Matthew H. Mead
Governor

State of Wyoming
Department of Workforce Services
DIVISION OF WORKERS' COMPENSATION
1510 East Pershing Boulevard, South Wing
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John Cox
Director
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Deputy Director

PREAUTHORIZATION CHECK SHEET
SPINAL CORD STIMULATOR/DRG STIMULATOR, PERMANENT

Claimant: _____ Claim Number: _____ DOI: _____
Surgeon: _____ Phone Number: _____Contact: _____

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

A. All requirements raised in this form MUST be documented.

B. Authorization for this procedure requires prior approval by a spinal surgeon at the time of the **trial** preauthorization request

C. Trial stimulator completed for 7-14 days: _____
(Dates of actual trial must be included)

Specific Evaluation Criteria – all must be addressed.

A. Claimant diagnosis prior to the trial:	
B. Any change in Diagnosis If yes, please indicate:	☐ YES ☐ NO
C. Documented at least a 50% decrease in pain as demonstrated by 1-10 scale	☐ YES ☐ NO
D. Documented decrease in oral pain medications	☐ YES ☐ NO
E. Objective measurement of functional gain by a physical therapist (PT) or occupational therapist (OT) prior to and during trial	☐ YES ☐ NO
F. Results of urine drug screen within 30 days (does not include screen for trial preauthorization)	☐ YES ☐ NO

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G. Contraindications include:

1. Sepsis
2. Coagulopathy
3. Previous surgery or trauma that obliterates the canal
4. Localized infection at insertion/implantation site
5. Spina bifida
6. Inability to operate the system
7. Inability to demonstrate the objective functional improvement or reduction of pain
8. Future MRI's possible
9. Implanted pacemaker or defibrillator
10. Litigation in process
11. Pregnancy

Physician's Signature

Date

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