Shoulder Arthroplasty
Precertification Information Request Form

Applies to:

Aetna plans

Innovation Health® plans

Health benefits and health insurance plans offered and/or underwritten 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)

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.

This form will help you supply the right information with your precertification request. 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:

- 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 or learn more about Availity at www.availity.com/aetnatraining.

- 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.

- 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 #837: Shoulder Arthroplasty and Arthrodesis**, 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**)**

Shoulder Arthroplasty
Precertification Information Request Form

Section 1: Provide the following general information Typed responses are preferred. If the responses cannot be typed, they should be printed clearly.	
Member name:	**Reference number (required):**
Member Phone Number:	
Member ID:	**Member date of birth:**
Requesting provider/facility/vendor name:	
Requesting provider/facility/vendor NPI:	
Requesting provider/facility/vendor phone number: 1- - -	
Requesting provider/facility/vendor fax number: 1- - -	
Assistant/co-surgeon name (if applicable):	**TIN:**
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 shoulder will surgery be performed on? ☐ Left ☐ Right **Please submit a separate form for each shoulder.**	

Section 2: Total Shoulder Arthroplasty

Reason for surgery (Diagnosis):
(Select all that apply)

- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Avascular necrosis
- ☐ Post-traumatic arthritis
- ☐ Malunion fracture of the proximal humerus
- ☐ Fracture of proximal humerus
- ☐ Malignancy of the scapula, proximal humerus, shoulder joint or adjacent soft tissues by imaging
- ☐ Nonunion/failure of a previous proximal humeral fracture surgery (shown by imaging)

Does the member have any of the following contraindications?
(Select all 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 shoulder
- ☐ Allergy to components of the implant (such as cobalt, chromium, alumina)
- ☐ Corticosteroid injection into the joint within 12 weeks of the planned arthroplasty
- ☐ Rapidly progressive neurologic disease
- ☐ Osseous abnormalities that cannot be optimally managed and which would increase the likelihood of a poor surgical outcome (i.e., inadequate bone stock to support the implant)
- ☐ None of the above

Continued

Member ID:	**Reference number (required):**

Section 2: Total Shoulder Arthroplasty (continued)

Shoulder replacement system

Will a custom total shoulder implant be utilized? ☐ Yes ☐ No

Computer (robotic) assisted musculoskeletal surgical navigation

Will computer (robotic) assisted musculoskeletal surgical navigation be utilized? ☐ Yes ☐ No

Radiographic evidence of the following (Select all that apply)?

- ☐ Irregular joint surfaces
- ☐ Glenoid sclerosis
- ☐ Malunion of fracture (proximal humerus)
- ☐ Avascular necrosis of the humeral head with collapse
- ☐ Osteophyte changes
- ☐ Flattened glenoid
- ☐ Cystic changes in the humeral head
- ☐ Joint space narrowing of the shoulder join
- ☐ Fracture of proximal humerus
- ☐ Nonunion/failure of a previous proximal humeral fracture surgery
- ☐ Malignancy of the scapula, proximal humerus, shoulder joint or adjacent soft tissues

On exam, what is the ROM (range of motion) flexion/abduction/rotation?

☐ Normal or Mild Limitation ☐ Significant Limitation

How much does this limit the member's daily activities?

☐ Mildly ☐ Moderately ☐ Severely

What degree of pain is the member having?

☐ Mild ☐ Moderate ☐ Severe

Has the member experienced this degree of pain for 6 months or longer? ☐ Yes ☐ No

Does the member have Glenoid bony erosion with posterior or anterior subluxation (Walch Classification B2 glenoid)?

☐ Yes ☐ No

Has the member attempted and failed at least 12 weeks non-surgical treatment in the past 12 months?

☐ Yes ☐ No

Which of these treatments have been attempted in the past year?

