Medical Necessity Form - Lumbar Laminectomy/Hemilaminectomy/Discectomy

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 conservative therapy? Include any of the following:

☐ Acute spinal fracture and/or major trauma
☐ Cauda equina syndrome
☐ Spinal infection or abscess
☐ Spinal tumor, epidural compression due to cancer, or metastatic cancer
☐ Acute neural compression or impingement with severe, progressive, or rapid loss of strength

Surgical procedure requested: _____

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

Does the patient have a specific indication for **Lumbar-Laminectomy, Discectomy, or Microdiscectomy** (which must include "yes" answers for ALL of the following)? Check all that apply:

Diagnosis of herniated disc or spinal stenosis; ☐ Yes ☐ No

Chronic low back pain, including one of the following: ☐ Yes ☐ No
- ☐ Motor weakness
- ☐ Loss of lower extremity reflex
- ☐ Loss of skin sensation

Imaging findings consistent with corresponding symptoms and diagnosis; AND ☐ Yes ☐ No

Unremitting pain affecting activities of daily living with no improvement after trial of conservative therapy. ☐ Yes ☐ No

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Does the patient have specific indications for **Lumbar Hemilaminectomy with/ without discectomy (including micro-disectomy) and/or foraminotomy**? Check all that apply:

Diagnosis of spinal/foraminal stenosis, herniated disc, or bone spur — with ONE of the following types of unilateral radiculopathy: ☐ Yes ☐ No

(1) Unilateral radiculopathy with motor findings and at least ONE of the following: ☐ Yes ☐ No

- ☐ Severe weakness (1-2 out of 5 strength) on physical exam (No conservative treatment required)
- ☐ Mild to moderate weakness (3-4 out of 5 strength) on physical exam and failure of a trial of conservative treatment

OR

(2) Unilateral radiculopathy with sensory findings and ALL of the following: ☐ Yes ☐ No

- Imaging findings consistent with corresponding symptoms and diagnosis ☐ Needed
- All other causes of pain have been ruled out ☐ Needed
- Unremitting pain affecting activities of daily living with no improvement after trial of conservative therapy ☐ Needed

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