Authorization Request Form - **Part 2**

Spinal Fusion and Decompression

Complete and fax the clinical worksheet immediately following the Part 1 authorization request fax form, including any substantiating clinical documentation. Your responses enable faster processing of authorization requests and reduces the likelihood we may require you to submit additional clinical documentation to complete our review.

Please fill in each question option completely ⬭ → ⬬

Question 1

Which site of the spine is symptomatic? (Required, fill in all that apply)

- ⬭ Cervical Spine
- ⬭ Thoracic Spine
- ⬭ Lumbar Spine

Question 2

For what level(s) is the request? (Required, fill in all that apply)

- ⬭ C2 - C3
- ⬭ C3 - C4
- ⬭ C4 - C5
- ⬭ C5 - C6
- ⬭ C6 - C7
- ⬭ C7 - T1
- ⬭ L1 - L2
- ⬭ L2 - L3
- ⬭ L3 - L4
- ⬭ L4 - L5
- ⬭ L5 - S1
- ⬭ Other

Question 3

If the patient has a history of smoking (includes e-cigarettes, vaping, etc.), have they been nicotine free for 6 weeks? (Required, fill in one option)

- ⬭ Yes
- ⬭ No
- ⬭ Not Applicable (Patient does not have a history of nicotine use)

Question 4

Have the patient's symptoms persisted despite non-surgical management? (Required, fill in one option)

- ⬭ Yes
- ⬭ No

Question 5

How long has conservative care occurred within the past 12 months? (Required, fill in one option)

- ⬭ No conservative care occurred
- ⬭ Greater than 4 weeks
- ⬭ Greater than 6 weeks
- ⬭ Greater than 12 weeks
- ⬭ Greater than 6 months
- ⬭ None of the above

Question 6

What type of conservative care has been attempted? (Required, fill in all that apply)

- ⬭ Activity modification
- ⬭ Electrical Stimulation (TENS)
- ⬭ Injections (Facet, Epidural, Root block, etc.)
- ⬭ Medications
- ⬭ Physical Therapy
- ⬭ Home exercise program (Core Stabilization)
- ⬭ Bracing
- ⬭ Cognitive behavioral therapy
- ⬭ Cervical collar
- ⬭ None of the above

Question 7

Does the surgeon have a preference for where the patient is discharged for post-acute care (if still appropriate at the time of discharge)? (Required, fill in one option)

- ⬭ Discharge home, no post-acute services required
- ⬭ Discharge home, outpatient Physical Therapy services required
- ⬭ Discharge home, Home Health Agency (HHA) services required
- ⬭ Discharge to Skilled Nursing Facility
- ⬭ No discharge preference indicated

Question 8

Did the patient's primary care physician provide preoperative medical clearance for this patient? (Optional, fill in one option)

- ⬭ Yes
- ⬭ No