(Select all that apply)

- ☐ NSAIDS
- ☐ Formal Physical Therapy: Duration (weeks): Dates to and from:
- ☐ Activity Modification
- ☐ Joint injection
- ☐ **For rheumatoid arthritis only**: Anti-cytokine agents (e.g., etanercept, infliximab) and non-biologic DMARDs (e.g., azathioprine, cyclosporine, gold salts, hydroxychloroquine, leflunomide, methotrexate, or sulfasalazine)

Member ID:	**Reference number (required):**

Section 3: Reverse Total Shoulder Arthroplasty

Reason for Surgery (Diagnosis):

(Select all that apply)

- ☐ Massive rotator cuff tears with pseudo-paralysis and without osteoarthritis
- ☐ Deficient rotator cuff with glenohumeral arthropathy
- ☐ Failed hemiarthroplasty
- ☐ Failed total shoulder arthroplasty with failed rotator cuff that is non-repairable
- ☐ Proximal humeral fractures that are not repairable or cannot be reconstructed with other techniques and are associated with a deficient rotator cuff
- ☐ Reconstruction after a tumor resection

Does the member have any of the following contraindications?

(Select all 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 shoulder
- ☐ Allergy to components of the implant (such as cobalt, chromium, alumina)
- ☐ Corticosteroid injection into the joint within 12 weeks of the planned arthroplasty
- ☐ Rapidly progressive neurologic disease
- ☐ Osseous abnormalities that cannot be optimally managed and which would increase the likelihood of a poor surgical outcome (i.e., inadequate bone stock to support the implant)
- ☐ None of the above

Shoulder replacement system

Will a custom total shoulder implant be utilized? ☐ Yes ☐ No

Computer (robotic) assisted musculoskeletal surgical navigation

Will computer (robotic) assisted musculoskeletal surgical navigation be utilized? ☐ Yes ☐ No

Radiographic evidence of the following (Select all that apply)?

- ☐ MRI Massive Rotator Cuff Tear
- ☐ MRI Rotator Cuff Tear
- ☐ Irregular joint surfaces
- ☐ Glenoid sclerosis
- ☐ Osteophyte changes
- ☐ Flattened glenoid
- ☐ Cystic changes in the humeral head
- ☐ Joint space narrowing of shoulder joint
- ☐ Failed total shoulder arthroplasty with failed rotator cuff that is non-repairable
- ☐ Shoulder fracture that is not repairable or cannot be reconstructed with other techniques
- ☐ Need for reconstruction after a tumor resection
- ☐ Failed hemiarthroplasty

Continued

Member ID:	**Reference number (required):**

Section 3: Reverse Total Shoulder Arthroplasty (continued)

On exam, what is the ROM (range of motion) flexion/abduction/rotation?

☐ Normal or Mild Limitation ☐ Significant Limitation

How much does this limit the member's daily activities?

☐ Mildly ☐ Moderately ☐ Severely

What degree of pain is the member having?

☐ Mild ☐ Moderate ☐ Severe

Has the member experienced this degree of pain for 6 months or longer? ☐ Yes ☐ No

Does the member have Glenoid bony erosion with posterior or anterior subluxation (Walch Classification B2 glenoid)?

☐ Yes ☐ No

Does the member have avascular necrosis of the humeral head with collapse in the presence of severe osteoarthritis of the shoulder?

☐ Yes ☐ No

Has the member attempted and failed at least 12 weeks non-surgical treatment in the past 12 months?

☐ Yes ☐ No

Which of these treatments have been attempted in the past year?

(Select all that apply)

☐ NSAIDS

☐ Formal Physical Therapy: Duration (weeks): Dates to and from:

☐ Activity Modification

☐ Joint injection

☐ **For rheumatoid arthritis only**: Anti-cytokine agents (e.g., etanercept, infliximab) and non-biologic DMARDs (e.g., azathioprine, cyclosporine, gold salts, hydroxychloroquine, leflunomide, methotrexate, or sulfasalazine)

Section 4: Total Shoulder Revision Arthroplasty

Reason for surgery (Diagnosis)

(Select all that apply)

☐ Fracture or mechanical failure of 1 or more components of the prosthesis or worn or dislocated plastic insert

☐ Displaced periprosthetic fracture

☐ Progressive or substantial periprosthetic bone loss

☐ Migration of the humeral head

☐ Confirmed peri-prosthetic infection by gram stain and culture

☐ Instability or dislocation of the glenoid or humeral components

☐ Aseptic loosening of one or more prosthetic components

☐ Bearing surface wear leading to symptomatic synovitis

Continued

Member ID:	**Reference number (required):**

Section 4: Total Shoulder Revision Arthroplasty (continued)

Does the member have any of the following contraindications?

