Mark Gordon
Governor

State of Wyoming
Department of Workforce Services

DIVISION OF WORKERS' COMPENSATION
1510 East Pershing Boulevard, South Wing
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Robin Sessions Cooley
Director

PREAUTHORIZATION CHECK SHEET
SPINAL CORD STIMULATOR/DRG STIMULATOR, TRIAL

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

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

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

A. All requirements raised in this form MUST be addressed prior to submitting the record for peer review.

B. Physicians requesting authorization must be trained to perform the procedure. **COPY OF TRAINING CERTIFICATE INCLUDED WITH TRIAL REQUEST.**
☐ YES ☐ NO

C. For the DRG Stimulator, is there a confirmed diagnosis of lower extremity CRPS?
☐ YES ☐ NO

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

D. **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.

E. **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	☐ YES ☐ NO
2. Pain character related to activity	☐ YES ☐ NO
3. Pain severity using 1-10 scale	☐ YES ☐ NO

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4. Specific changes in pain during course of treatment 5. Perceived intensity of low back and/or radicular/CRPS 6. Noninvasive and invasive measures employed to reduce pain and specific response to each of these			☐ YES ☐ NO ☐ YES ☐ NO ☐ YES ☐ NO
C. Physical findings consistent with/corroborating lumbar radiculitis/radiculopathy or CRPS: 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)			☐ YES ☐ NO ☐ YES ☐ NO ☐ YES ☐ NO ☐ YES ☐ NO
D. Radiographic findings that are consistent with/corroborate patient complaints and above diagnosis (within last 12 months): 1. Plain radiographs 2. MRI (of affected body part) 3. MRI of spine (to check patency of Spinal Canal for lead placement)	☐ Yes ☐ Yes ☐ Yes	☐ No ☐ No ☐ No	Date: _____ Date: _____ Date: _____
E. Procedural results consistent with and corroborate patient complaints. 1. Nerve root blocks within one (1) year **AND/OR** 2. EMG within one (1) year 3. Other	☐ Yes ☐ Yes ☐ Yes	☐ No ☐ No ☐ No	Date: _____ Date: _____ Date: _____
F. Independent documentation by a neurologist of radiculopathy.		☐ Yes	☐ No
G. Objective measurement of functional gain by a physical therapist (PT) or occupational therapist (OT) prior to (and during trial)		☐ Yes	☐ No
H. Results of urine drug screen within thirty (30) days of this request		☐ Yes	☐ No
I. 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 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: _____

Sent for Peer Review_____ Date:_____

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