Hyperthermia in Cancer Therapy (HIPEC) 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.

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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. Typed responses are preferred. Failure to complete this form and submit all medical records we are requesting may result in the delay of review or denial of coverage.

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 #0278 Hyperthermia in Cancer Therapy** 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: Member Demographics Typed responses are preferred. If the responses cannot be typed, they should be printed clearly.	
Member name:	**Reference number (required):**
Member ID:	**Member date of birth:**
Member Phone Number: - -	**Member Address:**

Section 2: Provider Information		
Name:	NPI:	Billing TIN:
Phone number: - -	Fax number: - -	
Address:		
Is the provider participating? ☐ Yes ☐ No		

Section 3: Facility Information		
Name:	NPI:	Billing TIN:
Phone number: - -	Fax number: - -	
Address:		
Is the provider participating? ☐ Yes ☐ No		

Section 4: Assistant/Co-Surgeon Provider Information		
Name:	NPI:	Billing TIN:
Phone number: - -	Fax number: - -	
Address:		
Is the provider participating? ☐ Yes ☐ No	Is the provider an assistant surgeon? ☐ Yes ☐ No	Is the provider a co-surgeon? ☐ Yes ☐ No

Section 5: Place of Service	
Procedure to be performed: Inpatient	**Number of bed days requested:**
Scheduled Procedure Date:	

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

Section 6: Diagnosis, Procedures Requested

Diagnosis Codes:

CPT/HCPCS Code	Description	Number of units/services
96547	HIPEC and closure; first 60 minutes	1
96548	HIPEC and closure; each additional 30 minutes	

Section 7: Indication for procedure
Refer to CPB 0278 for coverage criteria

- ☐ Cytoreductive surgery combined with hyperthermic intraperitoneal chemotherapy (HIPEC) for the treatment of
  - ☐ **Pseudomyxoma peritonei** including disseminated peritoneal adenomucinosis (DPAM), characterized by histologically benign peritoneal tumors that are frequently associated with an appendiceal mucinous adenoma, as well as peritoneal mucinous carcinomatosis, which are defined as disseminated mucin-producing adenocarcinomas;
  - ☐ **Peritoneal mesothelioma**;
  - ☐ **Goblet cell carcinoid tumor**;
- ☐ HIPEC for use with cisplatin at the time of interval debulking surgery for FIGO (Federation of Gynecology and Obstetrics) stage III ovarian cancer
- ☐ Regional hyperthermic melphalan perfusion in members with stage II, IIIA, and stage III in-transit extremity melanoma
- ☐ Sequential radiation and local/regional external hyperthermia only for the treatment of primary or metastatic cutaneous or subcutaneous superficial malignancies
- ☐ Other personal history of cancer

  Provide short explanation of patient's history:

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

Section 8: Request for hospital admission pre and/or post-surgery

Are you requesting hospital admission for 2 inpatient days or more? ☐ Yes ☐ No
Are you requesting a pre-hospitalization for medical issues? ☐ 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 issues? ☐ 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 9: Required Documentation - *Submit the following documentation with this form*
Omitting required documentation may delay our decision

☐ Current history and physical
☐ Office notes related to the patient's current condition
☐ Description of proposed treatment
☐ Documentation of health conditions (if applicable)

Section 10: 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.

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Section 11: 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:
Contact name of office personnel to call with questions: **Telephone number:** 1- - -
Date: / /
Contact name of office personnel to call with questions: **Telephone number:** 1- - -