Dorsal Column Stimulator
Precertification Information Request Form

Applies to:

Aetna plans

Innovation Health® plans

Health benefits and health insurance plans offered, underwritten, and/or administered by the following:

Allina Health and Aetna Health Insurance Company (Allina Health | Aetna)

Banner Health and Aetna Health Insurance Company and/or Banner Health and Aetna Health Plan Inc. (Banner | Aetna)

Sutter Health and Aetna Administrative Services LLC (Sutter Health | Aetna)

Texas Health + Aetna Health Plan Inc. and Texas Health + Aetna Health Insurance Company (Texas Health Aetna)

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About this form

Do not use this form to initiate a precertification request. To initiate a request, submit electronically on Availity or call our Precertification Department. Submit your medical records to support the request with your electronic submission.

We've made it easy for you to authorize services and submit any requested clinical information. Just use our provider portal on Availity®. Register today at Availity.com/aetnaproviders. Once your account is ready, you can start submitting authorization requests right away.

- For additional information on Availity, go to https://www.aetna.com/health-care-professionals/resource-center/availity.html

Requesting authorizations on Availity is a simple two-step process

Here's how it works:

1. Submit your initial request on Availity with the Authorization (Precertification) Add transaction.
2. Then complete a short questionnaire, if asked, to give us more clinical information.
    - If you receive a pended response, then complete this form and attach it to the case electronically.

This form will help you supply the right information with your precertification request. Typed responses are preferred. Failure to complete this form and submit all medical records we are requesting may result in the delay of review or denial of coverage.

How to fill out this form

As the patient's attending physician, you must complete all sections of the form. You can use this form with all Aetna health plans, including Aetna's Medicare Advantage plans. You can also use this form with health plans for which Aetna provides certain management services.

When you're done

Once you've filled out the form, submit it and all requested medical documentation to our Precertification Department by:

- If your request was submitted via telephone, you can either:
    - Access our provider portal via Availity; enter the Reference number provided and attach this form and all requested medical documentation to the case or
    - Send your information by confidential fax to:
        - **Precertification**- Commercial and Medicare using FaxHub: **1-833-596-0339**
        - The fax number above (FaxHub) is for clinical information only. Please send specific information that supports your medical necessity review. Please continue to send all other information (claims etc) to appropriate fax numbers.
    - If you do not have fax or electronic means to submit clinical:
        - Mail your information to: **PO Box 14079**
          Lexington, KY 40512-4079
          (Please note mailing will add to the review response time)

What happens next?

Once we receive the requested documentation, we'll perform a clinical review. Then we'll make a coverage determination and let you know our decision. Your administrative reference number will be on the electronic precertification response.

How we make coverage determinations

If you request precertification for a Medicare Advantage member, we use CMS benefit policies, including national coverage determinations (NCD) and local coverage determinations (LCD) when available, to make our coverage determinations. If there isn't an available NCD or LCD to review, then we'll use the Clinical Policy Bulletin referenced below to make the determination.

For all other members, we encourage you to review **Clinical Policy Bulletin #194: Spinal Cord Stimulation**, before you complete this form.

You can find the Clinical Policy Bulletins and Precertification Lists by visiting the website on the back of the member's ID card.

Questions?

If you have questions about how to fill out the form or our precertification process, call us at:

- HMO plans: **1-800-624-0756**
- Traditional plans: **1-888-632-3862**
- Medicare plans: **1-800-624-0756**

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Section 1: Provide the following general information
Typed responses are preferred. If the responses cannot be typed, they should be printed clearly.
If submitting request electronically, complete member name, ID and reference number only.

Member name:	**Reference number (required):**
Member ID:	**Member date of birth:**
Member Phone number:	
Requesting provider/facility name:	
Requesting provider/facility NPI:	
Requesting provider/facility phone number: 1- - -	
Requesting provider/facility fax number: 1- - -	
Referring physician name:	
Referring physician phone number: 1- - -	**Referring physician fax number:** 1- - -
Assistant/co-surgeon name (if applicable):	**TIN:**

Section 2: Select applicable planned procedure:

- ☐ Percutaneous implantation of neurostimulator electrode array, epidural
- ☐ Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural
- ☐ Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), when performed
- ☐ Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed
- ☐ Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling
- ☐ Revision or removal of implanted spinal neurostimulator pulse generator or receiver

