# 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: ☐ Outpatient Surgery: ☐
Facility TIN & NPI: _____

Contact Number: _____
Participant ID: _____
Provider TIN & NPI: _____
Provider Address: _____
Facility Address: _____
Submission Date: _____
Office Fax #: _____
Facility Name: _____

Diagnosis:

ICD-10 Diagnostic Codes:

Procedure:
(Provide description of all planned procedures)

CPT Codes (Provide all planned CPT Codes):

Spinal Fusion Level(s):

Is the Participant a smoker or using other forms of tobacco?
☐ Yes ☐ No

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

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

Clinical Documentation:
- ☐ Consultation Notes
- ☐ Current MRI(s)
- ☐ X-ray Reports (extension/flexion)
- ☐ CT scan(s)

Conservative Treatment Documentation:
- ☐ Physical Therapy
- ☐ Chiropractic
- ☐ Epidural/facet injections
- ☐ Pain Medication Management
- ☐ 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.***