Dorsal Column Stimulator
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®

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About this form

You can't use this form to initiate a precertification request. To initiate a request, you have to call our Precertification Department. Or you can submit your request electronically. **Failure to complete this form and submit all of the medical records we are requesting may result in the delay of review.**

Effective **May 24, 2018**, this form replaces all other Dorsal Column Stimulator (DCS) precertification information request documents and forms. This form will help you supply the right information with your precertification request. You don't have to use the form. But it will help us adjudicate your request more quickly.

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:

- **(Preferred)** Upload your information electronically on our secure provider website on NaviNet® at **connect.navinet.net**.
    - Complete a Precertification Inquiry transaction for the patient.
    - When the inquiry is successful, click the "Add Attachment" link in the upper right corner of the screen.
    - Upload your document(s) and click "Attach." The window will close and you will return to Precert Inquiry screen.

- Send your information via confidential fax to:
    - Precertification – Commercial Plans: **859-455-8650**
    - Precertification - Medicare Advantage Standard Organization Determination: **859-455-8650**
    - Precertification - Medicare Advantage (expedited only): **860-754-5468**

- Mail your information to: **PO Box 14079**
  Lexington, KY 40512-4079

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 #194: Dorsal Column Stimulation,** 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**
- Traditional plans: **1-888-632-3862**

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Section 1: Provide the following general information	
Member name:	**Administrative reference number (required):**
Member ID:	**Member date of birth:**
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 fax number:** 1- - -
Assistant/co-surgeon name (if applicable):	**TIN:**

Section 2: Select applicable planned procedure:

- ☐ 63650 Percutaneous implantation of neurostimulator electrode array, epidural
  - ☐ Trial Placement ☐ Permanent Placement
- ☐ ***PERMANENT PLACEMENT*** 63655 Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural
- ☐ 63663 Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), when performed
- ☐ 63664 Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed
- ☐ 63685 Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling
- ☐ 63688 Revision or removal of implanted spinal neurostimulator pulse generator or receiver

The following codes require precert *only when used with one of the DCS codes listed above:*

- ☐ C1767 Generator, neurostimulator (implantable), nonrechargeable
- ☐ C1816 Receiver and/or transmitter, neurostimulator (implantable)
- ☐ C1820 Generator, neurostimulator (implantable), with rechargeable battery and charging system
- ☐ C1822 Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system

CPT codes of other procedures planned, with descriptions:

Select the type of stimulator that applies to this request:

- ☐ Dorsal column stimulator
- ☐ Dorsal root ganglion stimulator
- ☐ Other, please specify

Section 3: Provide the following patient-specific information for trial or permanent DCS placement *for indications other than intractable angina*

Select the type of stimulator requested: ☐ Trial ☐ Permanent

If permanent, did the patient experience significant pain reduction (50% or more) with a 3- to 7-day trial of percutaneous spinal stimulation? ☐ Yes ☐ No

Classify the patient's pain: ☐ Acute ☐ Chronic

Date of patient's last Visual Analog Scale (VAS) pain rating _____ Last VAS pain rating (1-10 on a 10-point scale) _____

Select the DCS indication that applies to your patient:

- ☐ Failed back surgery syndrome with low back pain and significant radicular pain
- ☐ Complex regional pain syndrome (also known as reflex sympathetic dystrophy)
- ☐ Inoperable chronic ischemic limb pain secondary to peripheral vascular disease
- ☐ Last resort treatment of moderate to severe (5 or more on a 10-point VAS scale) chronic neuropathic pain of certain origins (e.g., lumbosacral arachnoiditis, radiculopathies, phantom limb/stump pain, peripheral neuropathy, post-herpetic neuralgia, intercostal neuralgia, cauda equina injury, incomplete spinal cord injury, or plexopathy) that is refractory to 12 or more months of standard therapy (including non-steroidal anti-inflammatory drugs, tricyclic antidepressants, and anticonvulsants)
- ☐ Other, please specify

Indicate all that apply to your patient:

- ☐ Patient does not have any untreated existing drug addiction problems (per American Society of Addiction Medicine [ASAM] guidelines)
- ☐ Patient has obtained clearance from a psychiatrist or psychologist
- ☐ Patient has tried other more conservative methods of pain management that have failed
- ☐ There is documented pathology for the patient's pain

Section 4: Provide the following patient-specific information for trial or permanent DCS placement *for intractable angina*

Select the type of stimulator requested: ☐ Trial ☐ Permanent

If permanent, did the patient experience significant pain reduction (50% or more) with a 3- to 7-day trial of percutaneous spinal stimulation? ☐ Yes ☐ No

Select the DCS indications that apply to your patient:

- ☐ Patient has angiographically documented significant coronary artery disease
- ☐ Patient is not a suitable candidate for revascularization procedures (e.g., coronary artery bypass grafting [CABG], percutaneous transluminal coronary angioplasty [PTCA])
- ☐ Patient has had optimal pharmacotherapy for at least one month. (Optimal pharmacotherapy includes the maximal tolerated dosages of at least 2 of the following anti-anginal medications: long-acting nitrates, beta-adrenergic blockers, or calcium channel antagonists.)
- ☐ Patient's angina pectoris is New York Heart Association (NYHA) Functional Class III (patients are comfortable at rest; less than ordinary physical activity causes fatigue, palpitation, dyspnea, or anginal pain) or Class IV (symptoms of cardiac insufficiency or angina are present at rest; symptoms are increased with physical activity)
- ☐ Reversible ischemia is documented by symptom-limited treadmill exercise test
- ☐ Other, please specify

Indicate all that apply to your patient:

- ☐ Myocardial infarction or unstable angina in the previous 3 months, or
- ☐ Significant valve abnormalities as demonstrated by echocardiography, or
- ☐ Somatic disorders of the spine leading to insurmountable technical problems in treatment with DCS.

Section 5: Provide the following documentation for your request

- Current history and physical
- Office notes related to the member's condition, including the following:
  - Signs and symptoms, including duration and severity
  - Physical findings
  - Orthopedic, neurological and/or cardiac abnormalities
  - X-ray and imaging study reports
  - Psychiatric clearance (not required for DCS request for intractable angina)
  - Pharmacotherapy (required *only* for DCS request for intractable angina)
- Clinical records documenting the following:
  - Conservative management, including type, duration and outcome
  - Outcome of trial implantation, including date of trial and percentage of pain reduction
- Complete description of requested stimulator
- Medical records supporting the indications you selected in Section 3 or 4

Section 6: 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 7: Sign the form

Just remember: You can't use this form to initiate a precertification request. To initiate a request, you have to call our Precertification Department. Or you can submit your request electronically.

Signature of treating doctor or other qualified healthcare provider:

Date: / /

Contact name of office personnel to call with questions:

Telephone number: 1- - -