



Spine Surgery Information Request Form

Use this form for NYC Employees PPO (NYCE PPO) plan members only. Medicare, Medicaid, FHP, or SCHP have their own specific requirements; please do not use this form.

Please upload this document to the NYCE PPO portal at nyceppo.com as an accurate coverage decision cannot be made without this information.

If requested information is incomplete, procedure and payment for claim may be denied.

To _____	From _____
Fax _____	Phone _____
Reference # _____	Pages (including cover) _____

Certain devices and surgical techniques require clinical review to determine whether they are covered by the member’s policy and if their utilization is in accordance with FDA-approved indications. Please provide the following information to assist us in determining coverage of your patient’s planned procedure:

- Completed spine surgery information request form (attached)
- Clinical records, including patient history and progress notes
- Results of conservative care
- Radiology reports (X-rays/MRI)

UnitedHealthcare Commercial Medical & Drug Policies

Completion of the notification process is not a guarantee of claims payment. Claims payment is subject to member eligibility, benefits and application of coverage as outlined in the member’s coverage documents.

CONFIDENTIALITY NOTICE: Information accompanying this facsimile is considered to be UnitedHealthcare’s confidential and/or proprietary business information. Consequently, this information may be used only by the person or entity to which it is addressed. Such recipient shall be liable for using and protecting UnitedHealthcare’s information from further disclosure or misuse, consistent with applicable contract and/or law. The information you have received may contain protected health information (PHI) and must be handled according to applicable state and federal laws, including, but not limited to HIPAA. Individuals who misuse such information may be subject to both civil and criminal penalties. If you believe you received this information in error, please contact the sender immediately.

(Continued)

Complete this portion of the form

Patient's full name _____

Date of birth _____ / _____ / _____
(MM/DD/YYYY)

Member ID _____

Person completing the form _____

Patient's phone _____

Phone of person completing _____

Spine level(s) _____

Check one: Inpatient Outpatient Observation

I. Which of the following spine fusion techniques will you be using? Please indicate all techniques.

Annuloplasty

Axial lumbar interbody fusion (AXIALLIF)

Cervical interbody fusion

Direct lateral interbody fusion (DLIF)

Endoscopic lumbar fusion

Extreme lateral interbody fusion (XLIF)

Facet fusion without decompression

Facet fusion with decompression

Guided lateral interbody fusion (GLIF)

Guided oblique lateral interbody fusion (GOLIF)

Interlaminar lumbar instrumented fusion (ILIF)

Laparoscopic anterior lumbar interbody fusion (LALIF)

Posterior lumbar interbody fusion (PLIF)

Standard anterior lumbar interbody fusion (ALIF)

Standard posterior lumbar interbody fusion (PLIF)

Transforaminal lumbar interbody fusion (TLIF)

Transforaminal lumbar interbody fusion with endoscopy visualization (such as a percutaneous incision with video visualization)

Percutaneous endoscopic discectomy with or without laser

Percutaneous laser disc decompression

Nucleoplasty (percutaneous disc decompression)

Percutaneous lumbar discectomy

Other spinal fusion technique:

II. Which of the following other spine surgery techniques will you be using? Please indicate all techniques.

Accurascope

Discectomy

DSS brand stabilization system

Dynesys® dynamic stabilization system

Foraminotomy

Laminectomy

Laminotomy

Microdiscectomy

Total artificial disc replacement (please indicate which of the following):

Cervical 1 level

Cervical 2 contiguous levels

Cervical 2 non-contiguous levels

Lumbar

Artificial disc combined with fusion

Must provide the brand name of artificial disc:

(Continued)

II. Which of the following other spine surgery techniques will you be using? Please indicate all techniques. (Continued)

Image-guided minimally invasive lumbar decompression (mild®)

Percutaneous sacral augmentation (Sacroplasty)

Metrx microdiscectomy system with video visualization

Metrx microdiscectomy system with direct visualization

Total facet joint arthroplasty

X-stop product

Interspinous fixation device (e.g. Coflex-F device)

Other spine stabilization technique/system:

Other spinal decompression procedure:

III. Which of the following products will you be using? Please indicate all products.

None

Autograft

Cadaver allograft

Animal allograft

Demineralized bone matrix (please indicate which of the following):

Allograft DBM

Synthetic DBM

Must provide product and company name:

Amniotic tissue membrane

Bone morphogenetic protein-7 (BMP-7)

Bone morphogenetic protein-2 (BMP-2)

Please indicate which of the following:

Infuse™ bone graft/LT-cage lumbar tapered fusion device

Infuse™ bone graft/Interfix™ threaded fusion device

Infuse™ bone graft/inter fix™ RP threaded fusion device

Other cage type (for example PEEK or other).

Must provide the brand name:

Ceramic-based products (please indicate which of the following):

Beta tricalcium phosphate (b-TCP)

Other (must provide the brand name):

Cell-based products (please indicate which of the following):

Mesenchymal stem cells

Trinity evolution

Osteocel

Infuse/Mastergraft posterolateral revision device system

Optimesh

Platelet-rich plasma (PRP)

Other products (must provide the brand name):
