Knee 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

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. **Failure to complete this form and submit the medical records we are requesting may result in the delay of review.**

This form replaces all other Knee Arthroplasty 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, **complete the sections of the form for the appropriate procedure**.
For **Primary Knee Arthroplasty** complete ONLY sections: 1, 2, 5,6,7 and 8
For **Total knee revision, replacement or knee resurfacing arthroplasty** complete ONLY sections: 1,3,5,6,7 and 8
For **Unicompartmental Knee Replacement** complete ONLY sections: 1,4,5,6,7 and 8
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/aetnaproviders.**

- Send your information via confidential fax to: Precertification – Commercial and Medicare (including **expedited**) 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 # 660 Knee 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 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**

PCFX

Section 1: Provide the following general information for all requests ***If submitting request electronically, complete member name, ID and reference number only***	
Member name:	**Reference number (required):**
Phone Number:	
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 Surgeon and TIN:	

Section 2: Primary Knee Arthroplasty (complete ONLY sections: 1, 2, 5, 6, 7 and 8)

Reason for surgery (Diagnosis)

- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Avascular necrosis
- ☐ Post-traumatic arthritis
- ☐ Malunion of fracture (distal femur or proximal tibia)
- ☐ Fracture of Distal Femur/Proximal Tibia
- ☐ Nonunion/failure of a previous distal femur or proximal tibia fracture surgery (shown by imaging)
- ☐ Malignancy of the distal femur, proximal tibia, knee joint or adjacent soft tissues by imaging
- ☐ Failure of previous unicompartmental knee replacement
- ☐ Failure of previous osteotomy for osteoarthritis

The patient's advanced joint disease is demonstrated by:

Pain that interferes ADLs: ☐ Mild ☐ Moderate ☐ Severe

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

☐ **During the physical exam, that includes passive range of motion (ROM):**

Demonstrates limited ROM: ☐ Yes ☐ No

Effusion or swelling in the joint: ☐ Yes ☐ No

Crepitus (cracking, creaking or grating sounds): ☐ Yes ☐ No

Member age and BMI:

BMI over 40 ☐ Yes ☐ No

Age under 50 ☐ Yes ☐ No

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

Section 2: Primary Knee Arthroplasty (complete ONLY sections: 1, 2, 5, 6, 7 and 8) (continued)

☐ **Radiologic Exam:**

What Kellgren-Lawrence Grade is shown by X-ray?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ bone on bone ☐ Angular deformity (measurement in degrees) _____

Radiographic evidence of avascular necrosis (osteonecrosis) of tibial or femoral condyle: ☐ Yes ☐ No

Radiographic evidence or rheumatoid arthritis (joint space narrowing): ☐ Yes ☐ No

Has the patient tried any of these conservative therapies in the last year?

☐ Pain medication (ibuprofen, acetaminophen) Duration:

☐ Formal physical therapy: Duration: Dates:

☐ Activity Modification

☐ Assistive device (i.e cane)

☐ Therapeutic injections

☐ Therapy not appropriate

Reason:

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

Does the patient have any of the following?

☐ 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 knee

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

☐ Vascular insufficiency, significant muscular atrophy of the leg, or neuromuscular disease severe enough to compromise implant stability or post-operative recovery or quadriplegia

☐ 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)

Knee replacement system

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

Will the MAKOplasty/MAKO Tactile Guidance System be utilized? ☐ Yes ☐ No

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

Section 3: Total knee revision, replacement or knee resurfacing arthroplasty (complete ONLY sections: 1,3,5,6,7and 8)

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

☐ Aseptic loosening of one or more prosthetic components - confirmed by imaging

☐ Fracture or mechanical failure of 1 or more components of the prosthesis or worn or dislocated plastic insert - confirmed by imaging

☐ Periprosthetic fracture of distal femur, proximal tibia or patella - confirmed by imaging

☐ Progressive or substantial periprosthetic bone loss - confirmed by imaging

☐ Bearing surface wear leading to symptomatic synovitis

☐ Knee arthrofibrosis

☐ Implant or knee malalignment (valgus/varus or flexion/extension greater than 15 degrees),

☐ Instability of dislocation of the total knee replacement (TKA)

