

Breast Reduction and/or Reconstructive 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)



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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](https://www.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)

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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 #17: Breast Reduction Surgery and Gynecomastia 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 questions about how to fill out the form or our precertification process, call us at:

- HMO plans: [1-800-624-0756](tel:1-800-624-0756) (TTY: [711](tel:711))
- Traditional plans: [1-888-632-3862](tel:1-888-632-3862) (TTY: [711](tel:711))
- Medicare plans: [1-800-624-0756](tel:1-800-624-0756) (TTY: [711](tel: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: Provide the following patient-specific information for BREAST REDUCTION surgery

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

Has the patient had persistent symptoms in at least 2 body areas that have affected their daily activities for at least 1 year? Yes No

If yes, select the body areas/symptoms:

<input type="checkbox"/> Upper back	<input type="checkbox"/> Headaches
<input type="checkbox"/> Neck	<input type="checkbox"/> Painful kyphosis, documented by x-rays
<input type="checkbox"/> Shoulders	<input type="checkbox"/> Pain, discomfort and/or ulceration from bra straps cutting into shoulders
<input type="checkbox"/> Upper extremity parasthesias	<input type="checkbox"/> Skin breakdown from overlying breast tissue
<input type="checkbox"/> Other (list):	

Patient's current: Height: Weight:

List the amount of breast tissue (not fatty tissue), in grams, to be removed from each breast.

Left breast: Right breast:

Section 3: Provide the following patient-specific information for BREAST RECONSTRUCTION surgery

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

Has the member had a previous mastectomy or partial mastectomy for the purpose of breast or chest wall reconstruction?
 Yes No

Describe the planned procedure:

Describe any previous breast surgeries:

Reason for implant removal and/or reinsertion:

Is this a staged procedure? Yes No
 If yes, please describe the stages, including the date(s) of the procedure(s):

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Member name:	Member ID:
Reference number (required):	Member date of birth:
Section 4: Location where procedure will be performed	
Will the procedure be performed: <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	
If procedure to be performed outpatient indicate the setting: <input type="checkbox"/> Outpatient hospital <input type="checkbox"/> Ambulatory Surgical Center (free standing) <input type="checkbox"/> Office	
If request is for Outpatient hospital check any/all that apply: <input type="checkbox"/> Less than 12 years of age <input type="checkbox"/> American Society of Anesthesiologists (ASA) Physical Status classification III or higher <input type="checkbox"/> Danger of airway compromise <input type="checkbox"/> Morbid obesity (BMI > 35 with comorbidities or BMI > 40) <input type="checkbox"/> Pregnant <input type="checkbox"/> Advanced liver disease <input type="checkbox"/> Poorly controlled diabetes (hemoglobin A1C > 7) <input type="checkbox"/> End stage renal disease (ESRD) with hyperkalemia <input type="checkbox"/> or undergoing dialysis <input type="checkbox"/> <input type="checkbox"/> Active substance use related disorders (Includes alcohol dependence and/or current use of high dose opioids). <input type="checkbox"/> Personal or family history of complication of anesthesia <input type="checkbox"/> History of solid organ transplant requiring anti-rejection medication(s) <input type="checkbox"/> Other unstable or severe systemic diseases, intellectual disabilities or mental health conditions that would be best managed in an outpatient hospital setting <input type="checkbox"/> This will be a prolonged surgery (>3 hrs.)	
High risk cardiac status: <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> Myocardial infarction in last 90 days <input type="checkbox"/> Significant heart valve disease <input type="checkbox"/> Hypertension resistant to 3 or more medications <input type="checkbox"/> Uncompensated chronic heart failure </div> <div style="width: 45%;"> <input type="checkbox"/> Ongoing symptoms from previous MI <input type="checkbox"/> Symptomatic cardiac arrhythmia </div> </div>	
Coronary artery disease (CAD) or peripheral vascular disease (PVD) with: <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> Ongoing ischemia or recent MI/angioplasty PCI <input type="checkbox"/> Angioplasty in last 90 days </div> <div style="width: 45%;"> <input type="checkbox"/> Drug Eluting Stent (DES) Bare Metal Stent placed in last year <input type="checkbox"/> Current use of Aspirin or prescription anticoagulants </div> </div>	

Continued

Breast Reduction and/or Reconstructive Surgery Precertification Information Request Form

Member name:	Member ID:
Reference number (required):	Member date of birth:

Section 4: Location where procedure will be performed (continued)

Comorbid neurological or neuromuscular condition

- | | |
|---|--|
| <input type="checkbox"/> Stroke/cerebrovascular accident (CVA) | <input type="checkbox"/> Mini stroke/transient ischemic attack (TIA) |
| <input type="checkbox"/> Uncontrolled epilepsy | <input type="checkbox"/> Cerebral palsy |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Amyotrophic lateral sclerosis |
| <input type="checkbox"/> Traumatic brain injury with significant cognitive or behavioral issues | |
| <input type="checkbox"/> 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:

- | | |
|--|--|
| <input type="checkbox"/> Requiring replacement factor, blood products or special infusion products to correct a coagulation defect | <input type="checkbox"/> Anticipated need for blood or blood product transfusion |
| <input type="checkbox"/> Thrombocytopenia (platelet <100,000/microL) | <input type="checkbox"/> History of Disseminated Intravascular Coagulation (DIC) |
| <input type="checkbox"/> Sickle cell disease | |

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

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Member name:	Member ID:
Reference number (required):	Member date of birth:
Section 5: Provide the following documentation for your request	
<ul style="list-style-type: none"> • Current history and physical • Lab/pathology and radiology reports, if applicable • Any supporting medical records documenting clinical findings, conservative management with outcome, and current plan of care. • Submit the following clinical documentation for <u>breast reduction surgery only</u>: <ul style="list-style-type: none"> – Clinical information documenting symptoms and type, length and outcome of treatment rendered – Most recent mammogram report for patients 50 years of age and older. (The patient must have received the mammography within two (2) years prior to the date of the planned reduction mammoplasty.) Date of mammography: / / – Photographs confirming severe breast hypertrophy – Evaluation by a physician, who has determined the following: <ul style="list-style-type: none"> ➤ The patient's symptoms are due primarily to macromastia, ➤ The procedure is likely to result in improvement of chronic pain, and – Pain symptoms persist despite at least a 3-month trial of therapeutic measures such as supportive devices, analgesic/NSAIDs interventions, and physical therapy/exercises/posturing maneuvers. 	
Section 6: Read this important information	
<p>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.</p>	
Section 7: Sign the form	
<p>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.</p>	
Signature of person completing form:	
Date: / /	
Contact name of office personnel to call with questions:	
Telephone number: 1- - -	