Sinus Surgery
Precertification Information Request Form

Applies to:

Aetna plans

Innovation Health® plans

Health benefits and health insurance plans offered and/or underwritten 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)

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.
    - 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 #937: Sinus Surgeries**, 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**
- Traditional plans: **1-888-632-3862**
- Medicare plans: **1-800-624-0756**

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Section 1: Provide the following general information If submitting request electronically, complete member name, ID and reference number only	
Member name:	**Reference number (required):**
Member Phone Number: - -	
Member ID:	**Member date of birth:**
Requesting provider/facility/vendor name:	
Requesting provider/facility/vendor NPI:	
Requesting provider/facility/vendor phone number: 1- - -	
Requesting provider/facility/vendor fax number: 1- - -	
Assistant/co-surgeon name (if applicable):	**TIN:**

Section 2: Provide the following patient-specific information
What diagnosis(es) you are treating (ICD-10)? What are the requested procedures (CPT codes)?
Has the procedure been scheduled: ☐ Yes ☐ No **If yes: Date of service:**
Describe the indication for the sinus surgery:
Will the surgery be image-guided? ☐ Yes ☐ No If yes, please provide the indication for image guidance.
How long has the patient had symptoms? Date symptoms started: / /
Document the medical therapy that has been tried and failed. Antibiotics: Start date / / End date / / Intranasal steroids: Start date / / End date / / Daily saline nasal irrigation: Start date / / End date / / Other (please describe):
Has the patient had a CT scan within the past 12 months? ☐ Yes ☐ No **If yes, please submit report(s).**
Is this a re-do or revision sinus surgery? ☐ Yes ☐ No **If yes, please provide the following information:** Description of previous sinus surgery: Date of previous sinus surgery: / / How long has the patient had symptom? Antibiotics after surgery: Start date / / End date / / Has the patient had endoscopic or CT imaging since surgery? ☐ Yes ☐ No **If yes, please submit report(s).**

Member Name:	**Member Phone Number:**
Member ID:	**Reference number (required):**

Section 3: 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).

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

Unstable respiratory status:

- ☐ Poorly controlled asthma (FEV1 < 80% despite medical management)
- ☐ COPD or
- ☐ Ventilator dependent patient

Continued

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Member Name:	Member Phone Number:
Member ID:	Reference number (required):

Section 3: Location where procedure will be performed (continued)

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)

- ☐ 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.)

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 free-standing ambulatory surgical centers or office based surgical centers that allow procedure(s) planned

Section 4: Provide the following documentation for your request

- ☐ CT imaging of sinuses
- ☐ Nasal endoscopy report (if done)
- ☐ Current history and physical
- ☐ Description of proposed treatment
- ☐ Laboratory/pathology reports, as applicable
- ☐ Supporting medical records documenting clinical findings, conservative management, outcome, and current plan of care.

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 can 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- - -