Autologous Chondrocyte Implantation 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. 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 #247: Autologous Chondrocyte Implantation** 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 any questions about how to fill out the form or our precertification process, call us at:

- HMO plans: **1-800-624-0756**
- Traditional plans: **1-888-632-3862**
- Medicare plans: **1-800-624-0756**

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Section 1: Provide the following general information If submitting request electronically, complete member name, ID and reference number only	
Member name:	**Reference number (required):**
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 (if applicable):	**TIN:**

Section 2: Provide the following patient-specific information.
Has the procedure been scheduled? ☐ Yes ☐ No If yes, what is the date of service:
Does the patient have symptoms of disabling knee pain related to a full thickness, focal chondral defect? ☐ Yes ☐ No
Patient's current: Height: Weight:
Is the patient willing to cooperate with post-operative weight bearing limitations, activity restrictions and rehabilitation? ☐ Yes ☐ No
Has the patient failed to respond to a minimum of 2 months of physical therapy? ☐ Yes ☐ No
Has the patient undergone a surgical procedure for treatment of the condition? ☐ Yes ☐ No If yes, specify the type of surgical procedure Date of surgical procedure: / /
Does the patient have a focal articular cartilage defect down to, but not through the subchondral bone on a load bearing surface of the femoral condyle? ☐ Yes ☐ No
Is the opposing articular surface generally free of disease or injury? ☐ Yes ☐ No
Is there an informed consent with realistic expectations? ☐ Yes ☐ No
Is there clinical or x-ray evidence whether the patient has active inflammatory or other arthritis, including *but not limited* to degenerative arthritis (osteoarthritis)? ☐ Yes ☐ No
Does the patient have disabling pain and/or knee locking which limits activities of daily living? ☐ Yes ☐ No
Provide defect measurements. _____ Depth _____ Length _____ Area in Square cm
Is the patient's knee stable with an intact meniscus and normal joint space on X-ray? ☐ Yes ☐ No

Member ID:	**Reference Number:**

Section 3: 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).

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

Continued

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Member ID:	**Reference Number:**

Section 3: Location where procedure will be performed (Continued)

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

Section 4: Provide the following documentation for your request

- Current history and physical
- Office notes related to the patient's condition, including the following:
  - Signs and symptoms, including duration and severity of the medical condition
  - Description of the cartilage defect, including size
  - X-ray and imagine study reports
- Clinical records documenting any conservative management, including duration and outcome

Section 5: 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 6: 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- - -