Hip Arthroplasty
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

Do not use this form to initiate a precertification request. To initiate a request, submit electronically on Availity or call our Precertification Department. Submit your medical records to support the request with your electronic submission.

We've made it easy for you to authorize services and submit any requested clinical information. Just use our provider portal on Availity®. Register today at **Availity.com/aetnaproviders**. Once your account is ready, you can start submitting authorization requests right away.

- For additional information on Availity, go to **https://www.aetna.com/health-care-professionals/resource-center/availity.html**

Requesting authorizations on Availity is a simple two-step process

Here's how it works:

1. Submit your initial request on Availity with the Authorization (Precertification) Add transaction.
2. Then complete a short questionnaire, if asked, to give us more clinical information.
    - If you receive a pended response, then complete this form and attach it to the case electronically.

This form will help you supply the right information with your precertification request. Typed responses are preferred. Failure to complete this form and submit all medical records we are requesting may result in the delay of review or denial of coverage.

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:

- If your request was submitted via telephone, you can either:
    - Access our provider portal via Availity; enter the Reference number provided and attach this form and all requested medical documentation to the case or
    - Send your information by confidential fax to:
        - **Precertification**- Commercial and Medicare 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.
    - If you do not have fax or electronic means to submit clinical:
        - Mail your information to: **PO Box 14079**
          Lexington, KY 40512-4079
          (Please note mailing will add to the review response time)

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 #287: Hip Arthroplasty,** 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 questions about how to fill out the form or our precertification process, call us at:

- HMO plans: **1-800-624-0756 (TTY: 711)**
- Traditional plans: **1-888-632-3862 (TTY: 711)**
- Medicare plans: **1-800-624-0756 (TTY: 711)**

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Section 1A: Provide the following general information for all requests Typed responses are preferred. If the responses cannot be typed, they should be printed clearly	
Member name:	**Reference number (required):**
Section 1B: Provide the following general information	
Member ID:	**Member date of birth:**
Member phone number:	
Requesting provider/facility name:	
Requesting provider/facility NPI:	
Requesting provider/facility phone number: 1- - -	
Requesting provider/facility fax number: 1- - -	
Assistant/Co-Surgeon name and TIN (if applicable):	
Physical Therapist Name:	
Physical Therapist Phone Number: - -	
Physical Therapist Fax Number: - -	
Has the procedure been scheduled? ☐ Yes ☐ No If yes, what is the date of service:	
Which hip will surgery be performed on? ☐ Left ☐ Right	

Section 2: Primary Hip Arthroplasty	
1.	**Reason for surgery (Diagnosis)** (Check all that apply) ☐ Moderate/Severe Osteoarthritis or Rheumatoid arthritis (shown on imaging) with any a, b or c ☐ a. severe narrowing or obliteration of the joint space; *or* b. severe deformity of the femoral head; *or* c. *all* of the following: i. small cysts in the femoral head or acetabulum; *and* ii. increasing narrowing of the joint space; *and* iii. moderate loss of sphericity of the femoral head ☐ Post-traumatic arthritis ☐ Malunion of fracture (acetabular, femoral head, or proximal femur) ☐ Fracture of femoral neck (shown on imaging) ☐ Nonunion/failure of a previous hip fracture surgery (shown on imaging) ☐ Imaging shows cancer of the joint: bones or soft tissues of the pelvis or proximal femur
2.	**Member's advanced joint disease is demonstrated by:** Pain that interferes ADLs: ☐ Mild ☐ Moderate ☐ Severe Functional disability that interferes with ADLs: ☐ Mild ☐ Moderate ☐ Severe
3.	☐ **Physical exam including passive range of motion (ROM):** Demonstrates limited ROM (internal rotation/flexion) ☐ Yes ☐ No Antalgic gait: ☐ Yes ☐ No Pain in hip joint: ☐ Yes ☐ No

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Member name:	Member ID:
Member Phone Number:	Reference number (required):

4.

☐ **Radiologic Exam:**

Avascular necrosis (osteonecrosis) with stage III collapse of the femoral head: ☐ Yes ☐ No

Rheumatoid arthritis (joint space narrowing): ☐ Yes ☐ No

5.

Which of these conservative therapies in the last year?

☐ Pain medication (ibuprofen, acetaminophen) Duration (weeks):

☐ Formal physical therapy: Duration (weeks): Dates to and from:

☐ Activity Modification

☐ Assistive device (i.e. walker, cane)

☐ Therapeutic injections

☐ Therapy not appropriate

Reason:

Did the patient complete a minimum of 12 weeks of non-surgical treatments? ☐ Yes ☐ No

6.

