Spinal Surgery
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

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.

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:

- 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 # CPB #16: Back Pain – Invasive Procedures, CPB #411: Bone and Tendon Graft Substitutes, CPB #591: Intervertebral Disc Prostheses and CPB #743: Spinal Surgery: Laminectomy and Fusion**, 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 (TTY: 711)**
- Traditional plans: **1-888-632-3862 (TTY: 711)**
- Medicare plans: **1-800-624-0756 (TTY: 711)**

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Section 1: To be completed by the Precertification Department Typed responses are preferred. If the responses cannot be typed, they should be printed clearly If submitting request electronically, complete member name, ID and reference number only.	
Member name:	**Reference number (required):**
Member ID:	**Member date of birth:**
Member Phone Number:	
Requesting provider/facility name:	
Requesting provider/facility NPI:	
Requesting provider/facility phone number: 1- - -	
Requesting provider/facility fax number: 1- - -	
Referring physician name:	
Referring physician phone number: 1- - -	**Referring physician phone number:** 1- - -
Physical Therapist Name:	
Physical Therapist Phone Number: - -	
Physical Therapist Fax Number: - -	

Section 2: Assistant Surgeon or Co-Surgeon Requests, if applicable

Assistant Surgeon with credentials and NPI:
Modifier requested:
Co-surgeon name and NPI:
CPT codes requested:

Section 3: General Surgical Questions

This request is for: ☐ Inpatient ☐ Outpatient
What is the requested Date of surgery?
Is this a re-do or revision surgery? ☐ Yes ☐ No
If yes, when was the previous surgery performed?
Provide the ICD-10 diagnosis codes:
Does the member have a present or past history of smoking (nicotine use)? ☐ Yes ☐ No
If yes, include documentation of nicotine cessation, this should include lab report (drawn within 6 weeks prior to surgery)

Section 4: **Conservative Therapy:**

Has the patient completed a course of *formal physical* therapy WITHIN THE LAST 12 MONTHS? ☐ Yes ☐ No
If yes, when did the physical therapy start? / /
How many weeks of physical therapy were completed?
Is there a discharge note from a Licensed Physical Therapist? ☐ Yes ☐ No
Please provide initial and last PT NOTES FROM THE MOST RECENT COURSE OF THERAPY. Please note, this is limited to formal physical therapy. Notes are required to support this conservative treatment.

Has the patient had any other forms of conservative therapy? ☐ **Yes** ☐ **No**
Type:

Dates: / / / / / / / /

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

Section 5: Provide the following information for all cervical, thoracic, or lumbar requests

Procedure: Provide a detailed description. Refer to **CPB #743** and CPB#16

Levels of surgery:

CPT codes requested:

Select the planned procedure, if applicable:

- ☐ Anterior cervical disc fusion (ACDF)
- ☐ ACDF with corpectomy
- ☐ Anterior lumbar interbody fusion (ALIF) with posterior instrumentation
- ☐ ALIF and posterolateral fusion
- ☐ ALIF with anterior instrumentation
- ☐ Cervical Disc Replacement
- ☐ Cervical Laminoplasty
- ☐ Direct lateral interbody fusion (DLIF)
- ☐ Discseel
- ☐ Extreme lateral interbody fusion (XLIF)
- ☐ Interlaminar lumbar instrumented fusion (ILIF)
- ☐ Kyphectomy
- ☐ Lumbar disc replacement
- ☐ Multiple level scoliosis correction surgery
- ☐ Oblique Lateral Interbody Fusion (OLIF)
- ☐ Posterior Cervical Decompression and Fusion (PCDF)
- ☐ Posterior lumbar interbody fusion (PLIF)
- ☐ PLIF/TLIF and posterolateral fusion
- ☐ Posterolateral fusion with posterior instrumentation
- ☐ Sacroiliac Joint Fusions
- ☐ Transforaminal lumbar interbody fusion (TLIF)
- ☐ Vertebral Corpectomy
- ☐ Verterbroplasty/Kyphoplasty

Section 6: Provide the following information for prosthetic intervertebral discs, instrumentation, and bone grafts

Instrumentation: Provide a detailed description, including the manufacturer and name of implant. Refer to CPB #16. Includes intervertebral body fixation devices or cages, interspinous or interlaminar distraction devices, interspinous fixation devices and dynamic stabilization spacers, rods, pedicle screws and plates. *

Anterior:
CPT/HCPCS code:
Manufacturer (e.g., Medtronic):
Device name (e.g., Solera or Xia):

Posterior:
CPT/HCPCS code:
Manufacturer (e.g., Depuy):
Device name (e.g., Expedium):

Cages:
CPT/HCPCS code:
Manufacturer (e.g., Depuy):
Device name (e.g., Concorde):

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

Section 6 (continued): Provide the following information for prosthetic intervertebral discs, instrumentation and bone grafts

