Innovative Care Management

PO Box 22386, Portland, OR 97269
Internet Site: http:\\www.innovativecare.com
Telephone: (503) 654-9447 Fax: (503) 654-8570 Toll Free: 1-800-862-3338
Healthcare savings and satisfaction through innovation and respect.

Please complete and FAX this questionnaire with the following clinical information to 503-654-8570:

1. *Most recent* ***History & Physical***.
2. Most recent ***office visit note(s)*** documenting symptoms and conservative therapy.
3. Most recent ***imaging reports***, i.e., X-ray, MRI, CT.

Note: Please do not resend clinical if already submitted by separate fax.

Patient Name: _____ DOB: _____

Employer/Plan Name: _____ Plan ID: _____

Submitted By: _____ Phone: _____ Fax: _____

Physician: _____ Phone: _____ Fax: _____

Facility: _____ Phone: _____

Please indicate the ***date of service*** for this pending request: _____ or ☐ Not Scheduled
☐ Inpatient ☐ Outpatient

CPT code(s): _____ ICD10 code(s): _____

Please indicate the ***level(s)*** of this spinal surgery (e.g. C2-C3): _____

Will Intraoperative Nerve Monitoring (IONM) be performed during this procedure? If yes, please complete the attached IONM form and submit. ☐ Yes (See attached form.) ☐ No

As part of the review of the request, **we require documentation of the type of graft material** to be used during the procedure. Please identify the type of graft material(s) to be used below. If a combination of materials is being used, please check all appropriate boxes and fill out accompanying fields.

☐ **Synthetic Graft Material:**
Including, but not limited to, bone morphogenic protein, bone void fillers, ceramic or polymer based, etc.

Product name(s): _____ Manufacturer(s): _____

☐ **Allograft:**
Type(s): _____
e.g. cadaver, demineralized bone matrix, cancellous, morselized bone, etc.

Product name(s): _____ Manufacturer(s): _____

☐ **Autograft (Autologous) – Patient's own bone**

Please note: if a different or additional graft materials not preauthorized are used at the time of surgery, the additional graft material(s) may be reviewed for medical necessity retrospectively and applicable plan language (including Experimental & Investigational exclusions) will be considered prior to claims payment. We *strongly* encourage pre-service review of all graft materials.

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2. Most recent ***office visit note(s)*** documenting symptoms and conservative therapy.
3. Most recent ***imaging reports***, i.e., X-ray, MRI, CT.

Note: Please do not resend clinical if already submitted by separate fax for the primary procedure.

Patient Name: _____ DOB: _____

Employer/Plan Name: _____ Plan ID: _____

Submitted By: _____ Phone: _____ Fax: _____

Physician: _____ Phone: _____ Fax: _____

Facility: _____ Phone: _____

Please indicate the ***date of service*** for this pending request: _____ or ☐ Not Scheduled
☐ Inpatient ☐ Outpatient

Our records indicate there has been a request for preauthorization for a back procedure which requires we determine if Intraoperative Nerve Monitoring will be performed.

Will Intraoperative Nerve Monitoring (IONM) be performed during this procedure?

☐ Yes (Continue) ☐ No (Stop here and return form)

Will the **requesting surgeon** be performing Intraoperative Nerve Monitoring (IONM)? ☐ Yes ☐ No

If no, will **another entity** be performing Intraoperative Nerve Monitoring (IONM)? ☐ Yes ☐ No

NOTE: If the requesting surgeon will not be billing for IONM, but the outside entity will be, they will need to obtain preauthorization for the procedure.

If the requesting surgeon will be performing IONM, what type of nerve monitoring will be conducted:

Evoked Potentials – ☐ Yes ☐ No
CPT Codes: _____

Electromyographic - EMG monitoring – ☐ Yes ☐ No
CPT Codes: _____

Electroencephalographic - EEG monitoring – ☐ Yes ☐ No
CPT Codes: _____

Please fax this form to us at 503-654-8570 and include clinical information documenting the use of IONM.