Authorization Request Form - **Part 2**

Neuromuscular Stimulators (Spinal Cord Injury)

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

What level is the patient's spinal cord injury? (Required, fill in all that apply)

- ⬭ Cervical
- ⬭ Lumbar
- ⬭ Thoracic

Question 2

Which of the following findings were documented at the most recent encounter? (Required, fill in all that apply)

- ⬭ Brisk muscle contraction to functional electrical stimulator and sensory perception of electrical stimulation sufficient for muscle contraction
- ⬭ Ability to manipulate controls with hands and fingers
- ⬭ Ability to transfer independently and demonstrate independent standing tolerance for at least three minutes
- ⬭ Demonstrate a willingness to use the device long-term
- ⬭ Intact lower (L1 and below) motor units (both muscle and peripheral nerve)
- ⬭ Muscle and joint stability for weight bearing at upper and lower extremities that can demonstrate balance and control to maintain an upright support posture independently
- ⬭ Possess high motivation, commitment and cognitive ability to use such devices for walking
- ⬭ None of the above

Question 3

Has it been at least six months since the patient's spinal cord injury and/or restorative surgery? (Required, fill in one option)

- ⬭ Yes
- ⬭ No

Question 4

Has the patient completed a training program of at least 32 Physical Therapy sessions with the device over a three-month period? (Required, fill in one option)

- ⬭ Yes
- ⬭ No

Question 5

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

- ⬭ Autonomic Dysreflexia
- ⬭ Cardiac pacemakers
- ⬭ Presence of irreversible contracture
- ⬭ Presence of skin disease or cancer at area of stimulation
- ⬭ Severe osteoporosis
- ⬭ Hip and knee degenerative disease and no history of long bone fracture secondary to osteoporosis
- ⬭ Severe scoliosis
- ⬭ None of the above

Question 6

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)

- ⬭ Discharge home, no post-acute services required
- ⬭ Discharge home, outpatient Physical Therapy services required
- ⬭ Discharge home, Home Health Agency (HHA) services required
- ⬭ Discharge to Skilled Nursing Facility
- ⬭ No discharge preference indicated