The following codes require precert *only when used with one of the DCS codes listed above:*

- ☐ Generator, neurostimulator (implantable), non-rechargeable
- ☐ Receiver and/or transmitter, neurostimulator (implantable)
- ☐ Generator, neurostimulator (implantable), with rechargeable battery and charging system
- ☐ Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system

Select the type of stimulator requested: ☐ Trial ☐ Permanent

If permanent, did the patient experience significant pain reduction (50% or more) with a 3- to 7-day trial of percutaneous spinal stimulation? ☐ Yes ☐ No

Has the procedure been scheduled? ☐ Yes ☐ No If yes, what is the date of service:

CPT codes of other procedures planned, with descriptions:

Select the type of stimulator that applies to this request:

- ☐ Dorsal column stimulator
- ☐ Dorsal root ganglion stimulator
- ☐ Other, please specify

Member ID:	**Reference Number:**

Section 3: Provide the following patient-specific information for trial or permanent DCS placement *for indications other than intractable angina*

Classify the patient's pain: ☐ Acute ☐ Chronic

Date of patient's last Visual Analog Scale (VAS) pain rating _____ Last VAS pain rating (1-10 on a 10-point scale) _____

Select the DCS indication that applies to your patient:

- ☐ Failed back surgery syndrome with low back pain and significant radicular pain
- ☐ Complex regional pain syndrome (also known as reflex sympathetic dystrophy)
- ☐ Inoperable chronic ischemic limb pain secondary to peripheral vascular disease
- ☐ Last resort treatment of moderate to severe (5 or more on a 10-point VAS scale) chronic neuropathic pain of certain origins (i.e., lumbosacral arachnoiditis, phantom limb/stump pain, peripheral neuropathy (including diabetic peripheral neuropathy, post-herpetic neuralgia, intercostal neuralgia, cauda equina injury, incomplete spinal cord injury, or plexopathy) that has been present for 12 or more months
- ☐ Other, please specify

- ☐ Does your patient have any untreated existing drug addiction problems (per American Society of Addiction Medicine [ASAM] guidelines)? ☐ Yes ☐ No
- ☐ Has your patient obtained clearance from a psychiatrist, psychologist or other qualified mental health professional? ☐ Yes ☐ No
- ☐ Has your patient tried and failed at least 6 months of other more conservative methods of pain management (including non-steroidal anti-inflammatory drugs, tricyclic antidepressants, and anticonvulsants)? ☐ Yes ☐ No
- ☐ Has the patient's functional disability been assessed using the Oswestry Disability Index (ODI)? ☐ Yes ☐ No
  - ☐ Please specify the patient's Oswestry Disability Index (ODI) score
- ☐ Please provide documented pathology for the patient's pain

Section 4: Provide the following patient-specific information for trial or permanent DCS placement *for intractable angina*

Select the DCS indications that apply to your patient:

- ☐ Patient has angiographically documented significant coronary artery disease
- ☐ Patient is not a suitable candidate for revascularization procedures (e.g., coronary artery bypass grafting [CABG], percutaneous transluminal coronary angioplasty [PTCA])
- ☐ Patient has had optimal pharmacotherapy for at least one month. (Optimal pharmacotherapy includes the maximal tolerated dosages of at least 2 of the following anti-anginal medications: long-acting nitrates, beta-adrenergic blockers, or calcium channel antagonists.)
- ☐ Patient's angina pectoris is New York Heart Association (NYHA) Functional Class III (patients are comfortable at rest; less than ordinary physical activity causes fatigue, palpitation, dyspnea, or anginal pain) or Class IV (symptoms of cardiac insufficiency or angina are present at rest; symptoms are increased with physical activity)
- ☐ Reversible ischemia is documented by symptom-limited treadmill exercise test
- ☐ Other, please specify

Indicate all that apply to your patient:

- ☐ Myocardial infarction or unstable angina in the previous 3 months, or
- ☐ Significant valve abnormalities as demonstrated by echocardiography, or
- ☐ Somatic disorders of the spine leading to insurmountable technical problems in treatment with DCS.

