



State of Wyoming

Department of Workforce Services



Matthew H. Mead
Governor

DIVISION OF WORKERS' COMPENSATION
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John Cox
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PREAUTHORIZATION CHECK SHEET SPINAL CORD STIMULATOR TRIAL

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

- A. Compensability should NOT be in question at the time of preauthorization for this procedure.
- B. All requirements raised in this form MUST be addressed prior to submitting the record for peer review.
- C. Physicians requesting authorization must be trained to perform that procedure. **COPY OF TRAINING CERTIFICATE INCLUDED WITH TRIAL REQUEST.**
 YES NO
- D. For the DRG Stimulator, is there a confirmed diagnosis of lower extremity CRPS
 YES NO
- E. Authorization for this procedure requires prior approval by a spinal surgeon at the time of the trial preauthorization request.

F. **A TRIAL IS CONSIDERED A MINIMUM OF 7-14 DAYS.**

- I. **General indications:** Implantation of a dorsal column stimulator is approved for injured workers with chronic, intractable limb pain of a radicular nature and/or intractable low back pain following failed lumbar spine surgery and/or complex regional pain syndrome in patients who have not obtained satisfactory long term relief with oral medications, rehabilitation therapy, therapeutic nerve blocks, and biofeedback or other psychological help. Whether the procedure is performed open or percutaneously depends upon the presence of epidural fibrosis and anatomical placement required for optimal efficacy. The patient must be motivated for improvement and must understand the potential for complications.
- II. **Specific evaluation criteria – all must be addressed:** Documentation must include a precise and well understood physical anatomical etiology of the patient's pain corroborated by history, exam, imaging, and appropriate interventional diagnostic studies.

A. Claimant Diagnosis:	
B. Pertinent history to include:	
1. Anatomical description of pain pattern	<input type="checkbox"/> YES <input type="checkbox"/> NO
2. Pain character related to activity	<input type="checkbox"/> YES <input type="checkbox"/> NO
3. Pain severity using 1-10 scale	<input type="checkbox"/> YES <input type="checkbox"/> NO
4. Specific changes in pain during course of treatment	<input type="checkbox"/> YES <input type="checkbox"/> NO
5. Perceived intensity of low back and/or radicular/CRPS	<input type="checkbox"/> YES <input type="checkbox"/> NO
6. Noninvasive and invasive measures employed to reduce pain and specific response to each of these	<input type="checkbox"/> YES <input type="checkbox"/> NO



<p>C. Physical findings consistent with/corroborating lumbar radiculitis/radiculopathy or CRPS:</p> <ol style="list-style-type: none"> 1. Lumbar range of motion (degrees) flexion/extension. 2. Straight leg raise limitations (degrees). 3. Deficits in sensation/motor/reflex functions. 4. Distribution of sensory and sudomotor signs consistent with chronic regional pain syndrome (if applicable) 		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO	
<p>D. Radiographic findings that are consistent with/corroborate patient complaints and above diagnosis:</p> <ol style="list-style-type: none"> 1. Plain radiographs 2. MRI 		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____ Date: _____
<p>E. Procedural results consistent with and corroborate patient complaints.</p> <ol style="list-style-type: none"> 1. Nerve root blocks within one (1) year AND/OR 2. EMG within one (1) year 3. Other 		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____ Date: _____ Date: _____
<p>F. Independent documentation by a neurologist of radiculopathy.</p>		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>G. Objective measurement of functional gain by a physical therapist (PT) or occupational therapist (OT) prior to (and during trial)</p>		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>H. Results of urine drug screen within thirty (30) days of this request</p>		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>I. Contraindications include:</p> <ol style="list-style-type: none"> 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 objective functional improvement or reduction of pain 8. Future MRI's possible 9. Implanted pacemaker or defibrillator 10. Litigation in process 11. Pregnancy 			

Physician Signature _____ Date: _____

NCM Signature _____ Date: _____

Sent for Peer Review _____ Date: _____

