Instructions for Submitting Requests for Predeterminations

Meritain Health®
an aetna company

Complete and return to:
Meritain Health®
P.O. Box 853921
Richardson, TX 75085-3921
Fax: 1.716.541.6735
Email: predetermination@meritain.com

PLEASE NOTE: sending anything other than a predetermination request will delay the review of your information.

IMPORTANT PREDETERMINATION REMINDERS
Surgery should not be scheduled prior to determination of coverage

1. Always verify eligibility and benefits first.
2. All applicable fields are required. If all information is not provided, this may cause a delay in the predetermination process. (Inquiries received without the member/patient's group number, ID number, and date of birth cannot be completed and may be returned to you to supply this information.)
3. Fax information for each patient separately, using the fax number indicated on the form.
4. Always place the Predetermination Request Form on top of other supporting documentation. Please include any additional comments if needed with supporting documentation.
5. Do not send in duplicate requests, as this may delay the process.
6. If photos are required for review, the photos should be mailed along with the Predetermination Request Form and not faxed. Faxed photos are not legible and cannot be used to make a determination.

Please note: The fact that a guideline is available for any given treatment or that a service or treatment has been preauthorized or predetermined for benefits, is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and plan provisions in effect at the time the service is rendered.

Please note: Attach all clinical documentation to support medical necessity. For bariatric surgeries, please verify guidelines in your patient's plan. If the plan does not provide specific criteria, please review Aetna CPB 0157.

The patient's plan document supersedes this and Aetna® clinical policy bulletin criteria.

How to fill out this form
As the patient's attending physician, you must complete all sections of the form.

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.

SECTION 1: PROVIDE THE FOLLOWING GENERAL INFORMATION	
MEMBER NAME	MEMBER DATE OF BIRTH
MEMBER ID NUMBER	
REQUESTING PROVIDER/FACILITY NAME	PROVIDER PHONE NUMBER
PROVIDER ADDRESS	PROVIDER FAX NUMBER
FACILITY NAME/ADDRESS	PROVIDER TAX ID NUMBER

SECTION 2: PROVIDE THE FOLLOWING PATIENT-SPECIFIC INFORMATION

PATIENT'S PLAN DOCUMENT SUPERCEDES THIS AND AETNA CLINICAL POLICY BULLETIN CRITERIA

IS THIS A REPEAT BARIATRIC SURGERY? ☐ YES ☐ NO

IF YES, SELECT THE REASON FOR REPEAT SURGERY BELOW:

- ☐ Inadequate success (defined as loss of more than 50 percent of excess body weight) two years following the primary bariatric surgery procedure and the patient has been compliant with a prescribed nutrition and exercise program following the procedure.
- ☐ Revision of a primary bariatric surgery procedure that has failed due to dilation of the gastric pouch, dilated gastro jejunal stoma, or dilation of the gastrojejunostomy anastomosis and the primary procedure was successful in inducing weight loss prior to the dilation of the pouch or gjanastomosis, and the member has been compliant with a prescribed nutrition and exercise program following the procedure.
- ☐ Replacement of an adjustable band due to complications (e.g., port leakage, slippage) that cannot be corrected with band manipulation or adjustments.
- ☐ Conversion from an adjustable band to a sleeve gastrectomy, roux-en-y gastric bypass (rygb), biliopancreatic diversion (bpd) or duodenal switch (ds) and the patient has been compliant with a prescribed nutrition and exercise program following the band procedure and there are complications that cannot be corrected with band manipulation, adjustments or replacement.
- ☐ Conversion of sleeve gastrectomy to roux-en-y gastric bypass for the treatment of gastro-esophageal reflux disease (gerd) when anti-reflux medical therapy has been tried and failed.
- ☐ Other, please specify. Indicate below which of the following procedure(s) best describes the coverage request:

  - ☐ Roux-en-Y Gastric bypass (RYGB)
  - ☐ Biliopancreatic diversion (BPD)
  - ☐ Laparoscopic adjustable silicone gastric banding (LASGB)
  - ☐ Other, please specify: _____
  - ☐ Sleeve gastrectomy
  - ☐ Duodenal Switch
  - ☐ Vertical banded gastroplasty (VBG)

Submit Clinical Records to support all of the following:

Care and treatment of morbid obesity (including surgical treatment). Surgical treatment for morbid obesity will only be covered if all the following conditions are met:

- The covered person has either (1) a body mass index (BMI) of 40 or greater or (2) a BMI of 35 or greater in conjunction with a severe co-morbidity, such as obesity hypoventilation, sleep apnea, diabetes, hypertension, cardiomyopathy or musculoskeletal dysfunction.

- The covered person has at least a 24-month history of morbid obesity as documented in such person's medical records. Attach supporting medical records, a list of dates and weights will **not** suffice.

- The covered person does not have an underlying diagnosed medical condition that would cause morbid obesity e.g., an endocrine disorder) that can be corrected by means other than surgical treatment. Attach current lab results.

- The covered person has completed full growth (18 years old or supporting documentation of complete bone growth).

- The covered person has failed to achieve and maintain significant weight loss and such person has participated in a physician-supervised nutrition and exercise program for at least six months (occurring within the 24-month period prior to the proposed surgical treatment) and such participation is documented in their medical records. Attach medical records. **Please note**: Six months is a minimum of 180 days. If there is a break in program participation, credit will only be given for the months attended.

- The covered person must be evaluated by a licensed professional counselor, psychologist or psychiatrist within 12 months prior to the proposed surgical treatment. The evaluation should document the following:

  — There is no significant psychological problem that would limit the ability of the covered person to understand the procedure and comply with any medical and/or surgical recommendations.

  — There are no psychological co-morbidities that may be contributing to the covered person's inability to lose weight or a diagnosed eating disorder.

  — The covered person's willingness to comply with the preoperative and postoperative treatment plans.

SECTION 3: SIGNATURE	
SIGNATURE OF PERSON COMPLETING FORM	DATE
CONTACT NAME OF OFFICE PERSONNEL TO CALL WITH QUESTIONS	
PHONE NUMBER	