Shoulder Arthroplasty
Precertification Information Request Form

Applies to:

Aetna plans

Innovation Health® plans

Health benefits and health insurance plans offered and/or underwritten 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 cannot use this form to initiate a precertification request. To initiate a request, call our Precertification Department or you can submit your request 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:

- 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 by 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 #837: Shoulder Arthroplasty and Arthrodesis**, 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 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**

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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:**
Requesting provider/facility/vendor name:	
Requesting provider/facility/vendor NPI:	
Requesting provider/facility/vendor phone number: 1- - -	
Requesting provider/facility/vendor fax number: 1- - -	
Assistant/co-surgeon name (if applicable):	**TIN:**

Section 2: Provide the following patient-specific information for <u>total shoulder arthroplasty</u>
Skip to section 4 for reverse shoulder arthroplasty

1. a. Select the indication(s) that applies to your patient:

- ☐ Advanced joint disease
- ☐ Treatment of proximal humeral fracture, malunion or nonunion confirmed by imaging with pain interfering with ADLs
- ☐ Malignancy of glenohumeral joint or surrounding soft tissue confirmed by imaging
- ☐ Other, please specify

b. Select any of the following that apply to your patient:

- ☐ Pain and functional disability that interferes with activities of daily living (ADL) from advanced destructive joint disease associated with osteoarthritis, rheumatoid arthritis, avascular necrosis, or post-traumatic arthritis of the shoulder joint
- ☐ Limited range of motion and crepitus of the glenohumeral joint on physical examination
- ☐ Severe pain and loss of function of at least 6 months duration that interferes with ADL
- ☐ Radiographic evidence of destructive degenerative joint disease (as evidence by 2 or more of the following: irregular joint surfaces, glenoid sclerosis, osteophyte changes, flattened glenoid, cystic changes in the humeral head, or joint space narrowing) of shoulder joint)
- ☐ History of unsuccessful conservative therapy (non-surgical medical management) that is clearly addressed in the medical record

Note: If conservative therapy is not appropriate, the medical record must clearly document why such approach is not reasonable.

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Member ID:	Reference number (required)

Section 3: Provide the following patient-specific information for reverse shoulder arthroplasty

1. a. Select the indication(s) that applies to your patient:

- ☐ Deficient rotator cuff with glenohumeral arthropathy and limited ability to actively flex the upper extremity to 90 degrees against gravity
- ☐ Failed hemiarthroplasty
- ☐ Failed total shoulder arthroplasty with failed rotator cuff that is non-repairable
- ☐ Massive rotator cuff tears with pseudo-paralysis and without osteoarthritis
- ☐ Reconstruction after a tumor resection
- ☐ Shoulder fractures that are not repairable or cannot be reconstructed with other techniques
- ☐ Other, please specify

b. Select any of the following that apply to your patient:

- ☐ Pain and functional disability of at least 6 months duration that interferes with ADL (6 months not required for fractures or reconstruction for tumor resection
- ☐ Limited functional demands
- ☐ Deltoid is intact
- ☐ Joint is anatomically and structurally suited to receive selected implants (i.e., adequate bone stock to allow for firm fixation of implant); and
- ☐ 90 degrees or more of passive shoulder range of motion (elevation/flexion)
- ☐ Condition that would place excessive stress on the implant (i.e., Charcot' joint)

Section 4: Request for Revision of total shoulder arthroplasty

- ☐ Including allograft when performed; (humeral or glenoid side)
- ☐ Including allograft when performed; (humeral and glenoid side)

Section 5: Provide the following patient-specific information for conservative therapy

Note: Trial of conservative therapy is not required for fractures or reconstruction following tumor resection

1. a. Has the patient had at least six (6) weeks of non-surgical conservative therapy? ☐ Yes ☐ No

b. If yes, select the type(s) of conservative therapy:

- ☐ Anti-inflammatory medications or analgesics
- ☐ Flexibility and muscle strengthening exercises
- ☐ Activity modification
- ☐ Supervised physical therapy
- ☐ Intra-articular injections of steroids into the shoulder
- ☐ **For rheumatoid arthritis only**: Anti-cytokine agents (e.g., etanercept, infliximab) and non-biologic DMARDs (e.g., azathioprine, cyclosporine, gold salts, hydroxychloroquine, leflunomide, methotrexate, or sulfasalazine)
- ☐ Other, please specify:

c. If no, describe any contraindications the patient has for conservative therapy

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Member ID:	**Reference number (required)**

Section 6: 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 7: Sign the form
Signature of person completing form:
Date: / /
Contact name of office personnel to call with questions: **Telephone number:** 1- - -