Member ID:	**Reference Number:**

Section 5: Location where procedure will be performed

Will the procedure be performed:

☐ **Inpatient** ☐ **Outpatient**

If procedure to be performed outpatient indicate the setting:

- ☐ Outpatient hospital
- ☐ Ambulatory Surgical Center (free standing)
- ☐ Office

If request is for Outpatient hospital check any/all that apply:

- ☐ Less than 12 years of age
- ☐ American Society of Anesthesiologists (ASA) Physical Status classification III or higher
- ☐ Danger of airway compromise
- ☐ Morbid obesity (BMI > 35 with comorbidities or BMI > 40)
- ☐ Pregnant
- ☐ Advanced liver disease
- ☐ Poorly controlled diabetes (hemoglobin A1C > 7)
- ☐ End stage renal disease (ESRD) with hyperkalemia ☐ or undergoing dialysis ☐
- ☐ Active substance use related disorders (Includes alcohol dependence and/or current use of high dose opioids).
- ☐ Personal or family history of complication of anesthesia
- ☐ History of solid organ transplant requiring anti-rejection medication(s)
- ☐ Other unstable or severe systemic diseases, intellectual disabilities or mental health conditions that would be best managed in an outpatient hospital setting
- ☐ This will be a prolonged surgery (>3 hrs.)

High risk cardiac status:

- ☐ Myocardial infarction in last 90 days
- ☐ Ongoing symptoms from previous MI
- ☐ Significant heart valve disease
- ☐ Symptomatic cardiac arrhythmia
- ☐ Hypertension resistant to 3 or more medications
- ☐ Uncompensated chronic heart failure

Coronary artery disease (CAD) or peripheral vascular disease (PVD) with:

- ☐ Ongoing ischemia or recent MI/angioplasty PCI
- ☐ Drug Eluting Stent (DES) Bare Metal Stent placed in last year
- ☐ Angioplasty in last 90 days
- ☐ Current use of Aspirin or prescription anticoagulants

Comorbid neurological or neuromuscular condition

- ☐ Stroke/cerebrovascular accident (CVA)
- ☐ Mini stroke/transient ischemic attack (TIA)
- ☐ Uncontrolled epilepsy
- ☐ Cerebral palsy
- ☐ Multiple Sclerosis
- ☐ Amyotrophic lateral sclerosis
- ☐ Traumatic brain injury with significant cognitive or behavioral issues
- ☐ Muscular dystrophy

Respiratory conditions:

- ☐ Moderate to severe obstructive sleep apnea

Continued

Member ID:	**Reference Number:**

Section 5: Location where procedure will be performed *(continued)*

Unstable respiratory status:

- ☐ Poorly controlled asthma (FEV1 < 80% despite medical management)
- ☐ COPD or
- ☐ Ventilator dependent patient

Bleeding or clotting disorders or conditions:

- ☐ Requiring replacement factor, blood products or special infusion products to correct a coagulation defect
- ☐ Thrombocytopenia (platelet <100,000/microL)
- ☐ Anticipated need for blood or blood product transfusion
- ☐ Sickle cell disease
- ☐ History of Disseminated Intravascular Coagulation (DIC)

Do any of the following apply when procedure(s) to be performed at **outpatient hospital setting**:

- ☐ The required operative equipment is not available at a participating free-standing ambulatory surgical center or office based surgical center

  List specific equipment not available:
- ☐ There are no participating general or specialty surgery free-standing ambulatory surgical centers or office based surgical centers to perform procedure(s) planned

Section 6: Provide the following documentation for your request

- ☐ Current history and physical
- ☐ Office notes related to the patient's condition, including the following:
  - ☐ Signs and symptoms, including duration and severity
  - ☐ Physical findings
  - ☐ Orthopedic, neurological and/or cardiac abnormalities
  - ☐ X-ray and imaging study reports
  - ☐ Oswestry Disability Index (ODI) (not required for DCS request for intractable angina)
  - ☐ Psychiatric clearance (not required for DCS request for intractable angina)
  - ☐ Pharmacotherapy (required *only* for DCS request for intractable angina)
- ☐ Clinical records documenting the following:
  - ☐ Conservative management, including type, duration and outcome
  - ☐ Outcome of trial implantation, including date of trial and percentage of pain reduction
- ☐ Complete description of requested stimulator
- ☐ Medical records supporting the indications you selected in Section 3 or 4

Section 7: Read this important information

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Section 8: Sign the form

Just remember: This form cannot be used to initiate a precertification request. To initiate a request, you may submit your request electronically or call our Precertification Department.

Signature of person completing form:

Date: / /

Contact name of office personnel to call with questions:

Telephone number: 1- - -