Left Atrial Appendage Closure (LAAC) Devices 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)

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.

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. Typed responses are preferred. 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.
  - 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 #791 Cardiac Devices and Procedures for Occlusion of the Left Atrial Appendage**

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

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Fax to: Precertification Department	**Fax number:** 1-833-596-0339
Section 1: Provide the following general information for all requests **Typed responses are preferred. If the responses cannot be typed, they should be printed clearly**	
Member name:	
Member Phone Number:	
Member ID:	**Member date of birth:**
Reference number:	
If you do not have a reference number, DO NOT use this form. Please submit your request electronically through Availity at www.availity.com or call 888-632-3862 (TTY: 711) or 1-800-624-0756 (TTY: 711) to initiate precertification.	
Physician name:	**Physician NPI:**
Physician fax number: 1-	**Physician status:** ☐ Participating ☐ Non-participating
Office phone number: 1-	**Requestor phone number:** 1-
Section 2: Provide the following general information	
Facility name:	
Facility fax number: 1-	**Facility status:** ☐ Participating ☐ Non-participating
Assistant/Co-surgeon name and TIN (if applicable):	
Date of procedure: / /	
Section 3: Provide the following provider/facility specific information	

1. Has the patient had a formal shared decision-making interaction with an independent non-interventional physician using an evidence-based decision tool on oral anticoagulation in persons with non-valvular atrial fibrillation (NVAF) prior to LAAC? ☐ Yes ☐ No
   If yes, submit the shared decision-making interaction documentation
2. Will the patient be under the care of a cohesive, multidisciplinary team (MDT) of medical professionals, preoperatively and postoperatively? ☐ Yes ☐ No
3. Does the hospital in which this procedure will be completed have an established structural heart disease (SHD) and/or electrophysiology (EP) program? ☐ Yes ☐ No
4. Will the procedure be performed by an interventional cardiologist(s), electrophysiologist(s) or cardiovascular surgeon(s)? ☐ Yes ☐ No
   If no, what is the physician's specialty:
5. Has the physician performing the procedure received training prescribed by the manufacturer on the safe and effective use of the device prior? ☐ Yes ☐ No
6. Has the physician performing the procedure completed greater than or equal to 25 interventional cardiac procedures that involve transeptal puncture through an intact septum? ☐ Yes ☐ No
7. Has the physician performing the procedure perform greater than or equal to 25 interventional cardiac procedures that involve transeptal puncture through an intact septum, of which at least 12 are LAAC, over a two-year period? ☐ Yes ☐ No
8. Will the procedure be performed in a hospital that takes part in the National Cardiovascular Data Registry for this specific heart procedure? ☐ Yes ☐ No

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Member name:	
Member Phone Number:	
Member ID:	**Reference number:**

Section 4: Provide the following patient specific information

9. What is the patient's $CHADS_2$ score?

OR

10. What is the patient's CHA_2DS_2-VASc score?

11. Is the patient suitable for short-term oral anticoagulation or dual antiplatelet therapy? ☐ Yes ☐ No
12. Is the patient suitable for long-term oral anticoagulation? ☐ Yes ☐ No

If no, check reason(s) why patient is not suitable:

- ☐ Patient has thromboembolism while on an oral anticoagulant (i.e., while INR is in therapeutic range)
- ☐ Patient has major bleed (intracranial bleed, significant gastrointestinal bleeding (not just guaiac positive stools) while on an oral anticoagulant (i.e., while INR is in therapeutic range)
- ☐ Patient has elevated risk of bleeding on oral anticoagulant with a HAS-BLED score of 3 or more
- ☐ Patient has other absolute contraindication to long-term anticoagulation
- ☐ Other:

Section 5: Provide the following documentation for your request

- ☐ Current history and physical
- ☐ Office notes related to the patient's condition for which treatment is proposed
- ☐ Documentation of formal shared decision-making interaction with an independent non-interventional physician
- ☐ Description of proposed treatment

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-