ Analgesic Medication(s)

Medication: _____ Dates of use: _____ Results: _____

Medication: _____ Dates of use: _____ Results: _____

☐ Prescription gradient support stockings

Dates of use: _____ Results: _____

Note: A trial of conservative management is not required for persons with persistent or recurrent varicosities who have undergone prior endovenous catheter ablation procedures or stripping/division/ligation in the same leg because conservative management is unlikely to be successful in this situation

Section 3: Provide the following information for the coverage request

Include both primary and secondary codes, if applicable

Left Leg					Right Leg			
Procedure Details		Reflux Duration In milliseconds (ms)	Vessel size in millimeters (mm)	Vessel	Vessel size in millimeters (mm)	Reflux Duration In milliseconds (ms)	Procedure Details	
Units	Code(s)						Units	Code(s)
				Saphenofemoral Junction				
				Greater Saphenous Vein proximal/mid/distal				
				Perforator				
				Tributary				
				Accessory Vein				
				Saphenopopliteal Junction				
				Small Saphenous Vein				
				Perforators				
				Tributary				
				Accessory Vein				

Section 4: Provide the following documentation for your request

- Current history and physical
- All supporting medical records documenting clinical findings, including the following:
  - Signs and symptoms, including member's complaint; and, duration and severity of varicose vein condition
  - Physical findings
  - X-ray and imaging study reports
- Doppler or duplex ultrasound scanning study **performed within the past 6 months** (submit actual reports and document results on this form)
- Clinical records documenting the following:
  - Activities the patient must modify or cannot perform due to the varicose vein condition conservative management, including duration and outcome
  - Plan of care for treatment of the varicose vein(s)

Section 5: 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 6: Sign the form

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

Signature of treating doctor or other qualified healthcare provider:

Date: / /

Contact name of office personnel to call with questions:

Telephone number: 1- - -