

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)



Spinal Surgery Precertification Information Request Form

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](https://www.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)

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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**
- Traditional plans: **1-888-632-3862**
- Medicare plans: **1-800-624-0756**

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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- - -

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:

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.

Levels of surgery:

CPT codes requested:

Select the planned procedure, if applicable:

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

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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the graft material include stem cells or materials other than bone? <input type="checkbox"/> Yes <input type="checkbox"/> No	
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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Will the surgeon be billing for the neuromonitoring? <input type="checkbox"/> Yes <input type="checkbox"/> 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:	
<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	
If procedure to be performed outpatient indicate the setting:	
<input type="checkbox"/> Outpatient hospital	
<input type="checkbox"/> Ambulatory Surgical Center (free standing)	
<input type="checkbox"/> Office	
If request is for Outpatient hospital check any/all that apply:	
<input type="checkbox"/> Less than 12 years of age	
<input type="checkbox"/> American Society of Anesthesiologists (ASA) Physical Status classification III or higher	
<input type="checkbox"/> Danger of airway compromise	
<input type="checkbox"/> Morbid obesity (BMI > 35 with comorbidities or BMI > 40)	
<input type="checkbox"/> Pregnant	
<input type="checkbox"/> Advanced liver disease	
<input type="checkbox"/> Poorly controlled diabetes (hemoglobin A1C > 7)	
<input type="checkbox"/> End stage renal disease (ESRD) with hyperkalemia <input type="checkbox"/> or undergoing dialysis <input type="checkbox"/>	
<input type="checkbox"/> Active substance use related disorders (Includes alcohol dependence and/or current use of high dose opioids).	
<input type="checkbox"/> Personal or family history of complication of anesthesia	
<input type="checkbox"/> History of solid organ transplant requiring anti-rejection medication(s)	
<input type="checkbox"/> Other unstable or severe systemic diseases, intellectual disabilities or mental health conditions that would be best managed in an outpatient hospital setting	
<input type="checkbox"/> This will be a prolonged surgery (>3 hrs.)	

