Outpatient Behavioral Health (BH) Request – TMS Requests: Transcranial Magnetic Stimulation Precertification Information Request

Applies to:

Aetna Medicare 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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PRECERTIFICATION only. DO NOT use this form for EXTENSION requests.

About this form

Do not use in Maryland or Massachusetts for commercial plans. This form may be used for Aetna Medicare Advantage plans in these states.

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

Effective **June 1, 2023**, this form replaces all other Transcranial Magnetic Stimulation precertification request documents and forms. **Failure to complete this form and submit all of the medical records we are requesting may result in the delay of review.**

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 (TTY: 711)** or **1-888-632-3862 (TTY: 711)**.

How to fill out this form

As the patient's attending physician, you must complete Sections 1 through Section 6 of the form.

You can use this form with Aetna's Medicare Advantage plans. You can also use this form with health plans for which Aetna provides certain management services. This includes Innovation Health Plan, Inc. and Innovation Health Insurance Company. You can't use the form with Traditional Choice/Indemnity plans or other commercial plans. For commercial plans, call the number on the member's card to pre-certify the care.

When you're done

Once you've filled out the form, submit it and all requested medical documentation to our Precertification Department by one of the following:

- **(Preferred)** Upload your information electronically on our secure provider website on the Provider Portal at **www.Availity.com**.

- Send your information by confidential fax to:
  - Aetna Leap Plans: **888-934-7941 (TTY: 711)**
  - Medicare Plans: **959-282-8799 (TTY: 711)**
  - Commercial Plans: **888-463-1309 (TTY: 711)**

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 #469: Transcranial Magnetic Stimulation and Cranial Electrical Stimulation**, before you complete this form. You can find the policy 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 Aetna Leap Plans: **1-888-632-3862 (TTY: 711)** or All Other Plans: **1-800-424-4047 (TTY: 711)**.

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Fax to	Fax number
Behavioral Health Precert	• Aetna Leap Plans: **1-888-934-7941 (TTY: 711)** • Medicare Plans: **1-959-282-8799 (TTY: 711)** • Commercial Plans: **1-888-463-1309 (TTY: 711)**

Section 1

Member name	Member telephone number - -
Member ID	Member date of birth / /
Facility, Physician, Provider or Vendor name	
Facility, Physician, Provider or Vendor address	
Facility, Physician, Provider or Vendor telephone number	Facility, Physician, Provider or Vendor TIN
Facility, Physician, Provider or Vendor fax number **1 - - -**	Facility, Physician, Provider or Vendor status ☐ Participating ☐ Non-participating

We've received a coverage request for **Enter service request**

for the above member. Your reference number for this request is _____-_____-_____. **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 (please write legible)

Facility, Physician, Provider or Vendor name	
Facility, Physician, Provider or Vendor TIN	Provider Specialty
Facility, Physician, Provider or Vendor fax number **1 - - -**	Facility, Physician, Provider or Vendor status ☐ Participating ☐ Non-participating
If you are a non-participating provider and this request is for Medicare: • Have you opted out of Medicare?	
Who referred member for TMS service (name, specialty and TIN)?	
Current diagnosis code(s) please include any co-occurring medical diagnosis:	
Was the diagnosis of Major Depression Severe confirmed by a psychiatrist?	
Planned start date of procedure or service **/ /**	**Select the CPT/HCPCS codes** which best describe the service(s) you will provide and indicate the number of sessions requested: ☐ 90867 _____ ☐ 90868 _____ ☐ 90869 _____ ☐ Other: _____

Section 3 – Provide the following patient-specific information

1. Presenting problems and symptoms:
2. Date of the most recent onset of acute symptoms:
3. Depression rating scales that support the diagnosis of Major Depression Severe (e.g., Beck Depression Scale [BDI], Hamilton Depression Rating Scale [HDRS], Montgomery-Asberg Depression Rating Scale [MADRS], etc.) Rating scale(s) Name, Date, and Score: _____
4. Is there a history of TMS treatment? If yes MUST include note dates, number of sessions and response to treatment including rating scales results and dates.

Continued

Section 3 – Provide the following patient-specific information *(continued)*

5. Check any of the following that currently exist:

- ☐ High alcohol or illicit drug consumption
- ☐ Metal implant in or around the head
- ☐ Other implants (e.g. pace maker etc.)
- ☐ Neurological condition
- ☐ Psychosis
- ☐ Acute suicidal risk
- ☐ Catatonia
- ☐ Life-threatening inanition
- ☐ Cardiovascular disease
- ☐ Member currently receiving ECT
- ☐ Seizure disorder/epilepsy – if yes, include history: _____
- ☐ **Other** _____

6. If yes to cardiovascular disease or seizure disorder/epilepsy, provide the name and specialty of the provider that cleared the member for TMS:

7. Has the Member had evidence based psychotherapy known to be effective for the treatment of Major Depression during the current episode?

- Type of therapy and provider: _____
- Dates of this therapy trial (start/finish): _____
- Frequency of sessions attended: _____
- Therapy effectiveness: _____
- Rating scales scores with dates that support the effectiveness, or lack of effectiveness of therapy: _____

8. Please document all psychopharmacologic trails (with augmentative agents) during the current depressive episode**. Please include the dates, doses and outcome of each trial. Please describe why, including specific side effects that led to discontinuation.**
For detail about this requirement see:

- Commercial Plans: Aetna.com and Clinical Policy Bulletin #469
- Medicare Plans: LCD for treatment state available at CMS.gov

Medication	Dosage	Dates (day/month/year)	Results of Medication Trials/Side Effects that limited dosing	Primary or Augmenting Medication (if augmenting, indicate which antidepressant it is augmenting)

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

Form completed by	**Title**