Matthew H. Mead
Governor

State of Wyoming
Department of Workforce Services

DIVISION OF WORKERS' COMPENSATION
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PREAUTHORIZATION CHECK SHEET
SPINAL 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 UNLESS NOTED TO BE OPTIONAL.**
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.

MRI or CT scan	☐ Yes	☐ No	Doc Date:
Plain Upright x-rays obtained	☐ Yes	☐ No	Doc Date: _________
a. Standing AP?	☐ Yes	☐ No	Doc Date: _________
b. Standing Lateral Flexion	☐ Yes	☐ No	Doc Date: _________
c. Standing Lateral Extension	☐ Yes	☐ No	Doc Date:
Discogram (OPTIONAL)	☐ Yes	☐ No	Doc Date:
Myelogram (OPTIONAL)	☐ Yes	☐ No	Doc Date:
Electrodiagnostics (OPTIONAL)	☐ Yes	☐ No	Doc Date:

Surgeon has clearly documented in the medical record all radiographic findings and abnormalities.	☐ Yes	☐ No
Bone Density (DEXA or SPECT) completed in all patients 51 years or older and those with risk factors for osteoporosis.	☐ Yes	☐ No
Complete history and physical documenting the need for surgery and any contraindications.	☐ Yes	☐ No
Previous spine surgeries and dates:		
Surgeon documents discussion of procedure, anticipated outcome, & claimant ability to comprehend the procedure	☐ Yes	☐ No
Body Mass Index > 40	☐ Yes	☐ No
Active smoker (smoking)	☐ Yes	☐ No
Psychological Evaluation (OPTIONAL): Date: _______________		
a. History of Psychosis (eg schizophrenia)	☐ Yes	☐ No
b. Bipolar Disorder	☐ Yes	☐ No
c. Evidence of severe depression	☐ Yes	☐ No
d. Evidence of personality disorder	☐ Yes	☐ No
Substance abuse	☐ Yes	☐ No

Mental Illness or issues affecting surgical outcome List:	☐ Yes	☐ No
Is there evidence of inability to comprehend the procedure.	☐ Yes	☐ No
Will supportive psychological care be needed post-operatively.	☐ Yes	☐ No
Psychological clearance by psychologist to have the procedure.	☐ Yes	☐ No

II. PATIENT SELECTION INDICATIONS

LUMBAR

Mechanical Spine Instability	☐ Yes	☐ No
Recurrent Disc Herniation	☐ Yes	☐ No
Spondylolisthesis	☐ Yes	☐ No
Spondylolysis	☐ Yes	☐ No
Neurogenic claudication with unilateral/bilateral radiculopathy	☐ Yes	☐ No
Spine Fracture	☐ Yes	☐ No
Spine Dislocation	☐ Yes	☐ No
Pseudarthrosis; Post-surgical complication (i.e. retained disc fragment	☐ Yes	☐ No
Post-surgical complication procedures such as laminectomy may cause a degenerative spinal segment to become unstable which may necessitate a concurrent fusion	☐ Yes	☐ No
Degenerative discogenic work related disease	☐ Yes	☐ No
*Annular tear (**MULTI-LEVEL REQUIRES PEER REVIEW**)	☐ Yes	☐ No
*Discogenic pain (**MULTI-LEVEL REQUIRES PEER REVIEW**)	☐ Yes	☐ No

CERVICAL

Cervical Herniated Disc	☐ Yes	☐ No
*Cervical disc injury such as annular tear or internal disc disruption (**MULTI-LEVEL REQUIRES PEER REVIEW**)	☐ Yes	☐ No
Cervical stenosis with or without cervical myelopathy	☐ Yes	☐ No
Spine fracture and/or dislocation	☐ Yes	☐ No
Pseudarthrosis that is a failed fusion	☐ Yes	☐ No
Other postsurgical complications requiring re-operation such as failure of the hardware, residual stenosis, or disc herniation.	☐ Yes	☐ No
Degenerative disc disease at the cervical spine considered to be work related.	☐ Yes	☐ No
Adjacent segment disease that is breakdown of a disc above or below a fusion when that disc was previously documented to be normal or with minimal degenerative changes after the initial procedure. (**MULTI-LEVEL REQUIRES PEER REVIEW**)	☐ Yes	☐ No

IV. OPERATIVE APPROVAL

Mechanical instability: Plain x-rays show anterolisthesis of >3 millimeters, or at least 3 millimeters of translation on flexion and extension views.	☐ Yes	☐ No
Spondylolisthesis/Spondylolysis/Scoliosis: x-rays, CT or MRI confirm spondylolisthesis	☐ Yes	☐ No
Recurrent disc herniation: MRI or CT confirms herniated disc at the same location which was treated with surgery in the past	☐ Yes	☐ No
Pseudarthrosis: (failed fusion) or post-surgical deformity (flat back deformity), must be confirmed by CT scan OR motion on flexion/extension X-rays at previously fused level.	☐ Yes	☐ No
Degenerative disc disease: MRI must be positive for one or more degenerative discs. If no other diagnoses are seen on MRI, the symptomatic level must be determined by discograms, nerve blocks, or other testing.	☐ Yes	☐ No
Radiculopathy: Progressive neurologic deficit in the distribution of single spinal nerve as indicated by motor deficit, sensory deficit, reflex change, or positive EMG.	☐ Yes	☐ No
MULTIPLE level fusions: **AUTOMATIC PEER REVIEW**	☐ Yes	☐ No

V. RELATIVE CONTRAINDICTIONS
REQUIRES PEER REVIEW

Tumor, Neoplasm	☐ Yes	☐ No
Arachnoiditis	☐ Yes	☐ No
History of chronic steroid use *(If a history of long term steroid use, may still have procedure if now off of steroids, bone density scan with factor > or equal 1.0, and not expected to require chronic steroid therapy in the future.)*	☐ Yes	☐ No
Spinal infection	☐ Yes	☐ No

______________________________________ ______________________

Requesting Surgeon Signature: Date

Nurse Name:______________________________ Date:__________________

Sent for Peer Review: ______________________ Date: __________________

Notes: _________________________________ Date: __________________

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