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: Typed responses are preferred. If the responses cannot be typed, they should be printed clearly

Provide the following documentation for your 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.

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

- ☐ Most recent operating physician note including:
  - ☐ Documentation of all clinical findings
  - ☐ Detailed neurological/orthopedic examination
  - ☐ Current plan of care
  - ☐ Conservative therapy, including type, duration, and outcome
- ☐ Physical therapy notes including initial and final PT visit with discharge note from licensed physical therapist
- ☐ All formal radiological and imaging reports read by a radiologist (myelogram, CT, MRI, spinal X-rays)
- ☐ For spinal and SI joint fusions: documentation of nicotine status with quit date and negative nicotine lab result within 6 weeks prior to surgery, if applicable

- ☐ In addition to the above, for vertebral augmentation:
  - ☐ Documentation of osteoporosis prevention/treatment program
  - ☐ Documentation of percentage of vertebral height loss/compression

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- - -	

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

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

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

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**?**

N**ote:** provide initial and last PT notes from the most recent course of therapy. Recent physical therapy needs to be completed in the last 12 months. Please note, this is limited to formal physical therapy under the direct supervision of a licensed therapist. If the physical therapist discharged the patient, a discharge note from the physical therapist is required. Notes are required to support this conservative treatment. Chiropractic care and home exercise programs are not considered formal physical therapy.

Section 5: Nicotine Status (For Spinal and SI Joint Fusions Only)

Please indicate the nicotine status of the patient:

Active nicotine user: ☐

Previous nicotine user: ☐
Quit Date: / /

Never nicotine user: ☐

A blood or urine test is required for all active nicotine users and those who have quit within the last year. Please submit a nicotine/cotinine blood or urine test that was drawn within six weeks prior to surgery.

Section 6: Provide the following information for all cervical, thoracic, or lumbar requests

Procedure: Provide a detailed description of the surgery including the approach**.** Refer to **CPB #743** and CPB#16

Spinal levels of surgery (example: L2-4):

CPT codes requested:

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

Section 7: 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.
Must include both Manufacturer (examples: Medtronic, Depuy Synthes, etc.) and Device/Set name (examples: Solera, Xia, Expedium, Concorde, etc.)

Anterior:
CPT/HCPCS code:
Manufacturer:
Device name:

Posterior:
CPT/HCPCS code:
Manufacturer:
Device name:

Cages:
CPT/HCPCS code:
Manufacturer:
Device name:

Section 7 (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):
Will you be using Medtronic BMP/Infuse? ☐ Yes ☐ No

Structural Allograft (CPT code 20931)
Manufacturer or Tissue Bank:
Implant Name:

Prosthetic intervertebral discs. Refer to CPB # 591.
Example: Prestige, ProDisc, MobiC
CPT/HCPCS code:
Manufacturer:
Device name:

Section 8: 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.

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

Section 9: 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 10: 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- - -