



Mark Gordon
Governor

State of Wyoming
Department of Workforce Services
 DIVISION OF WORKERS' COMPENSATION
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PREAUTHORIZATION CHECK SHEET
SPINAL FUSION

Claimant: _____ **Claim Number:** _____ **DOI:** _____
Surgeon: _____ **Phone Number:** _____ **Contact:** _____

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

1. Pre-operative work up should be documented in the medical record. **ALL CRITERIA ARE REQUIRED.**
2. Dates should be documented for all diagnostic tests performed.
3. If medical data is lacking, the surgeon will be required to provide the missing information.

1. MRI or CT scan (within last 12 months)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Doc Date: _____
2. Plain Upright x-rays obtained (within last 12 months)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Doc Date: _____
a. Standing AP?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Doc Date: _____
b. Standing Lateral Flexion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Doc Date: _____
c. Standing Lateral Extension	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Doc Date: _____
3. Surgeon has clearly documented in the medical record all radiographic findings and abnormalities.	<input type="checkbox"/> Yes		<input type="checkbox"/> No
4. Complete history and physical documenting the need for surgery and any contraindications.	<input type="checkbox"/> Yes		<input type="checkbox"/> No
5. Previous spine surgeries and dates:			
6. Surgeon documents discussion of procedure, anticipated outcome, & claimant ability to comprehend the procedure	<input type="checkbox"/> Yes		<input type="checkbox"/> No
7. Is there evidence of inability to comprehend the procedure.	<input type="checkbox"/> Yes		<input type="checkbox"/> No

I. PATIENT SELECTION INDICATIONS

LUMBAR

1. Mechanical Spine Instability	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Recurrent Disc Herniation	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Spondylolisthesis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Spondylolysis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Neurogenic claudication with unilateral/bilateral radiculopathy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Spine Fracture	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Spine Dislocation	<input type="checkbox"/> Yes	<input type="checkbox"/> No

8. Pseudarthrosis; Post-surgical complication (i.e. retained disc fragment)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Post-surgical complication procedures such as laminectomy may cause a degenerative spinal segment to become unstable which may necessitate a concurrent fusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Degenerative discogenic work related disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. *Annular tear (MULTI-LEVEL REQUIRES PEER REVIEW)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12. *Discogenic pain (MULTI-LEVEL REQUIRES PEER REVIEW)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

CERVICAL

1. Cervical Herniated Disc	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. *Cervical disc injury such as annular tear or internal disc disruption (MULTI-LEVEL REQUIRES PEER REVIEW)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Cervical stenosis with or without cervical myelopathy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Spine fracture and/or dislocation	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Pseudarthrosis that is a failed fusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Other postsurgical complications requiring re-operation such as failure of the hardware, residual stenosis, or disc herniation.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Degenerative disc disease at the cervical spine considered to be work related.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Adjacent segment disease that is breakdown of a disc above or below a fusion when that disc was previously documented to be normal or with minimal degenerative changes after the initial procedure. (MULTI-LEVEL REQUIRES PEER REVIEW)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

II. OPERATIVE APPROVAL

1. Mechanical instability: Plain x-rays show anterolisthesis of >3 millimeters, or at least 3 millimeters of translation on flexion and extension views.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Spondylolisthesis/Spondylolysis/Scoliosis: x-rays, CT or MRI confirm spondylolisthesis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Recurrent disc herniation: MRI or CT confirms herniated disc at the same location which was treated with surgery in the past	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Pseudarthrosis: (failed fusion) or post-surgical deformity (flat back deformity), must be confirmed by CT scan OR motion on flexion/extension X-rays at previously fused level.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Degenerative disc disease: MRI must be positive for one or more degenerative discs. If no other diagnoses are seen on MRI, the symptomatic level must be determined by discograms, nerve blocks, or other testing.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Radiculopathy: Progressive neurologic deficit in the distribution of single spinal nerve as indicated by motor deficit, sensory deficit, reflex change, or positive EMG.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. MULTIPLE level fusions: **AUTOMATIC PEER REVIEW*	<input type="checkbox"/> Yes	<input type="checkbox"/> No

III. RELATIVE CONTRAINDICATIONS

*****REQUIRES PEER REVIEW*****

1. Tumor, Neoplasm	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Arachnoiditis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. History of chronic steroid use <i>(If a history of long term steroid use, may still have procedure if now off of steroids, bone density scan with factor > or equal 1.0, and not expected to require chronic steroid therapy in the future.)</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Spinal infection	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Requesting Surgeon Signature

Date

Sent for Peer Review: _____

Date: _____

Notes: _____

Date: _____