☐ Extensor mechanism instability

☐ Confirmed periprosthetic infection by gram stain and culture,

☐ Persistent knee pain of unknown etiology that has not responded to non-surgical care for six (6) months, including:

- ☐ NSAIDS duration _____
- ☐ Formal PT duration and dates _____
- ☐ Activity Modification
- ☐ Assistive device (for example, cane)
- ☐ Joint injection

Member's advanced joint disease is demonstrated by:

Pain that interferes ADLs: ☐ None/Mild ☐ Moderate/Severe

Functional disability that interferes with ADLs: ☐ None/Mild ☐ Moderate/Severe

☐ **Does patient have any of the following?**

☐ Persistent infection

☐ Poor bone quality,

☐ Highly limited quadriceps or extensor function

☐ Osteoporosis or other bone abnormalities which would make the likelihood of a poor outcome more probable

☐ Poor skin coverage

☐ Poor vascular status

Knee replacement system

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

Will the MAKOplasty/MAKO Tactile Guidance System be utilized? ☐ Yes ☐ No

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

Section 4: Unicompartmental Knee Replacement (complete ONLY sections: 1, 4, 5, 6, 7 and 8)

Reason for surgery (Diagnosis)

☐ Advanced osteoarthritis

☐ Posttraumatic arthritis of the knee affecting only a single compartment

During the physical exam, that includes passive range of motion (ROM):

☐ Demonstrates limited ROM

☐ Effusion or swelling in the joint

☐ Crepitus (cracking, creaking or grating sounds)

☐ Intact, stable ligaments, in particular the anterior cruciate ligament

☐ Knee arc of motion (full extension to full flexion) is not limited to 90 degrees or less

Radiologic Exam:

What Kellgren-Lawrence Grade is shown by X-ray affecting only a single (medial, lateral or patellofemoral) compartment of the knee joint

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ bone on bone ☐ Angular deformity (measurement in degrees) _____

Has the patient tried any of these conservative therapies in the last year?

☐ Pain medication (ibuprofen, acetaminophen) Duration:

☐ Formal physical therapy: Duration: Dates:

☐ Flexibility and muscle strengthening exercise

☐ Activity Modification

☐ Assistive device (i.e cane)

☐ Therapeutic injections

☐ Therapy not appropriate

Reason:

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

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

Section 4: Unicompartmental Knee Replacement (continued)

Has the patient had:

- ☐ Previous proximal tibial osteotomy or distal femoral osteotomy
- ☐ Tibial or femoral shaft deformity
- ☐ Radiographic evidence of medial or lateral subluxation
- ☐ Flexion contracture greater than 15º
- ☐ Varus deformity greater than 15º (medial Unicompartmental knee arthroplasty) or a valgus deformity greater than 20º (lateral Unicompartmental knee arthroplasty)
- ☐ Inflammatory or crystalline arthropathy
- ☐ Subchondral bone loss due to large subchondral cysts or extensive focal osteonecrosis.

Member has none of the following absolute contraindications to joint replacement:

- ☐ Active infection of the joint or active systemic bacteremia that has not been totally eradicated
- ☐ Active skin infection (exception recurrent cutaneous staph infections) or open wound within the planned surgical site of the knee
- ☐ Vascular insufficiency, significant muscular atrophy of the leg, or neuromuscular disease severe enough to compromise implant stability or post-operative recovery or quadriplegia
- ☐ 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
- ☐ Allergy to components of the implant (e.g., cobalt, chromium or alumina).

Section 5: Provide the following documentation for your 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.

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Member name:	**Phone Number:**
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 2 inpatient days or greater? ☐ 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 40: ☐ Yes ☐ No
COPB (Chronic obstructive Pulmonary Disease): ☐ Yes ☐ No
Member is on home oxygen: ☐ Yes ☐ No
Cardiac Condition: ☐ Yes ☐ No
Acute Cardiac event in the last 3 months:

a. Heart attack/myocardial infarction (MI): ☐ Yes ☐ No
b. Stroke/cerebrovascular accident (CVA) : ☐ Yes ☐ No
c. Mini stroke/transient ischemic attack (TIA) : ☐ Yes ☐ No

History of angioplasty or other cardiac surgery: ☐ Yes ☐ No
Implanted pacemaker or another cardiac device: ☐ Yes ☐ No
Congested 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: 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, 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- - -