Neurostimulator Implantation
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)

Neurostimulator Implantation Precertification Information Request Form

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.

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 #0004 Obstructive Sleep Apnea in Adults; Clinical Policy Bulletin #0223 Urinary Incontinence; Clinical Policy Bulletin #0611Fecal Incontinence** 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** **(TTY: 711)**
- Traditional plans: **1-888-632-3862** **(TTY: 711)**
- Medicare plans: **1-800-624-0756** **(TTY: 711)**

Neurostimulator Implantation
Precertification Information Request Form

Section 1: Member Demographics Typed responses are preferred. If the responses cannot be typed, they should be printed clearly.	
Member name:	**Reference number (required):**
Member ID:	**Member date of birth:**
Member Phone Number: - -	**Member Address:**

Section 2: Provider Information		
Name:	NPI:	Billing TIN:
Phone number: - -	Fax number: - -	
Address:		
Is the provider participating? ☐ Yes ☐ No		

Section 3: Facility Information		
Name:	NPI:	Billing TIN:
Phone number: - -	Fax number: - -	
Address:		
Is facility participating with patient's medical plan? ☐ Yes ☐ No		

Section 4: Assistant/Co-Surgeon Provider Information		
Name:	NPI:	Billing TIN:
Phone number: - -	Fax number: - -	
Address:		
Is the provider participating? ☐ Yes ☐ No	Is the provider an assistant surgeon? ☐ Yes ☐ No	Is the provider a co-surgeon? ☐ Yes ☐ No

Neurostimulator Implantation
Precertification Information Request Form

Member name:	**Phone Number:** - -
Member ID:	**Reference number (required):**

Section 5: Complete if request is for Implantable Sacral Nerve Stimulators

Section 5a: Only complete if requesting stimulator for treatment of urge UI or symptoms of urge-frequency (e.g., Axonics and InterStim)

Has the patient experienced urge UI or symptoms of urge-frequency for at least 6 months? ☐ Yes ☐ No

Has the condition resulted in significant disability (the frequency and/or severity of symptoms are limiting the member's ability to participate in daily activities) for the patient? ☐ Yes ☐ No

Has the patient failed Pharmacotherapies? ☐ Yes ☐ No
If yes, which medications have been failed:

Has the patient failed behavioral treatments such as pelvic floor exercise, biofeedback, timed voids, and fluid management? ☐ Yes ☐ No

Did test stimulation (Stage 1) provide at least 50 % decrease in symptoms? ☐ Yes ☐ No
If yes, what % of decrease in symptoms did the patient experience?

Does the member have any of the following contraindications?

- ☐ Untreated urinary obstruction (e.g., benign prostatic hypertrophy, urethral stricture)
- ☐ Pure stress incontinence
- ☐ Neurologic disease origins (e.g., multiple sclerosis or diabetes with peripheral nerve involvement)

Provide the following information for Neurostimulator

CPT/HCPCS Code:

Manufacture:

Device Name:

Section 5b: Only complete if requesting stimulator for treatment of non-obstructive urinary retention

Has the patient experienced urinary retention for at least 6 months? ☐ Yes ☐ No

Has the patient failed Pharmacotherapies such as alpha blockers and antibiotics for urinary tract infections? ☐ Yes ☐ No

Has intermittent catheterization failed or is it not well-tolerated by the patient? ☐ Yes ☐ No

Did test stimulation provide at least 50 % decrease in residual urine volume? ☐ Yes ☐ No

Does the member have any of the following contraindications?

- ☐ Untreated urinary obstruction (e.g., benign prostatic hypertrophy, urethral stricture)
- ☐ Pure stress incontinence
- ☐ Neurologic disease origins (e.g., multiple sclerosis or diabetes with peripheral nerve involvement)

Provide the following information for Neurostimulator

CPT/HCPCS Code:

Manufacture:

Device Name:

Neurostimulator Implantation Precertification Information Request Form

Member name:	**Phone Number:** - -
Member ID:	**Reference number (required):**

Section 5c: Only complete if requesting stimulator for treatment of chronic fecal incontinence

Has the patient had inadequate response to conservative treatment? ☐ Yes ☐ No

Which of these conservative treatments has the patient had an inadequate response to?

