Initial Cochlear Implant 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)

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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. 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 #13 Cochlear Implants and Auditory Brainstem Implants**, 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 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

Has the procedure been scheduled? ☐ Yes ☐ No

If yes, what is the date of service:

Is the patient enrolled in an educational program that supports listening and speaking with aided hearing? ☐ Yes ☐ No

Has the patient had an assessment by an audiologist and an otolaryngologist experienced in this procedure indicating the likelihood of success with this device?

☐ Yes Date of exam _____ **Submit assessment report**

☐ No

Does the patient have any medical contraindications to cochlear implantation (e.g., cochlear aplasia, active middle ear infection)? ☐ Yes ☐ No

Does the patient have arrangements for appropriate follow-up care including the long-term speech therapy required to take full advantage of this device? ☐ Yes ☐ No

Note: Particular plans may place limits on benefits for speech therapy services. Please consult plan documents for details

Member name:	**Reference number (required):**

Section 3: Provide the following patient-specific information for uniaural (monaural) or binaural (bilateral) cochlear implantation in *children up to age 18 years*
(Skip to Section 5 if patient is 18 years of age or older)

Does the patient have profound, bilateral sensorineural hearing loss determined by an air conduction pure tone average of 70 dB or greater at 500 Hz? ☐ Yes ☐ No

Does the patient have profound, bilateral sensorineural hearing loss determined by an air conduction pure tone average of 90 dB or greater at 1000 and 2000 Hz? ☐ Yes ☐ No

Submit auditory exam findings (including pure tone average results at 500 Hz, 1000Hz and 2000Hz)

Does the patient have limited benefit from appropriately fitted binaural hearing aids? ☐ Yes ☐ No

***For children 4 years of age or younger*, submit the findings from the Infant-Toddler Meaningful Auditory Integration Scale, Meaningful Auditory Integration Scale, Early Speech Perception test, or open-set word recognition test (Multisyllabic Lexical Neighborhood Test) in conjunction with appropriate amplification and participation in intensive aural habilitation over a 3 to 6 month period.**

***For children older than 4 years of age*, submit the findings from the Phonetically Balanced-Kindergarten Test, Hearing in Noise Test for children, the open-set Multi-syllabic Lexical Neighborhood Test (MLNT) or Lexical Neighborhood Test (LNT), depending on the child's cognitive ability and linguistic skills.**

Has the patient had a 3- to 6- month hearing aid trial? ☐ Yes ☐ No

Does the patient have radiological evidence of cochlear ossification? ☐ Yes ☐ No

Section 4: Provide the following patient-specific information for uniaural (monaural) or binaural (bilateral) cochlear implantation in patients *age 18 years or older*

Does the patient have bilateral severe to profound sensorineural hearing loss determined by an air conduction pure tone average of 70 dB or greater at 500 Hz, 1000 Hz, and 2000 Hz? ☐ Yes ☐ No

Submit auditory exam findings (including pure tone average results at 500 Hz, 1000Hz and 2000Hz)

Does the patient have lack of benefit from a minimum of 30-day hearing aid trial with appropriately fit binaural hearing aids worn on a full-time basis (8 hours per day)? ☐ Yes ☐ No

Submit test scores in best-aided listening condition on open-set sentence cognition (e.g., Central Institute for the Deaf (CID) sentences, Hearing in Noise Test sentences (HINT), and consonant-nucleus-consonant (CNC) test).

Section 5: Provide the following patient-specific information for hybrid cochlear implantation (e.g., the Nucleus Hybrid L24 Cochlear Implant System)

Does the patient have severe or profound sensorineural hearing loss of high-frequency sounds in both ears, but can still hear low-frequency sounds with or without a hearing aid? ☐ Yes ☐ No

Does the patient have normal to moderate hearing loss in the low frequencies (thresholds no poorer than 60 dB HL up to and including 500 Hz)? ☐ Yes ☐ No

Does the patient have severe to profound mid to high frequency hearing loss (threshold average of 2000, 3000, and 4000 Hz greater than or equal to 75 dB HL) in the ear to be implanted? ☐ Yes ☐ No

Does the patient have moderate severe to profound mid to high frequency hearing loss (threshold average of 2000, 3000, and 4000 Hz greater than or equal to 60 dB HL) in the contralateral ear? ☐ Yes ☐ No

Does the patient have a Consonant-Nucleus-Consonant (CNC) word recognition test, conducted in the best aided-condition, with score between 0% and 60% inclusive in the ear to be implanted? ☐ Yes ☐ No

Is the CNC word recognition score in the contralateral ear equal to or better than in the ear to be implanted but not more than 80% in the best-aided condition? ☐ Yes ☐ No

Does the patient have lack of benefit from a minimum of 30-day hearing aid trial with appropriately fit binaural hearing aids worn on a full-time basis (8 hours per day)? ☐ Yes ☐ No

Does the patient have a patent cochlea and normal cochlear anatomy and no ossification or any other cochlear anomaly that might prevent complete insertion of the electrode array? ☐ Yes ☐ No

Is the patient current on age-appropriate pneumococcal vaccination? ☐ Yes ☐ No

Initial Cochlear Implant
Precertification Information Request Form

Member name:	Reference number (required):

Section 6: 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).
- ☐ 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.)

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

Continued

Initial Cochlear Implant
Precertification Information Request Form

Member name:	**Reference number (required):**

Section 6: Location where procedure will be performed (continued)

Unstable respiratory status:

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

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)

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

Section 7: Provide the following documentation for your request

- Current history and physical
- Office notes related to the member's condition for the proposed treatment
- Description of the proposed treatment
- Lab/pathology, auditory exam and x-ray reports, as applicable

Section 8: 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 9: Sign the form

Just remember: You cannot 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- - -