Authorization Request Form - **Part 2**

# Spinal Cord Stimulators

Complete and fax the clinical worksheet immediately following the Part 1 authorization request fax form, including any substantiating clinical documentation. Your responses enable faster processing of authorization requests and reduces the likelihood we may require you to submit additional clinical documentation to complete our review.

**Please fill in each question option completely** ⬭ → ⬬

## Question 1

**Which type of stimulator device is being considered? (Required, fill in one option)**

- ⬭ Spinal Cord Stimulator
- ⬭ Dorsal Root Ganglion stimulator (DRG)
- ⬭ Bladder Stimulator
- ⬭ Gastric Stimulator
- ⬭ Optic Nerve Stimulator
- ⬭ Phrenic Nerve Stimulator
- ⬭ Peripheral Nerve Stimulator
- ⬭ Other Neurostimulator

## Question 2

**Which of the following is being requested? (Required, fill in one option)**

- ⬭ Trial placement of stimulator
- ⬭ Permanent implantation of stimulator

## Question 3

**Does the patient have any of the following? (Required, fill in all that apply)**

- ⬭ Complex regional pain syndrome (CRPS)/reflex sympathetic dystrophy
- ⬭ Failed back surgery syndrome (FBSS) with primarily radicular pain
- ⬭ Inoperable chronic limb ischemia
- ⬭ Chronic pain syndrome
- ⬭ Chronic radicular pain
- ⬭ Cervical level spinal cord stimulation
- ⬭ Dorsal root ganglion stimulation
- ⬭ Simultaneous use of SCS and intrathecal opioid therapy/implantable infusion pump
- ⬭ Individuals with cardiac pacemakers and/or defibrillators
- ⬭ None of the above

## Question 4

**In the past 12 months, how long has the patient been receiving conservative care? (Required, fill in one option)**

- ⬭ No conservative care occurred
- ⬭ Greater than 6 weeks
- ⬭ Greater than 12 weeks
- ⬭ Greater than 6 months
- ⬭ None of the above options apply

## Question 5

**What type of other treatment modalities have been attempted? (Required, fill in all that apply)**

- ⬭ Pharmacological
- ⬭ Failed Surgery or not a candidate for surgical intervention
- ⬭ Physical Therapy
- ⬭ Psychological (cognitive behavioral therapy)
- ⬭ No modalities used since no conservative care attempted

## Question 6

**Has pain persisted despite other treatment modalities (pharmacological, surgical, physical and psychological therapies) that have been tried for six consecutive months? (Required, fill in one option)**

- ⬭ Yes, pain has persisted despite conservative care
- ⬭ No, pain has persisted BUT they have not attempted conservative care
- ⬭ No, pain has not persisted

## Question 7

**Has a psychological evaluation been obtained and determined that the individual is an acceptable candidate? (Required, fill in one option)**

- ⬭ Yes
- ⬭ No

Questions continued on following page

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**Please fill in each question option completely** ⬭ → ⬬

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|---|---|
| **Question 8** | **Has the individual undergone careful screening, physical evaluation and diagnosis by a multidisciplinary team prior to implantation? (Required, fill in one option)**<br>⬭ Yes<br>⬭ No |
| **Question 9** | **If this is a request for a permanent electrode placement, has a temporary trial of at least two days duration been completed? (Required, fill in one option)**<br>⬭ Yes, a temporary trial of two days has been completed<br>⬭ No, a temporary trial of two days has not been completed<br>⬭ No, this is a request for a Temporary Percutaneous Electrode Placement |
| **Question 10** | **Demonstration of at least 50% reduction in symptoms and improved function with the temporary implanted electrode prior to the permanent implantation? (Required, fill in one option)**<br>⬭ Yes<br>⬭ No<br>⬭ Not applicable, this is the first request |
| **Question 11** | **Which manufacturer's device is being used? (Required, fill in one option)**<br>⬭ Boston Scientific<br>⬭ Medtronic<br>⬭ Nevro<br>⬭ Abbot<br>⬭ Other |
| **Question 12** | **Does the surgeon have a preference for where the patient is discharged for post-acute care (if still appropriate at the time of discharge)? (Required, fill in one option)**<br>⬭ Discharge home, no post-acute services required<br>⬭ Discharge home, outpatient Physical Therapy services required<br>⬭ Discharge home, Home Health Agency (HHA) services required<br>⬭ Discharge to Skilled Nursing Facility<br>⬭ No discharge preference indicated |
| **Question 13** | **Did the patient's primary care physician provide preoperative medical clearance for this patient? (Optional, fill in one option)**<br>⬭ Yes<br>⬭ No |