ALLEGIANCE BENEFIT PLAN MANAGEMENT, INC.
SPINAL SURGERY QUESTIONNAIRE FORM

To allow more efficient and accurate processing of your spinal surgery request, please complete this form and fax it back along with copies of all supporting clinical documentation.

Office Contact:____________________________

Contact Number:______________________________

Patient Name:_____________________________

Participant ID:________________________________

Surgeon:_________________________________

Provider TIN:_________________________________

Date of Planned Surgery: ___________________

Submission Date: ____________________________

Office Telephone #: ________________________

Office Fax #:___________________________________

Inpatient Surgery: ___ Outpatient Surgery: ___

Facility Name:_________________________________

Diagnosis:

ICD-10 Diagnostic Codes:

Procedure:
(Provide description of all planned procedures)

CPT Codes (Provide all planned CPT Codes):

Spinal Fusion Level(s):

Is the Participant a smoker or using other forms of tobacco?
___ Yes ___ No

*****WITHOUT A CURRENT MRI & SURGICAL CONSULT THIS REVIEW WILL NOT BE CONSIDERED*****

Please include the ***REQUIRED*** items listed below if applicable.

Clinical Documentation:

___Consultation Notes

___ Current MRI(s)

___ X-ray Reports (extension/flexion)

___ CT scan(s)

Conservative Treatment Documentation:

___ Physical Therapy

___ Chiropractic

___ Epidural/facet injections

___ Pain Medication Management

___ NSAIDs Treatment

Return form to: Medical Review – Fax: (406) 532-1502

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1) Please list the manufacturer and provide for instrumentation hardware implants or any other implants to be used including cages.

2) Allograft or other Bone Graft Substitute

___ YES ___ NO

3) If allograft or other bone graft substitute will be used, will bone morphogenetic protein (INFUSE)*, platelet rich plasma, or bone graft substitutes which contain growth factor or are cell based be utilized? (e.g. 20930)

___ YES ___ NO

Note: The use of a single packet of bone morphogenetic protein (BMP-2) is covered as part of medical necessary, single level anterior lumbar interbody fusion. The use of more than one packet of BMP for any other lumbar fusion surgery is generally not covered.

4) Allograft or other Bone Graft Substitute: (Please specify if any of the following will be used with CPT code 20930)

___ Bone Morphogenetic Protein (INFUSE, please provide name of product below)*

___ Other factor based products (e.g. BioDFactor, please provide name of product below)

___ Cell based (e.g. Osteocell, Magnafuse, PureGen, Trinity, amniotic membrane based products)

Note: Platelet rich plasma, or bone graft substitutes which contain growth factor or are cell based are considered to be experimental, investigational or unproven for the enhancement of bone healing per Cigna medical policy 0118

5) All product name to be used with 20930, 20931:

6) Will there be a Co-Surgeon AND an assistant Surgeon involved in this spinal procedure?

___ YES ___ NO

Fully completed forms will result in an expedited review process

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