TMJ Treatment
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

This form replaces all other TMJ Surgery precertification information request documents and forms**. Failure to complete this form and submit all medical records we are requesting may result in the delay of review or denial of coverage.**

Once completed, this form contains confidential information. Only the individual or entity it's addressed to can use it. If you're not the intended recipient, or the employee or agent responsible for delivering the form to the intended recipient, you can't disseminate, distribute or copy the completed form. If you received the completed form in error, call us at **1-800-624-0756** or **1-888-632-3862**.

How to fill out this form

As the patient's attending physician, you must complete Sections 2 through 6 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:

- We prefer you submit precertification requests electronically. Use our provider portal on Availity® to also upload clinical documentation, check statuses, and make changes to existing requests. Register today at availity.com/aetnaproviders.
- Send your information by confidential fax to: **Precertification** – Commercial and Medicare (**including expedited**) 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.
- Mail your information to: **PO Box 14079**
  Lexington, KY 40512-4079
- Email requests that require photographs to*:* Precertification Commercial and Medicare (including expedited): **oralandmaxillofacialsurgery@aetna.com**

What happens next?

Once we receive the requested documentation, we will perform a clinical review. Then we'll make a coverage determination and let you know our decision.

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 is not an available NCD or LCD to review, then the Clinical Policy Bulletin referenced below will be used as a resource in decision making.

For all other members, we encourage you to review **Clinical Policy Bulletin #28: Temporomandibular Disorders**, 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.

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Fax to: Precertification Department	**Fax number: 1-833-596-0339**
Section 1: To be completed by the Precertification Department	
Member name:	
Member ID:	**Member date of birth:**
Physician name:	**Physician NPI:**
Physician fax number: 1-	**Physician status:** ☐ Participating ☐ Non-participating
Reference #: - - . This is the reference number for TMJ surgery request for the above member. **This is not an approval**. Your request requires clinical review and a decision is pending. We'll contact your office/facility once we make a coverage determination.	
Section 2: Provide the following general information	
Facility name:	
Facility fax number: 1-	**Facility status:** ☐ Participating ☐ Non-participating
Assistant/Co-surgeon name and TIN (if applicable):	
Date of procedure: / /	
Diagnosis code(s):	
CPT/HCPCS codes, with descriptions, which best describe the service(s) you'll provide. (For drugs/injectables, include any administration codes.)	

Fax to: Precertification Department	**Fax number: 1-833-596-0339**
Member name:	
Member ID:	**Reference Number:**

Section 3: Provide the following patient-specific information

Select the indication for the requested service(s):

- ☐ Reversible Intra-Oral Appliance
- ☐ Arthrocentesis
- ☐ Arthroscopy
- ☐ Open surgical procedure
  - ☐ Specify type of procedure:
- ☐ Arthroplasty
- ☐ Joint replacement
  - ☐ Specify type of prosthesis (e.g., TMJ Concepts prosthesis)
- ☐ Autogenous grafts
  - ☐ Specify type of graft
- ☐ Other; Please specify:

Section 4: Questionnaire for TMJ Surgical patients only

Date of Evaluation:	**Doctor**: _____ Last	_____ First	_____ TIN
Address:			
City:	**State:**	**ZIP Code:**	
Phone:	Fax:		

Please indicate any appropriate findings related to the chief complaint(s), history of present illness, and quantitative or qualitative description of the symptoms. You may append an additional page if necessary.

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Member ID:	**Reference Number:**

Section 4: Questionnaire for TMJ Surgical patients only (continued)

1.) Diagnostic Imaging: Please indicate the TMJ imaging reports or radiographs available for review (LIST DATES).
Panoramic _____ Transcranial _____ Tomogram _____ Arthrogram _____ MRI _____
Other (specify) _____

Please indicate the radiographic findings:

Right TMJ:	Left TMJ:

2.) Mandibular Range of Motion: Inter-incisal Measurements
Pain free opening: _____ mm Passive stretch opening _____ mm Maximum opening _____ mm
Maximum laterotrusion: Right _____ mm Left _____ mm
Deviation on opening to: Right _____ mm Left _____ mm No deviation _____
Maximum protrusion: _____ mm
Locking: Open _____ mm, Closed _____ mm, Occasionally _____ Frequently _____
Continuously _____

3.) Masticatory Muscle Examination: Tenderness/Severity = (1) slight, (2) moderate, (3) severe

	Right	Left
TMJ Lateral Capsule		
Masseter		
Temporalis		
Medial Pterygoid		
Lateral Pterygoid		
Sternocleidomastoid		
Posterior Cervical Muscles		
High Back/Shoulder Muscles		

Other areas (specify)
_____

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Section 4: Questionnaire for TMJ Surgical patients only (continued)

4.) Auscultation with standard stethoscope: _____; Doppler: _____; Audible (No Amplification): _____;
Other: _____

TMJ Sounds: Indicate Right, Left or Bilateral
None _____ Clicking/popping _____ Crepitation _____

	Right TMJ	Left TMJ
Opening	_____ mm	_____ mm
Closing	_____ mm	_____ mm

Severity: (1) slight (soft), (2) moderate (3) severe

	Right TMJ	Left TMJ
Clicking severity	_____	_____
Crepitation severity	_____	_____

5.) Occlusal Examination: Indicate Right or Left
Type.....Class _____ Division _____
Open Bite... Anterior _____ Posterior _____ Cross-Bite... Anterior _____ Posterior _____
Vertical overlap (overbite) _____ mm Horizontal overlap (overjet) _____ mm
Occlusal wear Slight _____ Moderate _____ Severe _____ Generalized _____
Tooth mobility Slight _____ Moderate _____ Severe _____ Generalized _____
Anterior teeth faceting (key & lock or crossover faceting) None _____ Slight _____ Moderate _____ Severe _____
Missing teeth (non-third molar) _____
(Please circle the above teeth that have been replaced.)
Bruxism _____ Clenching _____ Night _____ Day _____ Patient aware _____
Stress: Slight _____ Moderate _____ Severe _____

6.) Psycho-social Evaluation (specify dates):
None _____ TMJ Scale _____ MMPI _____ Other _____

Please list your diagnoses:

(SURGICAL APPLICATION ONLY) TMJ surgery proposed (TYPE): Indicate Right, Left or Bilateral
Arthrocentesis _____ Arthroscopy _____ Arthroplasty _____ Condylotomy _____ Joint Prosthesis _____
Other (specify) _____

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Section 4: Questionnaire for TMJ Surgical patients only (continued)

I have fully informed the patient of the following potential risks associated with TMJ surgical intervention. Yes ☐ No ☐
Please specify risks:

I have explained to the patient alternate, non-surgical modalities of treatment (as applicable). Yes ☐ No ☐
Please specify alternatives:

HISTORY OF NON-SURGICAL MANAGEMENT- Include modality and length of time for each. (Medications, physical therapy, splint therapy, behavior modification, diagnostic/therapeutic injections, therapeutic steroid injections.)

Section 4: Provide the following documentation for your request

- Letter of medical necessity/rationale for requested procedure(s)
- Completed TMJ questionnaire
- MRI/CT scan report
- Documentation of non-surgical management to include types of therapy and results (physical, medical, behavioral, splint therapies)
- Previous/current TMJ operative reports

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

Signature of person completing form:

Date: / /

Contact name of office personnel to call with questions:
Telephone number: 1- - -