Does the patient have any of the following?

(check any that apply)

☐ Active infection of the joint or active systemic bacteremia, that has not been totally eradicated

☐ Active skin infection (other than recurrent cutaneous staph infections) or open wound within the planned surgical site of the hip

☐ Allergy to components of the implant (such as cobalt, chromium, alumina)

☐ Corticosteroid injection into the joint within 12 weeks of the planned arthroplasty

☐ Paraplegia or quadriplegia

☐ Muscle weakness without pain that is preventing ambulation (Y/N). Permanent: ☐ Yes ☐ No
Irreversible: ☐ Yes ☐ No

☐ Rapidly progressive neurological disease

☐ Skeletal immaturity

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Member name:	**Member ID:**
Member Phone Number:	**Reference number (required):**

Section 3: Total hip revision, replacement or hip resurfacing arthroplasty

☐ Is this a revision or replacement of a total hip or hip resurfacing arthroplasty? ☐ Yes ☐ No

Reason for surgery (Indication)

- ☐ Aseptic loosening of one or more prosthetic components
- ☐ Fracture or mechanical failure of 1 or more components of the prosthesis
- ☐ Displaced periprosthetic fracture
- ☐ Progressive or substantial periprosthetic bone loss
- ☐ Bearing surface wear leading to symptomatic synovitis or local bone or soft tissue reaction
- ☐ Recurrent (2 or more) dislocations not responsive to a reasonable course of conservative management
- ☐ Irreducible dislocation
- ☐ Clinically significant leg length discrepancy
- ☐ Confirmed periprosthetic infection, confirmed by gram stain and culture

Member's advanced joint disease is demonstrated by:

Pain that interferes ADLs:	☐ Mild	☐ Moderate	☐ Severe
Functional disability that interferes with ADLs:	☐ Mild	☐ Moderate	☐ Severe

☐ Does patient have any of the following?

(check any that apply)

- ☐ Loss of muscle (hip abductor muscle in particular), neuromuscular compromise, or vascular deficiency in the affected leg
- ☐ Osteoporosis or other bone abnormalities which would make the likelihood of a poor outcome more probable
- ☐ Poor skin coverage
- ☐ Severe instability due to anatomic causes that would make a poor surgical outcome more likely

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Member name:	**Member ID:**
Member Phone Number:	**Reference number (required):**

Section 4: Request for hospital admission pre and/or post-surgery

Are you requesting: ☐ Inpatient ☐ Outpatient
Are you requesting a hospital admission greater than 2 days? ☐ Yes ☐ No
Are you requesting a pre-hospitalization for medical issue? ☐ Yes ☐ No

Please indicate if the patient has any of the following:

Hypertension: complex treatment regimen will require close inpatient post-operative monitoring: ☐ Yes ☐ No
Diabetes: complex treatment regimen will require close inpatient post-operative monitoring: ☐ Yes ☐ No
BMI: Greater than 35 with an obesity related co-morbidity: ☐ Yes ☐ No
COPB (Chronic obstructive Pulmonary Disease) on oxygen: ☐ Yes ☐ No
Patient is on home oxygen: ☐ Yes ☐ No
Cardiac Condition:
- Acute Cardiac event in the last 3 months (CVA/MI/TIA) : ☐ Yes ☐ No
- History of angioplasty or other cardiac surgery: ☐ Yes ☐ No
- Implanted pacemaker or another cardiac device: ☐ Yes ☐ No
- Congestive Heart Failure: ☐ Yes ☐ No
- Cirrhosis of the liver: ☐ Yes ☐ No
- End Stage Renal Disease (ESRD) and undergoing regular dialysis: ☐ Yes ☐ No

Are you requesting pre-hospitalization for medical issue? ☐ Yes ☐ No
Patient has mental health diagnosis that requires inpatient support after surgery: ☐ Yes ☐ No
Patient is alcohol dependent and at risk for withdrawal syndrome: ☐ Yes ☐ No
Patient is opioid dependent: ☐ Yes ☐ No
Provide clinical rationale for inpatient hospitalization:

Section 5: Provide the following documentation for the request

- Current history and physical
- Description of proposed treatment
- Lab/pathology and radiology reports (X-rays, MRI, CT), if applicable
- Supporting medical records documenting clinical findings, conservative management with outcome and current plan of care.

Section 6: 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 7: Sign the form

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

Signature of person completing form:

Date: / /

Contact name of office personnel to call with questions:

Telephone number: 1- - -