



State of Wyoming
Department of Workforce Services
 DIVISION OF WORKERS' COMPENSATION
 1510 East Pershing Boulevard, South Wing
 Cheyenne, Wyoming 82002
<http://www.wyomingworkforce.org>



Matthew H. Mead
 Governor

John Cox
 Director
John Ysebaert
 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

- Pre-operative work up should be documented in the medical record. **ALL CRITERIA ARE REQUIRED.**
- Dates should be documented for all diagnostic tests performed.
- 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.

All requests for SI fusions that meet the required indications will be sent for peer review.

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

1. Post-traumatic injury of the SI joint	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Doc Date: _____
<u>OR ALL OF THE CRITERIA BELOW</u>			
1. Failure of non-operative treatment (include specific treat and treatment dates)	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No	Doc Date: _____ Doc Date: _____ Doc Date: _____ Doc Date: _____
2. Chronic pain lasting for years (include specific time frames and treatment modality if appropriate)		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> No



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

Requesting Surgeon Signature:

Date

Nurse Name: _____

Date: _____

Sent for Peer Review: _____

Date: _____

Notes: _____

Date: _____

December, 2014

