Matthew H. Mead
Governor

State of Wyoming
Department of Workforce Services

DIVISION OF WORKERS' COMPENSATION
1510 East Pershing Boulevard, South Wing
Cheyenne, Wyoming 82002
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John Cox
Director
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Deputy Director

PREAUTHORIZATION CHECK SHEET
SACROILIAC (SI) FUSION

Claimant:_____ **Claim Number:**_____ **DOI:** _____
Surgeon:_____ **Phone Number:**_____ **Contact:** _____

Compensability should NOT be in question at the time of preauthorization for this procedure

1. Pre-operative work up should be documented in the medical record. **ALL CRITERIA ARE REQUIRED.**
2. Dates should be documented for all diagnostic tests performed.
3. If medical data is lacking, the surgeon will be required to provide the missing information.

SI fusions are recommended only as the last resort for chronic or severe sacroiliac joint pain. The provider must document that all reasonable, conservative treatment has been tried.

*****This procedure REQUIRES peer review by spine surgeons.*****

Per the ODG Evidence-Based Decision Support, the indications for SI fusion are:

1. Post-traumatic injury of the SI joint	☐ Yes	☐ No	Doc Date:
OR ALL OF THE CRITERIA BELOW			
1. Failure of non-operative treatment **(include specific treatment and dates)**	☐ Yes ☐ Yes ☐ Yes ☐ Yes	☐ No ☐ No ☐ No ☐ No	Doc Date: _____ Doc Date: _____ Doc Date: _____ Doc Date:
2. Chronic pain lasting for years **(include specific time frames and treatment modality if appropriate)**	☐ Yes	☐ No	

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3. Diagnosis confirmed by pain relief with intraarticular sacroiliac injections and recurrence of symptoms after the initial response. **(include specific treatments with dates)**	☐ Yes	☐ No
4. Preoperative general health and function assessed and documented	☐ Yes	☐ No
5. Retrospective review of the medical record, to include plain radiographs to determine the clinical and radiographic outcome	☐ Yes	☐ No

Requesting Surgeon Signature _____ Date _____

Workers' Comp NCM Name _____ Date _____

Sent for Peer Review _____ Date: _____

Notes: _____ Date: _____

December, 2017

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