Mark Gordon
Governor

State of Wyoming
Department of Workforce Services
DIVISION OF WORKERS' COMPENSATION
5221 Yellowstone Rd
Cheyenne, Wyoming 82002
http://www.wyomingworkforce.org

Robin Sessions Cooley, J.D.
Director
Elizabeth Gagen, J.D.
Deputy Director

SPINAL CORD STIMULATOR PERMANENT POLICY CHECKLIST

Date: _____ Date of Procedure (if scheduled)_____

Claimant Name:_____ Claim Number: _____

Date of Birth:_____ ***Date of Injury**: _____

Requesting Physician: _____

****Per Rules and Regulations; Chapter 10, Section 32: "The Division shall not authorize payment for any neurostimulator procedures, including spinal cord dorsal stimulators and dorsal root ganglion neuroaugmentation, or any medical or surgical costs related to the placement, revision, or removal of any spinal cord stimulator." This applies to any claim with a Date of Injury after April 16, 2020.***

Spinal cord stimulators (SCS) may be recommended on a case-by-case basis for the following indications:

• Failed back surgery with persistent leg pain that is determined to be related to nerve damage from the initial pathology and/or surgery as confirmed by exam and electrodiagnostic study.
• Neuropathic pain in post-spinal surgery patients in which there is no evidence of a nociceptive component to symptoms.
• Chronic Regional Pain Syndrome (CRPS)

SCS are not recommended for the following indications:
• Not recommended for radiculopathy in patients who have not undergone spinal surgery.
• Not recommended for axial back pain in patients who have not undergone spinal surgery.
• Not recommended to facilitate weaning of pain medications.
• Not recommended to remove a current functional SCS (such as a traditional/tonic model) and replace with a newer waveform technology until there is documentation of a need for battery change or other medical necessity.
• Not recommended as a salvage treatment by replacing a traditional/tonic SCS that has failed with a newer waveform model, such as high frequency or burst.
• Not recommended to perform a repeat trial in patients who have failed a trial of SCS in the past.
• Not recommended for patients who will require future MRI evaluation for existing pathology.

- ***Request for the trial and request for the permanent must be submitted separately.***
- ***Trial period to last 7-14 days.***
- ***Functional analysis performed by an independent PT/OT PRIOR to and DURING the trial.***
- ***The permanent placement will not be approved unless specific criteria are met from the trial.***
- ***Requests will be sent for Peer Review at the time of the initial request for the trial placement, which can take up to 45 days. A second Peer review is not required for the permanent placement. Permanent placement requests will be reviewed for evidence of a successful SCS Trial as outlined.***
- ***Provider bulletins and check sheets are available at: http://wyomingworkforce.org***

Specific evaluation criteria – all must be addressed:

The following criteria must be met within 45 days from date of request or no further action will be taken

ALL QUESTIONS MUST BE ADDRESSED OR REQUEST WILL BE DEEMED INCOMPLETE

A. Authorization for this procedure requires prior approval by Peer Review at the time of the Trial preauthorization request.

B. Date of Peer Approval for Trial:_____

C. Trial completed for 7-14 days Date:_____to_____

Claimant Diagnosis:	ICD-10 Code
1. Documented at least 50% decrease in pain as documented on a 0-10 scale.	☐ YES ☐ NO
2. Documented decrease in oral pain medications.	☐ YES ☐ NO
3. Objective measurement of functional gain by a physical therapist (PT) or occupational therapist (OT) prior to and during trial. This should include a pain drawing before and after	☐ YES ☐ NO

4. Results of urine drug screen within thirty (30) days of this request and documentation of consistent drug screens over the past year.	☐ YES ☐ NO Date_____
5. Any contraindications: (select all that apply)	☐ YES ☐ NO
☐ Litigation in process	
☐ History of drug abuse, alcohol use disorder	
☐ History of suicidal ideation or suicide attempt	
☐ Chronic high dose opioid use – (>90 MEQ/MED) SCS is not indicated for reduction of medications	
☐ Elevated BMI/Obesity	
☐ Current tobacco use	
☐ History of infection/ sepsis/ localized infection	
☐ Coagulopathy	
☐ Previous surgery obliterating the spinal canal	
☐ Inability for patient or caregiver to understand/ operate system	
☐ Need for future MRI	
☐ Psychological factors (see above)	
☐ Pregnancy	

Physician Signature _____

Date:_____

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Fax 1-307-777-8724
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