

ALLEGIANCE BENEFIT PLAN MANAGEMENT, INC.

SPINAL SURGERY QUESTIONNAIRE FORM

To allow more efficient and accurate processing of your spinal surgery request, please complete this form and fax it back along with copies of all supporting clinical documentation.

Office Contact: _____ Patient Name: _____ Surgeon: _____ Date of Planned Surgery: _____ Office Telephone #: _____ Inpatient Surgery: <input type="checkbox"/> Outpatient Surgery: <input type="checkbox"/> Facility TIN & NPI: _____ Diagnosis: <div style="border: 1px solid black; height: 50px; width: 100%;"></div>	Contact Number: _____ Participant ID: _____ Provider TIN & NPI: _____ Provider Address: _____ Facility Address: _____ Submission Date: _____ Office Fax #: _____ Facility Name: _____ ICD-10 Diagnostic Codes: <div style="border: 1px solid black; height: 50px; width: 100%;"></div>
Procedure: (Provide description of all planned procedures) <div style="border: 1px solid black; height: 80px; width: 100%;"></div>	CPT Codes (Provide all planned CPT Codes): <div style="border: 1px solid black; height: 80px; width: 100%;"></div>
Spinal Fusion Level(s): <div style="border: 1px solid black; height: 60px; width: 100%;"></div>	Is the Participant a smoker or using other forms of tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No

*****WITHOUT A CURRENT MRI & SURGICAL CONSULT THIS REVIEW WILL NOT BE CONSIDERED*****

Please include the **REQUIRED** items listed below if applicable.

Clinical Documentation: <input type="checkbox"/> Consultation Notes <input type="checkbox"/> Current MRI(s) <input type="checkbox"/> X-ray Reports (extension/flexion) <input type="checkbox"/> CT scan(s)	Conservative Treatment Documentation: <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Chiropractic <input type="checkbox"/> Epidural/facet injections <input type="checkbox"/> Pain Medication Management <input type="checkbox"/> NSAIDs Treatment
---	--

1) Please list the manufacturer and product name for instrumentation, hardware, fixation devices, or any other implants to be used including cages.

2) Allograft or other Bone Graft Substitute

YES NO

3) If allograft or other bone graft substitute will be used, will bone morphogenetic protein (INFUSE)*, platelet rich plasma, or bone graft substitutes which contain growth factor or are cell based be utilized? (e.g. 20930)

YES NO

*****Note: The use of a single packet of bone morphogenetic protein (BMP-2) is covered as part of medical necessary, single level anterior lumbar interbody fusion. The use of more than one packet of BMP for any other lumbar fusion surgery is generally not covered. *****

4) Allograft or other Bone Graft Substitute: (Please specify if any of the following will be used with CPT code 20930)

Bone Morphogenetic Protein (INFUSE, please provide name of product below)*

Other factor based products (e.g. BioDFactor, please provide name of product below)

Cell based (e.g. Osteocell, Magnafuse, PureGen, Trinity, amniotic membrane based products)

*****Note: Platelet rich plasma, or bone graft substitutes which contain growth factor or are cell based are considered to be experimental, investigational or unproven for the enhancement of bone healing per Cigna medical policy 0118*****

5) Manufacturer and product name to be used with codes 20930, 20931:

6) Please check the boxes below if any of the following will be taking part in this surgery.

Co-Surgeon Assistant Surgeon

7) Is Intraoperative neuromonitoring requested for this case?

YES NO

Upon receipt of all required information, the Plan will provide a written response to the written request for pre-treatment. Please allow 3 business days for response.

*Requests that include unlisted procedure code(s) will require additional documentation supporting the use of that code(s). If documentation is not submitted supporting the requested unlisted code(s) your request may be delayed and/or denied. Unlisted codes will not be considered eligible if accurate and listed codes are available to describe the requested service or procedure.