(Select all that apply)

- ☐ Active skin infection (other than recurrent cutaneous staph infections) or open wound within the planned surgical site of the shoulder
- ☐ Allergy to components of the implant (such as cobalt, chromium, alumina)
- ☐ Corticosteroid injection into the joint within 12 weeks of the planned arthroplasty
- ☐ Rapidly progressive neurologic disease
- ☐ Osseous abnormalities that cannot be optimally managed and which would increase the likelihood of a poor surgical outcome (i.e., inadequate bone stock to support the implant)
- ☐ None of the above

Shoulder replacement system

Will a custom total shoulder implant be utilized? ☐ Yes ☐ No

Computer (robotic) assisted musculoskeletal surgical navigation

Will computer (robotic) assisted musculoskeletal surgical navigation be utilized? ☐ Yes ☐ No

How much does this limit the member's daily activities?

☐ Mildly ☐ Moderately ☐ Severely

What degree of pain is the member having?

☐ Mild ☐ Moderate ☐ Severe

Has the member experienced this degree of pain for 6 months or longer? ☐ Yes ☐ No

Member ID:	**Reference number (required):**

Section 5: Shoulder Hemiarthroplasty

Reason for surgery (Diagnosis)

(Select all that apply)

- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Avascular necrosis
- ☐ Post-traumatic arthritis
- ☐ Malunion of fracture (proximal humerus)
- ☐ Arthritic conditions in which the glenoid bone stock is inadequate to support a glenoid prosthesis
- ☐ Rotator cuff tear arthropathy
- ☐ Fracture of proximal humerus
- ☐ Nonunion/failure of a previous proximal humeral fracture surgery (shown by imaging)

Does the member have any of the following contraindications?

(Select all 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 shoulder
- ☐ Allergy to components of the implant (such as cobalt, chromium, alumina)
- ☐ Corticosteroid injection into the joint within 12 weeks of the planned arthroplasty
- ☐ Rapidly progressive neurologic disease/paralytic disorder of the shoulder
- ☐ Osseous abnormalities that cannot be optimally managed and which would increase the likelihood of a poor surgical outcome (i.e., inadequate bone stock to support the implant)
- ☐ None of the above

Shoulder replacement system

Will a custom total shoulder implant be utilized? ☐ Yes ☐ No

Computer (robotic) assisted musculoskeletal surgical navigation

Will computer (robotic) assisted musculoskeletal surgical navigation be utilized? ☐ Yes ☐ No

Radiographic evidence of the following (Select all that apply)?

- ☐ Irregular joint surfaces
- ☐ Glenoid sclerosis
- ☐ Malunion of a fracture (proximal humerus)
- ☐ Avascular necrosis of the humeral head with collapse
- ☐ Rotator cuff tear arthropathy
- ☐ Osteophyte changes
- ☐ Flattened glenoid
- ☐ Cystic changes in the humeral head
- ☐ Joint space narrowing of shoulder joint
- ☐ Fracture of proximal humerus
- ☐ Nonunion/failure of a previous proximal humeral fracture surgery

Continued

Member ID:	**Reference number (required):**

Section 5: Shoulder Hemiarthroplasty (continued)

On exam, what is the ROM (range of motion) flexion/abduction/rotation?

☐ Normal or Mild Limitation ☐ Significant Limitation

How much does this limit the member's daily activities?

☐ Mildly ☐ Moderately ☐ Severely

What degree of pain is the member having?

☐ Mild ☐ Moderate ☐ Severe

Has the member experienced this degree of pain for 6 months or longer? ☐ Yes ☐ No

Does the member have avascular necrosis of the humeral head with collapse in the presence of severe osteoarthritis of the shoulder?

☐ Yes ☐ No

Has the member attempted and failed at least 12 weeks of non-surgical treatment in the past 12 months?

☐ Yes ☐ No

Which of these treatments have been attempted in the past year?

