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Governor

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Department of Workforce Services
DIVISION OF WORKERS' COMPENSATION
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SPINAL CORD STIMULATOR TRIAL POLICY & CHECKLIST
Chronic Regional Pain Syndrome (CRPS)

*****This procedure REQUIRES Peer Review*****

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.

Based on review by the Wyoming Medical Commission and active practicing spine surgeons, any request for preauthorization for SCS *or any neurostimulator procedures* with a claim date prior to April 16, 2020 will be reviewed on a case-by-case basis as a third-line, last resort treatment. All requests will be sent to Peer Review utilizing the updated associated Spinal Cord Stimulator Policy Checklist(s). All items identified are required.

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

Claimant Diagnosis:	ICD-10 Code
1. A clinical diagnosis of CRPS can be made when the following criteria are met. Please check all that apply and date documented	
☐ Continuing pain disproportional to any inciting event	Date of onset:
☐ Symptoms present for more than one year	☐ YES ☐ NO
☐ Diagnosis verified by more than one physician Independent Examiner: _____	☐ YES ☐ NO Date: _____ Date:_____
At least 1 symptom reported in at least 3 of the following categories **(select all that apply)**	☐ YES ☐ NO Date:_____
☐ Sensory: Hyperesthesia or allodynia	
☐ Vasomotor: Temperature asymmetry, skin color changes, skin color asymmetry	
☐ Sudomotor/edema: Edema, sweating changes, or sweating asymmetry	
☐ Motor/trophic: Decreased range of motion, motor dysfunction (eg, weakness, tremor, dystonia), or trophic changes (eg, hair, nail, skin)	
At least 2 signs at the time of evaluation in at least two of the following categories with dated color photographs documenting findings of color change, dystonia, trophic changes. **(select all that apply)**	☐ YES ☐ NO Date:_____

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☐ Sensory: Evidence of hyperalgesia (to pinprick), allodynia (to light touch, temp sensation, deep somatic pressure, or joint movement)	
☐ Vasomotor: Evidence of temperature asymmetry (>1°C), skin color changes or asymmetry	
☐ Motor/trophic: Evidence of decreased range of motion, motor dysfunction (eg, weakness, tremor, dystonia), or trophic changes (eg, hair, nail, skin).	
There is no other diagnosis that better explains the signs and symptoms: all other potential diagnoses have been ruled out, including somatization, factitious syndrome, personality disorder, malingering and/or other psychological/ psychiatric diagnoses. This should include a list of other diagnoses considered and process of ruling these out. With documentation of referral to appropriate specialists to address differential diagnoses.	☐ YES ☐ NO
2. All pertinent history AS DOCUMENTED in the medical records: A. Anatomical description of pain pattern accompanied by symptom diagram. B. Pain character related to activity C. Pain severity using 1-10 scale range to include average, best, and worst. D. AAOS Lower Limb Outcome Scale, DASH, or PDQ as indicated. E. Noninvasive and invasive measures employed to reduce pain and specific response to each of these. F. Treatment history a. Surgical Procedure(s) ☐ YES ☐ NO Procedure: _____ Date:_____ b. Injections ☐ YES ☐ NO c. Medications ☐ YES ☐ NO d. Psychosocial and behavioral management ☐ YES ☐ NO	☐ YES ☐ NO
3. Radiographic findings that are consistent with/corroborate patient complaints and above diagnosis (within last 12 months): A. Plain radiographs B. MRI (of affected body part) C. MRI of spine (to check patency of Spinal Canal for lead placement)	☐ YES ☐ NO A. Date_____ B. Date_____ C. Date_____
4. 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 Date_____
5. 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_____
6. Psychological evaluation to be performed by an independent psychologist with no conflict of interest. A one-on-one evaluation is required with inclusion of psychometric testing (MMPI-2RF or BHI-2). Substance use disorder screen should also be included.	☐ YES ☐ NO Date_____

7. 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	
☐ Pregnancy	

8. Physicians requesting authorization must be trained to perform this procedure.
COPY OF TRAINING CERTIFICATE INCLUDED WITH TRIAL REQUEST IS REQUIRED.

☐ YES

Physician Signature _____

Date:_____

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