Uvulopalatopharyngoplasty (UPPP)
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®

Uvulopalatopharyngoplasty (UPPP) Precertification Information Request Form

About this form

You can't use this form to initiate a precertification request. To initiate a request, you have to call our Precertification Department. Or you can submit your request electronically. **Failure to complete this form and submit all of the medical records we are requesting may result in the delay of review.**

Effective **May 31, 2018**, this form replaces all other Uvulopalatopharyngoplasty (UPPP) precertification information request documents and forms. This form will help you supply the right information with your precertification request. You don't have to use the form. But it will help us adjudicate your request more quickly.

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:

- **(Preferred)** Upload your information electronically on our secure provider website on NaviNet® at **connect.navinet.net**.
    - Complete a Precertification Inquiry transaction for the patient.
    - When the inquiry is successful, click the "Add Attachment" link in the upper right corner of the screen.
    - Upload your document(s) and click "Attach." The window will close and you will return to Precert Inquiry screen.

- Send your information via confidential fax to:
    - Precertification – Commercial Plans: **859-455-8650**
    - Precertification - Medicare Advantage Standard Organization Determination: **859-455-8650**
    - Precertification - Medicare Advantage (expedited only): **860-754-5468**

- Mail your information to: **PO Box 14079**
  Lexington, KY 40512-4079

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 #4: Obstructive Sleep Apnea in Adults,** before you complete this form.

You can find the Clinical Policy Bulletins or 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**
- Traditional plans: **1-888-632-3862**

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Section 1: Provide the following general information	
Member name:	**Administrative reference number (required):**
Member ID:	**Member date of birth:**
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 patient been diagnosed with either of the following? ☐ Obstructive sleep apnea ☐ Non-obstructive apnea

Has the patient tried CPAP or AutoPAP? ☐ Yes ☐ No If yes, was the member intolerant? ☐ Yes ☐ No

Does the patient have an apnea-hypopnea index (AHI) or respiratory disturbance index (RDI) greater than or equal to 15 events/hour with a minimum of 30 events? ☐ Yes ☐ No

OR

Does the patient have an AHI or RDI greater than or equal to 5 and less than 15 events/hour with a minimum of 10 events and at least one of the following: ☐ Yes ☐ No

- ☐ Documented history of stroke; or
- ☐ Documented hypertension (systolic blood pressure greater than 140 mm Hg and/or diastolic blood pressure greater than 90 mm Hg); or
- ☐ Documented ischemic heart disease; or
- ☐ Documented symptoms of impaired cognition, mood disorders, or insomnia; or
- ☐ Excessive daytime sleepiness (documented by either Epworth greater than 10 (see appendix)); or
- ☐ Greater than 20 episodes of oxygen desaturation (i.e., oxygen saturation of less than 85 %) during a full night sleep study, or any one episode of oxygen desaturation (i.e., oxygen saturation of less than 70 %).

Section 3: Provide the following documentation for your request

- Current history and physical
- Office notes related to the member's condition for which treatment is proposed
- Description of proposed treatment
- Initial and all subsequent sleep study reports
- Documentation of CPAP or AutoPAP titration

Section 4: 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 5: Sign the form
Just remember: You can't use this form to initiate a precertification request. To initiate a request, you have to call our Precertification Department. Or you can submit your request electronically.
Signature of treating doctor or other qualified healthcare provider:
Date: / /
Contact name of office personnel to call with questions: **Telephone number:** 1- - -