

Functional Endoscopic Sinus Surgery (FESS)

Prior Review Fax Form

PRESCRIBER INFORMATION		PATIENT INFORMATION	
PHYSICIAN NAME	PROVIDER ID/TAX ID (if out of state must have tax ID)	PATIENT NAME	
CONTACT PERSON/PRACTICE NAME		PATIENT'S BCBSNC ID	
PRACTICE PHONE	PRACTICE FAX	PATIENT'S DATE OF BIRTH	
PRACTICE ADDRESS	CITY	STATE	ZIP

Indicate requested CPT code(s) _____ 31254 _____ 31255 _____ 31256 _____ 31267
 _____ 31276 _____ 31287 _____ 31288 _____ 31295 _____ 31296 _____ 31297
 Other planned CPT: _____ Please describe "other" procedure: _____

For members with uncomplicated sinusitis, indicate which of the following are present:

1. Has member had four or more documented episodes of acute (<4 wks) rhinosinusitis in one year, or chronic (>12wks) sinusitis that interferes with life-style? ___ Y ___ N
2. Has appropriate therapy been tried and failed including allergy evaluation and treatment, decongestants, topical or systemic steroids, treatment of rhinitis medicamentosa, smoking cessation and avoidance of tobacco smoke as indicated? ___ Y ___ N
3. Has antibiotic therapy consisting of three consecutive weeks of appropriate antibiotic drugs, OR multiple two to three week courses of appropriate antibiotic drugs during the symptomatic periods failed? ___ Y ___ N
4. If member has **chronic** rhinosinusitis, does a coronal CT and/or nasal endoscopy following optimal medical therapy shows persistent sinus pathology? ___ Y ___ N ___ NA
5. If member has **recurrent acute** rhinosinusitis, does a CT and/or nasal endoscopy during acute rhinosinusitis document sinus pathology amenable to surgical treatment? ___ Y ___ N ___ NA

For members with multiple or recurrent polyps with airway obstruction, indicate which of the following are present:

6. Has appropriate therapy been tried and failed including assessment for allergy symptoms and allergy evaluation if indicated? ___ Y ___ N
7. Is persistent sinus disease documented on follow up CT scan and/or nasal endoscopy? ___ Y ___ N

Diagnosis Code: _____ Date of Procedure: _____ Place of Service: _____
 If surgery is advised for diagnosis other than sinusitis or polyposis, please include relevant medical records.
 Effective: 10/1/11

PHYSICIAN ATTESTATION: By signing below, I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.

Please certify the following by signing and dating below:

*Physician signature: _____ Date: _____
 (*Original Physician signature required. Stamped signatures not acceptable)

For BCBSNC members, fax form to 1-800-672-6587
For NC State Health Plan members, fax form to 1-866-225-5258

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