Continued

Spinal Surgery Precertification Information Request Form

Member name:	Reference number (required):																												
Member ID:	Member Phone Number:																												
Section 8: Location where procedure will be performed (continued)																													
<p>High risk cardiac status:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; padding: 2px;"><input type="checkbox"/> Myocardial infarction in last 90 days</td> <td style="width: 50%; padding: 2px;"><input type="checkbox"/> Ongoing symptoms from previous MI</td> </tr> <tr> <td style="padding: 2px;"><input type="checkbox"/> Significant heart valve disease</td> <td style="padding: 2px;"><input type="checkbox"/> Symptomatic cardiac arrhythmia</td> </tr> <tr> <td style="padding: 2px;"><input type="checkbox"/> Hypertension resistant to 3 or more medications</td> <td></td> </tr> <tr> <td style="padding: 2px;"><input type="checkbox"/> Uncompensated chronic heart failure</td> <td></td> </tr> </table> <p>Coronary artery disease (CAD) or peripheral vascular disease (PVD) with:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; padding: 2px;"><input type="checkbox"/> Ongoing ischemia or recent MI/angioplasty PCI</td> <td style="width: 50%; padding: 2px;"><input type="checkbox"/> Drug Eluting Stent (DES) Bare Metal Stent placed in last year</td> </tr> <tr> <td style="padding: 2px;"><input type="checkbox"/> Angioplasty in last 90 days</td> <td style="padding: 2px;"><input type="checkbox"/> Current use of Aspirin or prescription anticoagulants</td> </tr> </table> <p>Comorbid neurological or neuromuscular condition</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; padding: 2px;"><input type="checkbox"/> Stroke/cerebrovascular accident (CVA)</td> <td style="width: 50%; padding: 2px;"><input type="checkbox"/> Mini stroke/transient ischemic attack (TIA)</td> </tr> <tr> <td style="padding: 2px;"><input type="checkbox"/> Uncontrolled epilepsy</td> <td style="padding: 2px;"><input type="checkbox"/> Cerebral palsy</td> </tr> <tr> <td style="padding: 2px;"><input type="checkbox"/> Multiple Sclerosis</td> <td style="padding: 2px;"><input type="checkbox"/> Amyotrophic lateral sclerosis</td> </tr> <tr> <td style="padding: 2px;"><input type="checkbox"/> Traumatic brain injury with significant cognitive or behavioral issues</td> <td></td> </tr> <tr> <td style="padding: 2px;"><input type="checkbox"/> Muscular dystrophy</td> <td></td> </tr> </table> <p>Respiratory conditions:</p> <p><input type="checkbox"/> Moderate to severe obstructive sleep apnea</p> <p>Unstable respiratory status:</p> <p><input type="checkbox"/> Poorly controlled asthma (FEV1 < 80% despite medical management)</p> <p><input type="checkbox"/> COPD or</p> <p><input type="checkbox"/> Ventilator dependent patient</p> <p>Bleeding or clotting disorders or conditions:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; padding: 2px;"><input type="checkbox"/> Requiring replacement factor, blood products or special infusion products to correct a coagulation defect</td> <td style="width: 50%; padding: 2px;"><input type="checkbox"/> Anticipated need for blood or blood product transfusion</td> </tr> <tr> <td style="padding: 2px;"><input type="checkbox"/> Thrombocytopenia (platelet <100,000/microL)</td> <td style="padding: 2px;"><input type="checkbox"/> History of Disseminated Intravascular Coagulation (DIC)</td> </tr> <tr> <td style="padding: 2px;"><input type="checkbox"/> Sickle cell disease</td> <td></td> </tr> </table> <p>Do any of the following apply when procedure(s) to be performed at outpatient hospital setting:</p> <p><input type="checkbox"/> The required operative equipment is not available at a participating free-standing ambulatory surgical center or office based surgical center</p> <p style="padding-left: 40px;">List specific equipment not available:</p> <p><input type="checkbox"/> There are no participating general or specialty surgery free-standing ambulatory surgical centers or office based surgical centers to perform procedure(s) planned</p>		<input type="checkbox"/> Myocardial infarction in last 90 days	<input type="checkbox"/> Ongoing symptoms from previous MI	<input type="checkbox"/> Significant heart valve disease	<input type="checkbox"/> Symptomatic cardiac arrhythmia	<input type="checkbox"/> Hypertension resistant to 3 or more medications		<input type="checkbox"/> Uncompensated chronic heart failure		<input type="checkbox"/> Ongoing ischemia or recent MI/angioplasty PCI	<input type="checkbox"/> Drug Eluting Stent (DES) Bare Metal Stent placed in last year	<input type="checkbox"/> Angioplasty in last 90 days	<input type="checkbox"/> Current use of Aspirin or prescription anticoagulants	<input type="checkbox"/> Stroke/cerebrovascular accident (CVA)	<input type="checkbox"/> Mini stroke/transient ischemic attack (TIA)	<input type="checkbox"/> Uncontrolled epilepsy	<input type="checkbox"/> Cerebral palsy	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Amyotrophic lateral sclerosis	<input type="checkbox"/> Traumatic brain injury with significant cognitive or behavioral issues		<input type="checkbox"/> Muscular dystrophy		<input type="checkbox"/> Requiring replacement factor, blood products or special infusion products to correct a coagulation defect	<input type="checkbox"/> Anticipated need for blood or blood product transfusion	<input type="checkbox"/> Thrombocytopenia (platelet <100,000/microL)	<input type="checkbox"/> History of Disseminated Intravascular Coagulation (DIC)	<input type="checkbox"/> Sickle cell disease	
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Member name:	Reference number (required):
Member ID:	Member Phone Number:
Section 9: Provide the following documentation for your request	
<p>Medical records related to the member's condition for which treatment is proposed, including the following from the previous 12 months:</p> <p><input type="checkbox"/> Documentation of all clinical findings</p> <p><input type="checkbox"/> Detailed neurological/orthopedic examination</p> <p><input type="checkbox"/> Conservative therapy, including type, duration, and outcome</p> <p><input type="checkbox"/> Physical therapy notes, including duration and outcome</p> <p><input type="checkbox"/> Current plan of care</p> <p><input type="checkbox"/> All radiological and imaging reports (myelogram, CT, MRI, spinal X-rays)</p>	
Section 10: Read this important information	
<p>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.</p>	
Section 11: Sign the form	
<p>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.</p>	
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- - -	