Cigna Cervical Fusion or Cervical Disc Replacement 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 cervical fusion or disc replacement 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 or Disc Replacement Level(s):		Surgeon Name:	

Pertinent History and Physical Examination Information:

Does the patient have a fracture, neoplasm, infection, OPLL, congenital anomaly, rheumatoid arthritis, or radiographic instability? ☐ Yes ☐ No *If yes, list which.*
Does the patient have myelopathy, radiculopathy or both resulting in disability and/or neurological deficit that has been refractory to at least six weeks of standard conservative, nonoperative management in the absence of progressive or severe myelopathy? ☐ Yes ☐ No *If yes, fax clinical documentation which correlates the member's symptoms, physical examination and advanced imaging findings to support the anatomical levels being proposed for the surgery.*
What level(s) of decompression/fusion surgery are requested?
What clinical findings on exam are attributable to each level(s) requested? *e.g., specific muscle weakness, sensation loss, reflex change, Hoffman's, Lhermitte's, Spurling test?*
What is the duration of and forms of non-operative treatment?
Does patient have kyphosis >11 degrees or anterolisthesis >3.5 mm? At what location?

If Prior Cervical Fusion Surgery:

When was the prior cervical surgery?	What levels were previously fused?

If Pseudoarthrosis:

Which level(s) have pseudoarthrosis?
What imaging level is there of pseudoarthrosis?
Did the patient initially improve after the fusion? If so, for how long?

Tobacco History:

I confirm the patient has not smoked or otherwise used tobacco products within the past six weeks. ☐ Yes ☐ No		
Non-smoker ☐ Yes ☐ No	Former smoker ☐ Yes ☐ No Date:	Former smokeless tobacco user ☐ Yes ☐ No Date:

Iatrogenic Instability:

Will the facets require removal of 50% or more of the facets bilaterally or removal of 75% or more of a single facet? ☐ Yes ☐ No *If yes, fax clinical and advanced imaging documentation.*
Will a corpectomy be performed? ☐ Yes ☐ No *If yes, fax clinical and advanced imaging documentation.* *Note: A corpectomy code requires documentation of the need for and the removal of at least 50% of the vertebral body including the disc above and below.*

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.*

CLICK TO PRINT