

**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

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

This form replaces all other 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:

- 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 via 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

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 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
If submitting request electronically, complete member name, ID and reference number only.

Member name:	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

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

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 a pure tone average of 70 dB or greater at 500 Hz? Yes No

Does the patient have profound, bilateral sensorineural hearing loss determined by a 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

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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 a 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 limited benefit from appropriately fitted binaural hearing aids? 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 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

Section 6: 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 7: 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 8: Sign the form

Just remember: You cannot use this form to initiate a precertification request. To initiate a request, call our Precertification Department or you can submit your request electronically.

Signature of person completing form:

Date: / /

Contact name of office personnel to call with questions:

Telephone number: 1- - -