(Select all that apply)

☐ NSAIDS

☐ Formal Physical Therapy: Duration (weeks): Dates to and from:

☐ Activity Modification

☐ Joint injection

☐ **For rheumatoid arthritis only**: Anti-cytokine agents (e.g., etanercept, infliximab) and non-biologic DMARDs (e.g., azathioprine, cyclosporine, gold salts, hydroxychloroquine, leflunomide, methotrexate, or sulfasalazine)

Member ID:	**Reference number (required):**

Section 6: 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 member 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
COPD (Chronic obstructive Pulmonary Disease) on oxygen: ☐ Yes ☐ No
Member 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
Member has mental health diagnosis that requires inpatient support after surgery: ☐ Yes ☐ No
Member is alcohol dependent and at risk for withdrawal syndrome: ☐ Yes ☐ No
Member is opioid dependent: ☐ Yes ☐ No
Provide clinical rationale for inpatient hospitalization:

Section 7: Location where procedure will be performed

Will the procedure be performed:
☐ Inpatient ☐ Outpatient

If procedure to be performed outpatient indicate the setting:
- ☐ Outpatient hospital
- ☐ Ambulatory Surgical Center (free standing)
- ☐ Office

If request is for Outpatient hospital check any/all that apply:
- ☐ Less than 12 years of age
- ☐ American Society of Anesthesiologists (ASA) Physical Status classification III or higher
- ☐ Danger of airway compromise
- ☐ Morbid obesity (BMI > 35 with comorbidities or BMI > 40)
- ☐ Pregnant
- ☐ Advanced liver disease
- ☐ Poorly controlled diabetes (hemoglobin A1C > 7)
- ☐ End stage renal disease (ESRD) with hyperkalemia ☐ or undergoing dialysis ☐
- ☐ Active substance use related disorders (Includes alcohol dependence and/or current use of high dose opioids).

Continued

Member ID:	**Reference number (required):**

Section 7: Location where procedure will be performed (continued)

High risk cardiac status:

- ☐ Myocardial infarction in last 90 days
- ☐ Ongoing symptoms from previous MI
- ☐ Significant heart valve disease
- ☐ Symptomatic cardiac arrhythmia
- ☐ Hypertension resistant to 3 or more medications
- ☐ Uncompensated chronic heart failure

Coronary artery disease (CAD) or peripheral vascular disease (PVD) with:

- ☐ Ongoing ischemia or recent MI/angioplasty PCI
- ☐ Drug Eluting Stent (DES) Bare Metal Stent placed in last year
- ☐ Angioplasty in last 90 days
- ☐ Current use of Aspirin or prescription anticoagulants

Comorbid neurological or neuromuscular condition

- ☐ Stroke/cerebrovascular accident (CVA)
- ☐ Mini stroke/transient ischemic attack (TIA)
- ☐ Uncontrolled epilepsy
- ☐ Cerebral palsy
- ☐ Multiple Sclerosis
- ☐ Amyotrophic lateral sclerosis
- ☐ Traumatic brain injury with significant cognitive or behavioral issues
- ☐ Muscular dystrophy

Respiratory conditions:

- ☐ Moderate to severe obstructive sleep apnea

Unstable respiratory status:

- ☐ Poorly controlled asthma (FEV1 < 80% despite medical management)
- ☐ COPD or
- ☐ Ventilator dependent patient

Bleeding or clotting disorders or conditions:

- ☐ Requiring replacement factor, blood products or special infusion products to correct a coagulation defect
- ☐ Thrombocytopenia (platelet <100,000/microL)
- ☐ Anticipated need for blood or blood product transfusion
- ☐ Sickle cell disease
- ☐ History of Disseminated Intravascular Coagulation (DIC)

- ☐ Personal or family history of complication of anesthesia
- ☐ History of solid organ transplant requiring anti-rejection medication(s)
- ☐ Other unstable or severe systemic diseases, intellectual disabilities or mental health conditions that would be best managed in an outpatient hospital setting
- ☐ This will be a prolonged surgery (>3 hrs.)

Do any of the following apply when procedure(s) to be performed at **outpatient hospital setting**:

- ☐ The required operative equipment is not available at a participating free-standing ambulatory surgical center or office based surgical center

  List specific equipment not available:
- ☐ There are no participating general or specialty free-standing ambulatory surgical centers or office based surgical centers that allow procedure(s) planned

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Member ID:	**Reference number (required):**

Section 8: Provide the following documentation for your request

- Documentation of the indication for total arthroplasty, hemiarthroplasty or repeat shoulder arthroplasty
- Clinical records documenting the symptoms the patient experiencing
- Documentation of all conservative treatments, including type, duration, and outcome and
- Documentation of radiographic evidence of destructive degenerative joint disease.

Section 9: 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 10: Sign the form

Just remember: You can't use this form to initiate a precertification request. To initiate a request, you can 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- - -