Medical Necessity Form
Lumbar Spinal Fusion

TO: UPMC Health Plan
Clinical Operations Department
U.S. Steel Tower
600 Grant Street
Pittsburgh, PA 15219

Phone: 1-800-425-7800
Fax: 412-454-2057

Patient last name: _____ Patient first name: _____

Date of birth: _____ Insurance ID#: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone number: _____ Other insurance: _____

Physician Requesting Prior Authorization: _____ Office contact: _____

Address: _____ Office phone: _____ Fax: _____

Date of service: _____ Place of service: _____

Select one: ☐ Inpatient ☐ Outpatient

Please attach all clinical documentation to support medical necessity for surgical management, including office progress notes from referring physician and/or neurosurgical/orthopedic evaluation; details of the extent and response to conservative treatment and the effects on ADLs; smoking status and evidence of smoking cessation program or counseling (as applicable); ER notes; radiology reports; physical therapy/chiropractor/osteopathic visit notes; Documentation of participation in UPMC Health Plan low Back Program (if indicated); Report demonstrating completion of evaluation and one counseling session for patients with psychological factors; and all other relevant documentation.

Does the patient have any of the following urgent conditions that do not require three-month course of conservative therapy?
Include any of the following:

☐ Acute spinal fracture w/ mechanical instability ☐ Cauda equina syndrome ☐ Grade III or IV Spondylolisthesis (>50%) slippage

☐ Spinal infection or abscess ☐ Metastatic cancer

☐ Acute neural compression or impingement w/ severe, progressive, or rapid loss of strength

Surgical procedure requested: _____ Disc levels: _____

Diagnosis codes (ICD-10 codes): _____ Procedure codes (CPT codes): _____

Has the patient participated in any of the following conservative management treatment options? Include all that apply:

☐ Prescription strength anti-inflammatory meds ≥ six-week duration

☐ Physical therapy or chiropractic/osteopathic manipulative therapy ≥ two-month duration

☐ Enrollment and graduation from the UPMC Health Plan low back pain program

☐ Epidural steroids, if medically indicated and with member consent

☐ Bracing, if medically indicated

UPMC Health Plan

Specific indications for Lumbar Spinal Fusion

Spinal Stenosis
Requires all

- ☐ Medical history and physical exam supports diagnosis
- ☐ Imaging findings consistent with symptoms, signs, and diagnosis
- ☐ Instability demonstrated by imaging
- ☐ Significant functional impairment
- ☐ Unremitting pain with radicular or neurogenic components affecting activities of daily living and no improvement after trial of conservative therapy

OR

Spondylolisthesis
Requires all

Low Grade (<50% slippage)
also required

- ☐ Moderate or severe pain with radicular or neurogenic components
- ☐ Significant functional impairment with activities of daily living
- ☐ Imaging findings confirm diagnosis and corresponding symptoms
- ☐ Failure of conservative therapy

Grades: G-1: 1-25%, G-2: 26-50%, G-3: 51-75%, G-4: 76-100%

OR

Scoliosis
(without stenosis)
Requires at least one

- ☐ Progressive deformity of over 10° in the past 12 months **OR**
- ☐ Deformity of >45° **OR**
- ☐ Deformity of >35° AND failure of non-operative pain management (>1 month of therapy) and/or functional impairment

OR

Fusion following prior spinal surgery when at least one of the following criteria are met:

Requires at least one

- ☐ Recurrent disc herniation (after at least three months from previous surgery)

1. The patient has previously been operated at the same level for disk herniation, which resulted in meaningful symptom relief for at least 3 months; **AND**
2. Recurrent disk herniation is seen on imaging at the same level that was previously operated; **AND**
3. The patient has new pain or neurological symptoms consistent with the level of recurrence; **AND**
4. The patient either has acute neurological symptoms (e.g. new onset of bowel and/or bladder incontinence, paralysis, or symptoms of CES) that cannot wait longer for surgical treatment or has been unresponsive to three months of conservative medical management (including at least pain medication and exercise)

OR

- ☐ Adjacent segment degeneration with spinal stenosis or disc herniation (after at least six months from previous surgery).

1. The patient has previously undergone fusion (for any diagnosis), which at some point resulted in substantial clinical improvement for a period of at least six months; **AND**
2. Imaging shows clear signs of disk degeneration, instability, and/or stenosis, at a level immediately adjacent to the fusion, which either were not present at the time of the original operation or have worsened from their initial state an amount that is clinically substantial; **AND**
3. The patient presents with clinically meaningful pain or neurological symptoms, which have been unresponsive to a minimum of three consecutive months of structured conservative medical management (including at least pain medication, activity modification, and daily exercise).

OR

- ☐ Failure of previous fusion (nonunion) with continued motion or loosening of hardware

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