



Utilization Management
Phone: 1-877-284-0102 Fax: 1-800-510-2162

Lumbar Spine Surgery Precertification Review

Date: _____ Reference #: _____ (provided after initial review)
A Utilization Management representative will fax you a notification number by the next business day after receiving this completed form. This notification number does not indicate an approval or denial of benefits, but only proof that the Plan has been notified. This information will be forwarded to the Plan's Managed Care Department. If you have any questions, please call HealthLink at 1-877-284-0102.

Provider Information

Provider Name: _____
 Address: _____
 Phone: _____
 Fax: _____

Patient Information

Patient Name: _____
 ID Number: _____
 Address: _____
 Patient's DOB: _____
 Phone: _____

Ordering Physician Information

Ordering Physician Name: _____
 Address: _____
 Phone: _____
 Fax: _____
 TIN: _____

Treatment Information

Diagnosis (ICD-9) Code: _____
 Primary Procedure: _____
 Procedure (ICD-9) Code: _____
 Date of Procedure: _____
 Place of Service: _____

Is procedure related to an accident? YES NO
 If yes, please indicate date and describe injury: _____

Has the member had prior back surgery? YES NO
 If yes, please list surgeries and approximate dates performed: _____

Is there moderate to severe lumbar spinal stenosis? YES NO
 Is there Spondylolithesis? YES NO
 Is there a herniated disc with radiculopathy? YES NO

Benefits depend upon the eligibility of the patient at the time of admission, subject to all other Plan limitations, pre-admission review requirement and prior related claims. Verification of eligibility and description of benefits are based upon the information we have on file and does not guarantee payment.

Which approach will be used? Anterior Posterior

Which approach will be used during the surgery? Open Endoscopic Percutaneous

What are the results of the MRI or other neuro imaging diagnostics that demonstrates corresponding pathologic anatomy? (Please attach test results at the end of the form) _____

What conservative treatment has been tried? _____

Will surgery include an artificial disc? YES NO

For this procedure will rhBMP-2 or rhBMP-7 be used? rhBMP-2 rhBMP-7 None

If none, please proceed to selecting the correct procedure listed below:

Is the use of recombinant human bone morphogenetic protein-2 (rhBMP-2) InFUSE[®] bone graft being used for any of the following situations:

- As an adjunct to instrumented anterior lumbar interbody fusion (ALIF) procedure;
- As an adjunct to instrumented posterolateral lumbar intertransverse fusion procedure; or

Is the use of recombinant human bone morphogenetic protein-7 (rhBMP-7) Osteogenic Protein-1[™] (OP-1[™] Implant) being used as an alternative to autograft in compromised individuals requiring revision of posterolateral lumbar intertransverse fusion, when autologous bone and bone marrow harvest are not feasible or are not expected to promote fusion. Examples of compromising factors include osteoporosis, smoking and diabetes. YES NO

Will the use recombinant human bone morphogenetic protein-2 or recombinant human bone protein-7 be used for any of the conditions below?

- As an adjunct to cervical fusion procedures;
- As an adjunct to posterior lumbar interbody fusion (PLIF) or transforaminal lumbar interbody fusion (TLIF);

Procedure Information

Please indicate procedure from list below:

- Cervical fusion
- Intertransverse Fusion (ITF)
- Anterior Lumbar Interbody Fusion (ALIF)
- Posterior Lumbar Interbody Fusion (PLIF)
- Transforaminal Lumbar Interbody Fusion (TLIF)

Contact Information

Contact Person: _____

Title: _____

Phone: _____

Fax: _____