Hip Surgery for Impingement Syndrome 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 is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates (Aetna). Aetna provides certain management services on behalf of its affiliates.

Hip Surgery for Impingement Syndrome Precertification Information Request Form

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 all medical records we are requesting may result in the delay of review or denial of coverage.**

This form replaces all other Hip Surgery for Impingement Syndrome 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:

- 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**.
- 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 #736: Femoro-Acetabular Surgery for Hip Impingement Syndrome** before you complete this form.

You can find the Clinical Policy Bulletin 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 **1-800-424-4047**.

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Precertification Information Request Form

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:**
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.

- ☐ Diagnosis of definite femoro-acetabular impingement confirmed by imaging
  - ☐ Cam Impingement (alpha angle greater than 50 degrees)
  - ☐ Pincer Impingement (acetabular retroversion or coxa profunda)
  - ☐ Pistol Grip Deformity (nonspherical femoral head shape)

  Submit radiology report(s) (X-rays, MRI or CT scans)
- ☐ Moderate to severe symptoms typical of FAI (hip pain that is worsened by flexion activities (e.g., squatting or prolonged sitting)) that significantly limits activities

  Specify duration of symptoms
- ☐ Positive impingement sign with sudden pain on 90-degree hip flexion with adduction and internal rotation or extension and external rotation
- ☐ Failure to respond to all available conservative treatment options including the following:

  ☐ Activity modification ☐ Pharmacological intervention ☐ Physiotherapy
- ☐ Member is 15 years of age or older or skeletally mature (as indicated by epiphyseal closure)
- ☐ Absence of advanced osteoarthritis change on preoperative X-ray (Tonnis grade 2 or more) or severe cartilage injury (Outerbridge grade III or IV).
- ☐ Absence of joint space narrowing on plain radiograph of the pelvis. Joint space is not less than 2 mm wide anywhere along the sourcil.

  Submit X-ray report(s)
- ☐ Member does not have generalized joint laxity especially in diseases connected with hypermobility of the joints, such as Marfan syndrome and Ehlers-Danlos syndrome.
- ☐ Member does not have osteogenesis imperfecta.

Section 3: 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.

Member ID:	**Reference Number:**

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

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: