

## Ablative and Surgical Treatment for Venous Insufficiency Authorization

### **Purpose of this form.**

You can use this form to initiate your precertification request. The form will also help you know what supporting documentation is needed for GEHA to review your request.

### **How to complete the form.**

We recommend reviewing GEHA's coverage policy before completing this form. You can find our coverage policies at [geha.com/faqs-and-resources/for-providers/coverage-policies](http://geha.com/faqs-and-resources/for-providers/coverage-policies).

For us to review your request properly and to avoid delay, you must complete all sections of the form and provide the necessary supporting documentation. If you have questions about the form or need assistance, you can speak with a surgical specialist at 800.821.6136, ext. 3100.

### **After you have completed the form.**

You will fax this completed form along with supporting documentation to GEHA's Medical Management department at 816.257.3255 or email [caremanagementsurgery@geha.com](mailto:caremanagementsurgery@geha.com).

Our reviews are completed within 15 days from the time that we receive complete information. Please allow for this time when scheduling the procedure.

## Ablative and Surgical Treatment for Venous Insufficiency Authorization

Today's date: \_\_\_\_\_ Anticipated service date: \_\_\_\_\_

### Member information

Member's name: \_\_\_\_\_ Member's phone: \_\_\_\_\_

Member ID: \_\_\_\_\_ Member date of birth: \_\_\_\_\_

Member address: \_\_\_\_\_  
\_\_\_\_\_

### Provider information

Provider name: \_\_\_\_\_ Tax ID number: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Contact name: \_\_\_\_\_

Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Fax: \_\_\_\_\_

### Clinical information

ICD-10 codes: \_\_\_\_\_

Proposed CPT/procedure codes: \_\_\_\_\_

Has the member experienced incompetence (i.e., reflux) at the saphenofemoral junction (SFJ) or saphenopopliteal junction (SPJ) documented by Doppler or duplex ultrasound scanning?

Left leg:  SFJ  SPJ  NA Right leg:  SFJ  SPJ  NA

Measurement of the vein size (in mm) immediately below the saphenofemoral junction (if applicable)?

R  L \_\_\_\_\_ mm

Measurement of the vein size (in mm) immediately below the saphenopopliteal junction (if applicable)?

R  L \_\_\_\_\_ mm

Has the member experienced recurrent superficial thrombophlebitis?

Yes  No

Has the member experienced intractable ulceration secondary to venous stasis?

Yes\*  No \*If yes, what was the location? \_\_\_\_\_

Has the member had more than one episode of minor hemorrhage from a ruptured superficial varicosity?

Yes  No

Has the member had a single significant hemorrhage from a ruptured superficial varicosity?

- Yes  No

Has the member 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) \_\_\_\_\_

Has the member utilized any of the following for conservative management? (check all that apply)

- Analgesic medications(s)  
Medication: \_\_\_\_\_ Dates of use: \_\_\_\_\_ Outcome: \_\_\_\_\_  
Medication: \_\_\_\_\_ Dates of use: \_\_\_\_\_ Outcome: \_\_\_\_\_  
Medication: \_\_\_\_\_ Dates of use: \_\_\_\_\_ Outcome: \_\_\_\_\_
- Prescription gradient support stockings (minimum of 20-30 mm Hg) worn for a minimum of 3 months  
Dates of use: \_\_\_\_\_ Outcome: \_\_\_\_\_

Note: The conservative treatment requirement may be waived if the member has already undergone venous surgery or ablation and is presenting with recurrent disease.

**Clinical information**

<b>Left leg</b>				<b>Vessel</b>	<b>Right leg</b>			
Procedure details		Reflux duration in milliseconds (ms)	Vessel size in millimeters (mm)		Vessel size in millimeters (mm)	Reflux duration in milliseconds (ms)	Procedure details	
Units	Codes(s)						Units	Code(s)
				<b>Saphenofemoral Junction</b>				
				<b>Greater Saphenous Vein (proximal/mid/distal)</b>				
				Perforator				
				Tributary				
				Accessory Vein				
				<b>Saphenopopliteal Junction</b>				
				<b>Small Saphenous Vein</b>				
				Perforator				
				Tributary				
				Accessory Vein				

**Provide the following documentation with 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 of severity of varicose vein condition
  - Physical findings
  - X-ray and imaging study reports
- ✓ Doppler and duplex scanning report with clear results completed pre-treatment showing valve incompetence with reflux and diameter of veins (submit actual reports and document results on this form)
- ✓ Clinical records documenting the following:
  - Activities the member 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 veins(s)