Lower Limb Prostheses including Microprocessor-Controlled Knee 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 # 578: Lower Limb Prostheses,** 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, (TTY: 711)**
- Traditional plans: **1-888-632-3862, (TTY: 711)**
- Medicare plans: **1-800-624-0756, (TTY: 711)**

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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 physician name:	**Requesting physician NPI:**
Requesting physician phone number: 1- - -	
Requesting physician fax number: 1- - -	

Section 1B: Provide the following information
Is this prosthesis being fitted and programmed by a qualified prosthetist? ☐ Yes ☐ No
Prosthetic provider name:
Prosthetist's Credentials (e.g., American Board for Certification; Board of Certification/Accreditation; licensed by the state in which services are provided [where legally required]):
Prosthetic provider status: ☐ Participating ☐ Non-participating

Section 2: Provide the following information for a replacement prosthesis/component
Is this a replacement prosthesis/component? ☐ Yes ☐ No If yes, select the reason for the repair or replacement: ☐ Patient misuse Provide details ☐ Normal wear and tear ☐ A physical change in the patient's condition (e.g., change in weight) ☐ Damage Provide details Provide the reason the current prosthesis/component is not meeting the patient's needs
If the current prosthesis/component is broken and cannot be repaired, provide the details of repair versus replacement cost

Section 3: Provide the following patient specific information for your request
Provide a detailed description of the lower limb prosthesis/components requested (e.g., Ossur Rheo, Otto-Bock Genium Bionic Prosthetic System, etc.)
Select any of the following that applies to your patient: ☐ Healthy, active community ambulating adults (18 years of age or older) ☐ Variable cadence Explain: ☐ Knee disarticulation amputation ☐ Amputation cause Explain: ☐ Gait management in spinal cord injury ☐ Uses assistive device for ambulation What type?

Section 3 Continued: Provide the following patient specific information for your request

Select the below criteria that applies to your patient *if requesting a power flexion-extension assist*:

- ☐ Has a microprocessor (swing and stance phase type) controlled (electronic) knee
- ☐ Weight greater than 110 lbs. and less than 275 lbs.
- ☐ Documented comorbidity of the spine and/or sound limb affecting hip extension and/or quadriceps function that impairs K-3 level function with the use of a microprocessor-controlled knee alone
- ☐ Able to make use of a product that requires daily charging
- ☐ Able to understand and respond to error alerts and alarms indicating problems with the function of the unit

Section 4: Select the patient's rehabilitation potential classification level (K-level) based on clinical assessment(s)

- ☐ **Level 0:** Does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthesis does not enhance their quality of life or mobility.
- ☐ **Level 1:** Has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulator.
- ☐ **Level 2:** Has the ability or potential for ambulation with the ability to traverse low-level environmental barriers such as curbs, stairs or uneven surfaces. Typical of the limited community ambulator.
- ☐ **Level 3:** Has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.
- ☐ **Level 4:** Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete.

Section 5: Provide the following documentation for your request

Please check off all documents as you include them:

- ☐ Attending physician prescription and current history and physical, and the following:
  - ☐ Office notes related to the member's condition for which treatment is proposed
  - ☐ Standard Written Order (SWO)
- ☐ Prosthetist evaluation which must include:
  - ☐ Prosthetist name and credentials:
  - ☐ Clinical assessment(s) of patient's rehabilitation potential
  - ☐ Medical necessity for the prosthetic and all requested components
  - ☐ Current prosthetic type and age
  - ☐ Assistive Devices used
  - ☐ Patient's desire to ambulate (explain details)
  - ☐ Details of repair versus replacement cost, if applicable
  - ☐ Patient age, weight, height, functional level
  - ☐ If replacement prosthetic list details on why replacement is required
  - ☐ Information about the member's history and current condition that supports the designation of the functional level by the prosthetist
- ☐ Physical Therapy Notes which should include:
  - ☐ Physical Therapist Name and credentials
  - ☐ Functional Levels K3 or above include a documented evaluation from physical therapist to establish functional levels and activities.
  - ☐ Include information about the member's history and current condition that supports the designation of the functional level by the physical therapist

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Section 6: Provide the following information for each prosthetic component

Prosthetic components: Provide a detailed description, including the manufacturer name and device\component name.
Clinical Policy Bulletin # 578: Lower Limb Prostheses

CPT\HCPCS Code	Manufacturer	Device Name

Section 7: 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 8: Sign the form

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

Signature of person completing form:

Date: / /

Contact name of office personnel to call with questions:

Telephone number: 1- - -