# Autolougous 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)**

aetna®

# Autologous Chondrocyte Implantation Precertification Information Request Form

## About this form

**You can't use this form to initiate a precertification request.** To initiate a request, you have to call our Precertification Department. Or you can submit your request electronically. **Failure to complete this form and submit all of the medical records we are requesting may result in the delay of review.**

Effective **May 24, 2018**, this form replaces all other Autologous Chondrocyte Implantation precertification information request documents and forms. This form will help you supply the right information with your precertification request. You don't have to use the form. But it will help us adjudicate your request more quickly.

## 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:

- **(Preferred)** Upload your information electronically on our secure provider website on NaviNet® at **connect.navinet.net**.
    - Complete a Precertification Inquiry transaction for the patient.
    - When the inquiry is successful, click the "Add Attachment" link in the upper right corner of the screen.
    - Upload your document(s) and click "Attach." The window will close and you will return to Precert Inquiry screen.

- Send your information via confidential fax to:
    - Precertification – Commercial Plans: **859-455-8650**
    - Precertification - Medicare Advantage Standard Organization Determination: **859-455-8650**
    - Precertification - Medicare Advantage (expedited only): **860-754-5468**

- 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 #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**

# Autolougous Chondrocyte Implantation
# Precertification Information Request Form

| Section 1: Provide the following general information | |
|---|---|
| **Member name:** | **Administrative reference number (required):** |
| **Member ID:** | **Member date of birth:** |
| **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. |
|---|
| Does the patient have symptoms of disabling knee pain related to a full thickness, focal chondral defect?<br>☐ Yes ☐ No |
| Patient's current: Height: Weight: |
| Is the member willing to cooperate with post-operative weight bearing limitations, activity restrictions and rehabilitation?<br>☐ Yes ☐ No |
| Has the member failed to respond to a minimum of 2 months of physical therapy? ☐ Yes ☐ No |
| Has the member undergone a surgical procedure for treatment of the condition? ☐ Yes ☐ No<br>If yes, specify the type of surgical procedure<br>Date of surgical procedure: / / |
| Does the member 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 there an informed consent with realistic expectations? ☐ Yes ☐ No |
| Is there clinical or x-ray evidence whether the member has active inflammatory or other arthritis, including *but not limited* to degenerative arthritis (osteoarthritis)? ☐ Yes ☐ No |
| Does the member have disabling pain and/or knee locking which limits activities of daily living? ☐ Yes ☐ No |
| Provide defect measurements.<br>_____ Depth _____ Length _____ Area in Square cm |
| Is the member's knee stable with an intact meniscus and normal joint space on X-ray? ☐ Yes ☐ No |

| Section 3: Provide the following documentation for your request |
|---|
| • Current history and physical<br>• Office notes related to the patient's condition, including the following:<br>– Signs and symptoms, including duration and severity of the medical condition<br>– Description of the cartilage defect, including size<br>– X-ray and imagine study reports<br>• Clinical records documenting any conservative management, including duration and outcome |

| **Section 4: 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 5: Sign the form**<br>**Just remember: You can't use this form to initiate a precertification request.** To initiate a request, you have to call our Precertification Department. Or you can submit your request electronically. |
| **Signature of treating doctor or other qualified healthcare provider:** |
| **Date:** / / |
| **Contact name of office personnel to call with questions:**<br>**Telephone number:** 1- - - |