SecurityHealth Plan℠
Promises kept, plain and simple.®

1515 North Saint Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000

1.800.548.1224
TTY: 711
Fax: 715.221.6616

Low Back Pain – Orthopedic or Neurosurgery Consult

Prior Authorization Request

Date _____

Member information		
Member name (print)	SMID	Date of birth (month/day/year)
Provider information		
Provider name (print)	Telephone number	Fax number
Place of service: ☐ Ambulatory Surgery Center ☐ Hospital outpatient ☐ Hospital inpatient ☐ Provider's office ☐ Other _____		
Facility where services will be provided (include address if the provider provides services at more than one practice location)		
Referring provider name (print)	Telephone number	Fax number
Referring provider's contact person name (print)	Telephone number	
Procedure information		
Scheduled date of service (month/day/year)	Requested service/procedure	Procedure code(s)
Diagnosis	Diagnosis code(s)	

Answer all of the following questions.

Is this consult needed due to an acute injury ..... ☐ Yes ☐ No

If yes, date (month/day/year) of injury _____ /_____ /_____

If yes, clinical information is not required. Submit form to Security Health Plan for notification.

Clinical presentation requiring immediate or expedited orthopedic, neurosurgical or other specialty referral:

- The patient has a history of cancer, unexplained weight loss and /or fever, recurrent nighttime pain, immunosuppression or injection drug abuse ..... ☐ Yes ☐ No
- The patient has symptoms suggesting the cauda equine syndrome (typically bowel and bladder dysfunction, e.g. urinary retention; saddle anesthesia, and bilateral leg weakness and numbness) ..... ☐ Yes ☐ No
- The patient has suspected spinal cord compression, e.g. acute neurologic deficits in a patient with cancer and risk of spinal metastases, and requires emergent evaluation for surgical decompression or radiation therapy ..... ☐ Yes ☐ No
- The patient has progressive or severe neurologic deficit ..... ☐ Yes ☐ No

If yes to above questions, do not wait for approval. Submit form to Security Health Plan for notification.

Clinical presentations appropriate for elective orthopedic or neurosurgical referral:

- History of majority low back pain greater than 3 months and **ALL** of the following:
  - Failed at least a 4-week trial of acetaminophen or NSAIDs ☐ Yes ☐ No
  - AND the patient has failed to respond to at least a 6-week course of physical therapy or 6 weeks of spinal manipulation ☐ Yes ☐ No

OR

- History of low back pain with radicular leg pain greater than 6 weeks and failed at least a 4-week trial of acetaminophen or NSAIDs. ☐ Yes ☐ No

Has patient had back surgery within the last year ☐ Yes ☐ No

If yes, date (month/day/year) of surgery _____ /_____ /_____

By signing this form, the provider attests that the above information is accurate and documented in the medical record. Security Health Plan may, at its discretion, request medical records to make a final coverage determination.

_____ _____

Provider signature Date

Pre-service decisions: Initial review is received and a coverage determination is made within fourteen (14) calendar days of receipt of request. The member and/or provider are notified in writing of a denial decision within fourteen (14) calendar days of receipt of the request.

Urgent pre-service decisions: Initial review is received and a coverage determination is made within seventy-two (72) hours of receipt of request.

Mail or fax form to: Security Health Plan Health Services Department PO Box 8000 Marshfield, WI 54449-8000 Fax 715.221.6616	**Marshfield Clinic providers route to:** Health Services Department Routing location, SHP

If you have any questions, please contact Provider Assistance at 1.800.548.1224.