- ☐ Biofeedback
- ☐ Dietary Management
- ☐ Pharmacotherapy
- ☐ Strengthening exercises

Does the patient have a weak but structurally intact anal sphincter? ☐ Yes ☐ No

As applicable to the patient submit completed diagnostic testing:

- ☐ Anorectal manometry
- ☐ Anorectal ultrasonography
- ☐ Rectal sensory testing

Provide the following information for Neurostimulator

Is this a request for a temporary percutaneous peripheral nerve electrode? ☐ Yes ☐ No

Is this request for a permanent implantable pulse generator? ☐ Yes ☐ No

If yes, did the member have a 50% or greater improvement in incontinence symptoms from the temporary percutaneous peripheral nerve stimulation over a period of at last 48 hours? ☐ Yes ☐ No

CPT/HCPCS Code:

Manufacturer:

Device Name:

Section 6: Complete if request is for Hypoglossal Nerve Neurostimulation (e.g., Inspire System) Only complete if requesting stimulator for treatment of obstructive sleep apnea

What is the patient's Body mass index (BMI)?

Has polysomnography (PSG) been performed within 24 months of first consultation for Inspire implant? ☐ Yes ☐ No

Does the patient have predominantly obstructive events? ☐ Yes ☐ No

What is the patient's Apnea hypopnea index (AHI)?

Has the patient completed at least one month of CPAP monitoring? ☐ Yes ☐ No

If yes, did this demonstrate:

- ☐ CPAP failure
- ☐ CPAP intolerance

Has a drug-induced sleep endoscopy (DISE) procedure been completed? ☐ Yes ☐ No

If yes, sent in results of DISE procedure Date:

Have any other anatomical findings been found that would compromise performance of device? ☐ Yes ☐ No

Provide the following information for Neurostimulator

CPT/HCPCS Code:

Manufacturer:

Device Name:

Neurostimulator Implantation
Precertification Information Request Form

Member name:	**Phone Number:** - -
Member ID:	**Reference number (required):**

Section 7: Complete if requesting stimulator for treatment of any other indication not listed above

Diagnosis Codes:

CPT/HCPCS Code	Description	Number of Units/Services

Medical Indication(s):

Provide the following information for Neurostimulator

CPT/HCPCS Code:

Manufacture:

Device Name:

Neurostimulator Implantation
Precertification Information Request Form

Member name:	**Phone Number:** - -
Member ID:	**Reference number (required):**

Section 8: Place of Service

Procedure to be performed: ☐ **Outpatient** ☐ **Inpatient**	**Number of bed days requested:**
Scheduled Procedure Date: / /	

Section 9: Request for hospital admission pre and/or post-surgery

Are you requesting a pre-hospitalization for medical issues? ☐ Yes ☐ No

Please indicate if the member has any of the following:

Hypertension: complex treatment regimen will require close inpatient post-operative monitoring: ☐ Yes ☐ No
Diabetes: complex treatment regimen will require close inpatient post-operative monitoring: ☐ Yes ☐ No
BMI: Greater than 40: ☐ Yes ☐ No
COPB (Chronic obstructive Pulmonary Disease): ☐ Yes ☐ No
Member is on home oxygen: ☐ Yes ☐ No
Cardiac Condition: ☐ Yes ☐ No
Acute Cardiac event in the last 3 months:

a. Heart attack/myocardial infarction (MI): ☐ Yes ☐ No
b. Stroke/cerebrovascular accident (CVA): ☐ Yes ☐ No
c. Mini stroke/transient ischemic attack (TIA): ☐ Yes ☐ No

History of angioplasty or other cardiac surgery: ☐ Yes ☐ No
Implanted pacemaker or another cardiac device: ☐ Yes ☐ No
Congested Heart Failure: ☐ Yes ☐ No
Cirrhosis of the liver: ☐ Yes ☐ No
End Stage Renal Disease (ESRD) and undergoing regular dialysis: ☐ Yes ☐ No
Are you requesting pre-hospitalization for medical issues? ☐ Yes ☐ No
Member has mental health diagnosis that requires inpatient support after surgery: ☐ Yes ☐ No
Member is alcohol dependent and at risk for withdrawal syndrome: ☐ Yes ☐ No
Member is opioid dependent: ☐ Yes ☐ No
Provide clinical rationale for inpatient hospitalization:

Neurostimulator Implantation
Precertification Information Request Form

Member name:	**Phone Number:** - -
Member ID:	**Reference number (required):**

Section 10: Required Documentation
Omitting required documentation may delay our decision

Current history and physical office notes related to patient's condition, including the following:

- Sign and symptoms, including duration and severity
- Physical findings
- Failed conservative treatment(s); including pharmacotherapies failed or not well tolerated

Clinical records documenting the following:

- Conservative treatment, including type, duration, and outcome
- Outcome of trial implantation, including date of trial and percentage of decrease in symptoms (as applicable to request)
- Documentation of CPAP monitoring (if applicable)
- Lab/pathology and radiology reports (X-rays, MRI, CT), if applicable
- Diagnostic testing results (as applicable).
- Complete description of requested stimulator.
- Medical records supporting the indication in Section 5, 6, or 7

Section 11: 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 12: 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- - -