



**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-10) Code: \_\_\_\_\_  
 Primary Procedure: \_\_\_\_\_  
 Procedure (ICD-10) 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<sup>®</sup> 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<sup>™</sup> (OP-1<sup>™</sup> 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)

Will Xstop be used during the procedure?  YES  NO

Will intervertebral stabilization device or Dynesys (Pedicule System) be used?  YES  NO

### Contact Information

Contact Person: \_\_\_\_\_

Title: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_