PEHP Health & Benefits

PRIOR AUTHORIZATION for SPINAL CORD STIMULATOR (SCS) / DORSAL ROOT GANGLION STIMULATION (DRG)

For authorization, please complete this form, include patient chart notes to document information and FAX to the PEHP Prior Authorization Department at (801) 366-7449 or mail to: 560 East 200 South Salt Lake City, UT 84102. If you have prior authorization or benefit questions, please call PEHP Customer Service at (801) 366-7555 or toll free at (800) 753-7490.

Section I: PATIENT INFORMATION

Name (Last, First MI):	DOB:	Age:	PEHP ID #:

Section II: PROVIDER INFORMATION

Date Requested:		Ordering Physician:
Physician Provider NPI #:	Physician Tax ID #:	Physician Address:

Contact Person:	Phone: ( )	Facsimile: ( )

Section III: PRE-AUTHORIZATION REQUEST

Nature of Request: *Please check.* ☐ Auth Extension ☐ Pre-Auth ☐ Retro Auth ☐ Urgent	**Requested Date of Service:**	**Place of Service:** *Please check.* ☐ Ambulatory Surgical Center ☐ Inpatient ☐ Office ☐ Outpatient

Facility Name:	**Facility NPI #:**	**Facility Tax ID #:**

Primary Diagnosis/ICD-10 Code:	**Secondary Diagnosis/ICD-10 Code:**

Service (s) Requested: *Please list all requested services/CPT codes regardless of pre-authorization requirement.*

Procedure/Service: _____ CPT/HCPCS code: _____
Procedure/Service: _____ CPT/HCPCS code: _____
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Procedure/Service: _____ CPT/HCPCS code: _____

A. Spinal Cord Stimulator (SCS) Service Being Requested: *Please check.*

☐ Pulse Generator/Receiver Replacement ☐ Permanent Implantation ☐ Removal ☐ Replacement/Warranty Expired ☐ Revision ☐ Trial

B. Type of Stimulator Being Requested: *Please check.*

1. ☐ Cervical SCS 2. ☐ Dorsal Root Ganglion Stimulator 3. ☐ Lumbar SCS 4. ☐ Thoracic SCS 5. ☐ Other (*please specify*): _____

(Please check service being requested.) **QUESTION**	**YES**	**NO**	**COMMENTS/NOTES**
C. ☐ **Trial & Permanent Implantation of Stimulator:**			
1. Is the prescribing physician board certified in pain management and anesthesiology?	☐	☐	*Please submit copy of certifications.*
2. Has conventional medical treatment (pharmacological, surgical, physical, and/or psychological) failed?	☐	☐	
3. Has the patient exhausted all other available treatment options?	☐	☐	
4. Is there evidence of an existing untreated drug addiction?	☐	☐	
5. Was it determined that the pain is not psychological in origin through a psychological evaluation?	☐	☐	*Please submit report.*
5. a. Has the patient undergone any of the following psychological testing? *Please check all that apply.* 1. ☐ Beck Depression Inventory (BDI) 2. ☐ Hospital Anxiety and Depression Scale (HADS) 3. ☐ MMPI-2-RF (Minnesota Multiphasic Personality Inventory-2-Restructured Form) 4. ☐ Pain Self-Efficacy Questionnaire (PSEG)	☐	☐	*Please submit all psychological testing reports, including scores.*
6. Are there any contraindications to implantation (i.e. sepsis or coagulopathy issues)?	☐	☐	
7. Is **Dorsal Root Ganglion (DRG) Stimulator** being requested for any of the following conditions? *Please check.* ☐ Complex Regional Pain Syndrome (CRPS) Type I or II ☐ Failed Back Surgery at or below T9 ☐ Peripheral Nerve Damage/Causalgia (severe burning pain) of the Lower Extremity, including the Pudendal Nerve.	☐	☐	
8. Is **Spinal Cord Stimulator (SCS)** being requested for Complex Regional Pain Syndrome (CRPS) Type I or II?	☐	☐	

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(Please check service being requested.) **QUESTION (*cont'd*)**	YES	NO	COMMENTS/NOTES
9. Is **SCS** being requested for Failed (Lumbar) Back Surgery Syndrome (FBSS) with the patient having persistent low back pain and significant radicular pain?	☐	☐	
10. Is **SCS** being requested as a last resort treatment of severe painful diabetic neuropathy?	☐	☐	
10. a. Has nondiabetic etiologies been excluded as the cause of the severe painful neuropathy?	☐	☐	
10. b. Does the patient have stabilized glycemic control?	☐	☐	*Please submit most recent Hemoglobin A1C (HbA1c) result.*
10. c. Has the patient failed any of the following drug classes? *Please check all that apply.* 1. ☐ Anticonvulsants (e.g., gabapentin, typical dose 1.8 g/day) 2. ☐ Opioid or Opioid-Like Drugs (e.g., tramadol or controlled release oxycodone) 3. ☐ Tricyclic Drugs (e.g., amitriptyline 25 to 150 mg before bed)	☐	☐	
11. Is **DRG/SCS** being requested for any of the following conditions? *Please check all that apply.* ☐ Cancer Pain ☐ Central Deafferentation Pain *(due to CNS damage from a stroke or complete spinal cord injury)* ☐ Cervical Trauma ☐ Cervical Disc Herniation ☐ Cervicogenic Headache ☐ Chronic Low Back Pain ☐ Critical Limb Ischemia (*as a technique to forestall amputation*) ☐ Drug-Refractory Chronic Cluster Headaches ☐ Failed Cervical Spine Surgery Syndrome presenting with arm and neck pain ☐ Intractable Angina ☐ Migraine Headaches ☐ Nociceptive Pain (*resulting from irritation, not nerve damage*) ☐ Occipital Nerve Pain ☐ Peripheral Vascular Disease (PVD) ☐ Postherpetic Neuralgia ☐ Radiation-Induced Brain Injury ☐ Stroke ☐ Visceral Pain	☐	☐	
D. ☐ **Permanent Implantation of Stimulator:** *Completion of Section C. also required for permanent.* 1. Did the patient's symptoms improve by at least 50% during a minimum of 72-hour clinical trial of temporary percutaneous electrodes?	☐	☐	*Completion of Section C. and documented response to the trial required.*
E. ☐ **Replacement of Stimulator:** *Completion of Section C. also required for replacement.* 1. Can the existing stimulator and/or battery (generator) be replaced under warranty?	☐	☐	*Completion of Section C. also required.*
F. ☐ **Revision or Removal of Stimulator:** 1. Is revision or removal of stimulator indicated for any of the following reasons? *Please check.* ☐ Development of Neurological Deficits ☐ Infection ☐ Intolerance by Patient ☐ Loss of Effectiveness ☐ Migration of Lead(s) ☐ Need for AICD (Automatic Implantable Cardioverter Defibrillator) ☐ Need for MRI Study ☐ Painful Generator Site	☐	☐	

Additional Comments:

Please fax completed form and medical records to 801-366-7449.