Bone grafts (allografts). Provide a detailed description, including the manufacturer and name of implant.
Refer to CPB #411.
CPT/HCPCS code(s):
Manufacturer (e.g., Allosource):
Allograft name(s) (e.g., Allofuse):
If a cadaver graft is being used, is it a 100% bone material? ☐ Yes ☐ No
Does the graft material include stem cells or materials other than bone? ☐ Yes ☐ No
Sacroiliac Joint Fusions:
CPT/HCPCS code:
Manufacturer (e.g., SI-Bone):
Device name (e.g., I-Fuse SI Fusion System):

Prosthetic intervertebral discs. Refer to CPB # 591.
CPT/HCPCS code:
Manufacturer (e.g., Synthes):
Device name (e.g., ProDisc C Total Disc Replacement):

Section 7: Neuromonitoring Requests

Will any neuromonitoring be used? ☐ Yes ☐ No
Will the surgeon be billing for the neuromonitoring? ☐ Yes ☐ No
If yes, please provide the CPT codes:
Neuromonitoring requires precertification if the vendor is participating or non-participating. If a neuromonitoring request has not been requested by a secondary provider prior to date of service, depending on the contract, the provider, facility, or member may be responsible for uncovered charges for neuromonitoring.

Section 8: Location where procedure will be performed

Will the procedure be performed:
☐ Inpatient ☐ Outpatient

If procedure to be performed outpatient indicate the setting:
☐ Outpatient hospital
☐ Ambulatory Surgical Center (free standing)
☐ Office

If request is for Outpatient hospital check any/all that apply:
☐ Less than 12 years of age
☐ American Society of Anesthesiologists (ASA) Physical Status classification III or higher
☐ Danger of airway compromise
☐ Morbid obesity (BMI > 35 with comorbidities or BMI > 40)
☐ Pregnant
☐ Advanced liver disease
☐ Poorly controlled diabetes (hemoglobin A1C > 7)
☐ End stage renal disease (ESRD) with hyperkalemia ☐ or undergoing dialysis ☐
☐ Active substance use related disorders (Includes alcohol dependence and/or current use of high dose opioids).
☐ Personal or family history of complication of anesthesia
☐ History of solid organ transplant requiring anti-rejection medication(s)
☐ Other unstable or severe systemic diseases, intellectual disabilities or mental health conditions that would be best managed in an outpatient hospital setting
☐ This will be a prolonged surgery (>3 hrs.)

Continued

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

Section 8: Location where procedure will be performed (continued)

High risk cardiac status:

- ☐ Myocardial infarction in last 90 days
- ☐ Ongoing symptoms from previous MI
- ☐ Significant heart valve disease
- ☐ Symptomatic cardiac arrhythmia
- ☐ Hypertension resistant to 3 or more medications
- ☐ Uncompensated chronic heart failure

Coronary artery disease (CAD) or peripheral vascular disease (PVD) with:

- ☐ Ongoing ischemia or recent MI/angioplasty PCI
- ☐ Drug Eluting Stent (DES) Bare Metal Stent placed in last year
- ☐ Angioplasty in last 90 days
- ☐ Current use of Aspirin or prescription anticoagulants

Comorbid neurological or neuromuscular condition

- ☐ Stroke/cerebrovascular accident (CVA)
- ☐ Mini stroke/transient ischemic attack (TIA)
- ☐ Uncontrolled epilepsy
- ☐ Cerebral palsy
- ☐ Multiple Sclerosis
- ☐ Amyotrophic lateral sclerosis
- ☐ Traumatic brain injury with significant cognitive or behavioral issues
- ☐ Muscular dystrophy

Respiratory conditions:

- ☐ Moderate to severe obstructive sleep apnea

Unstable respiratory status:

- ☐ Poorly controlled asthma (FEV1 < 80% despite medical management)
- ☐ COPD or
- ☐ Ventilator dependent patient

Bleeding or clotting disorders or conditions:

- ☐ Requiring replacement factor, blood products or special infusion products to correct a coagulation defect
- ☐ Thrombocytopenia (platelet <100,000/microL)
- ☐ Anticipated need for blood or blood product transfusion
- ☐ Sickle cell disease
- ☐ History of Disseminated Intravascular Coagulation (DIC)

Do any of the following apply when procedure(s) to be performed at **outpatient hospital setting**:

- ☐ The required operative equipment is not available at a participating free-standing ambulatory surgical center or office based surgical center

  List specific equipment not available:

- ☐ There are no participating general or specialty surgery free-standing ambulatory surgical centers or office based surgical centers to perform procedure(s) planned

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

Section 9: Provide the following documentation for your request

Medical records related to the member's condition for which treatment is proposed, including the following from the **previous 12 months**:

- ☐ Documentation of all clinical findings
- ☐ Detailed neurological/orthopedic examination
- ☐ Conservative therapy, including type, duration, and outcome
- ☐ Physical therapy notes, including duration and outcome
- ☐ Current plan of care
- ☐ All radiological and imaging reports (myelogram, CT, MRI, spinal X-rays)
- ☐ Documentation of osteoporosis prevention/treatment program, if applicable
- ☐ Documentation of percentage of vertebral height loss/compression, 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.

Section 11: Sign the form

Just remember: This form cannot be used to initiate a precertification request. To initiate a request, please 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 and extension: 1- - - ext.

Direct Fax number: 1- - -