Cigna Lumbar Fusion Precertification Form

CLEAR FORM

Please fax this completed questionnaire and required documentation to 866-873-8279.

To allow more efficient and accurate processing of your lumbar fusion request, please complete this form and fax it back along with copies of all supporting clinical documentation including MRI and other imaging reports.

Customer Name:	Cigna Customer ID:	Customer Date of Birth:	Date of Planned Surgery
Diagnosis:		ICD-10 Diagnostic Codes:	
Procedure *(Provide description of all planned procedures):*		CPT Codes *(Provide all planned CPT codes):*	
Specify the Fusion Level(s):		Surgeon Name:	

I confirm the patient has not smoked or otherwise used tobacco products within the past six weeks. ☐ Yes ☐ No

Tobacco use history: Non-smoker ☐ Yes ☐ No Former smoker – quit date: _____

Former smokeless tobacco user – quit date: _____

The following clinical information must be included in your request to permit a timely review by Cigna:

Onset of Symptoms - Chief Complaint:

Primary location and distribution of pain:

Symptoms of Myelopathy/Radiculopathy - describe any of the following: weakness, gait imbalance, paresthesias, loss of sensation, bowel or bladder dysfunction:

Functional limitations: (ADLs- inability to perform household chores or prolonged standing, interference with essential job functions, Disabilities, Neurological deficits):

Conservative Treatment: List treatments provided and duration of conservative care: (exercise, nonsteroidal and/or steroidal medication unless contraindicated, physical therapy and activity lifestyle modification):

Objective Physical Examination/findings: this could include sensory changes, motor weakness, reflex changes, sustained clonus, Babinski test, toe-to-heel walk, Romberg test, łoss of sacral sensation or sphincter tone:

Reports of all Diagnostic studies performed:

1. X-ray Findings:
2. MRI or CT scan findings:
3. CT myelography:

The following clinical information must be included in your request to permit a timely review by Cigna *(Continued)*:

If prior lumbar fusion surgery: When was the prior lumbar surgery? _____

What level(s) were previously fused or decompressed?

Will ANY of the following surgical techniques or devices be utilized?	**Yes**	**No**
Pre-sacral interbody approach, including axial interbody approach [AxiaLif®] [22586, 0309T, 0195T or 0196T]	☐	☐
Dynamic spine stabilization device systems (e.g., Dynesys®, Stabilimax NZ®)	☐	☐
Total facet arthroplasty, including Total Facet Arthroplasty System™ [0202T]	☐	☐
Isolated facet fusion, with or without instrumentation, including allograft bone graft substitutes used exclusively as stand-alone stabilization devices (e.g., TruFUSE® [any level], NuFix™ [any level])* [0221T, 0222T]	☐	☐
Posterior interspinous fixation devices (e.g., Affic™, Aspen™, Spinous Process Fixation System)	☐	☐

Allograft or other Bone Graft Substitutes:

CPT code 20930 has the following CPT descriptor: allograft, morselized, or placement of osteopromotive material, for spine surgery only. Allograft morselized bone when utilized during medically necessary spinal fusion surgery is covered. However the application of osteopromotive cell or factor-based bone graft substitutes is not covered because these are considered experimental/investigational/unproven including rhBMP-2 (INFUSE® Bone Graft) when used for spinal fusion procedures other than single-level anterior lumbar or lumbosacral fusion.

Will you use any of the following allografts and which one(s): BMP, cell based, factor based products? ☐ Yes ☐ No

If yes, please specify the specific bone graft substitute by name which will be utilized:

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

If the planned surgery is a single level fusion for the treatment of discogenic low back pain due to single level degenerative disc disease without a spondylolisthesis, supporting documentation of each of the following is required:

Clinical records that support documentation of unremitting pain and significant functional impairment for at least 12 months duration, and during which time ALL of the following criteria have been met:

- unremitting pain and significant functional impairment continues despite at least six (6) consecutive months of structured*, physician supervised conservative medical management, including ALL of the following components:
  - ☐ exercise, including core stabilization exercises
  - ☐ nonsteroidal and/or steroidal medication (unless contraindicated)
  - ☐ physical therapy, including passive and active treatment modalities
  - ☐ activity/lifestyle modification
- participation in 3 or more individual or group cognitive behavioral therapy (CBT) sessions provided by a licensed healthcare professional, with competence in principles and practice of CBT, (e.g., PT, OT, psychiatrist, psychologist, social worker, psychiatric nurse, other licensed professional) providing individualized treatment that includes ALL of the following elements:
  - ☐ disease education
  - ☐ activity and lifestyle modification
  - ☐ stress management (stress management typically also includes strategies to deal with emotions such as fear, anxiety, sadness that can interfere with pain management)
- single level degenerative disc disease, demonstrated on appropriate imaging studies (i.e., computerized tomography [CT] scan, magnetic resonance imaging [MRI], or discography) as the likely cause of pain
- statement from a primary care physician, neurologist, physiatrist, psychiatrist, psychologist, or other licensed behavioral and/or medical health care provider attesting to the absence of untreated, underlying mental health conditions/issues (e.g., depression, drug, alcohol abuse) as a major contributor to chronic pain
- the individual is a nonsmoker, or in the absence of progressive neurological compromise will refrain from use of tobacco products for at least 6 weeks prior to the planned surgery

***__Note__: Structured medical management consists of medical care that is delivered through regularly scheduled appointments, including follow-up evaluation, with licensed healthcare professionals.**

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