



Common Ground Healthcare Cooperative
 PO Box 1630
 Brookfield, WI 53008-1630
 T: 877.825.9293 | F: 715.221.9749

HEALTHCARE COOPERATIVE

Spinal Cord Stimulator

Prior Authorization Request

Date _____

Member information		
Member name (print)	SMID	Date of birth (month/day/year)
Provider information		
Provider name (print)	Telephone number	Fax number
Place of service: <input type="checkbox"/> Ambulatory Surgery Center <input type="checkbox"/> Hospital outpatient <input type="checkbox"/> Hospital inpatient <input type="checkbox"/> Provider's office <input type="checkbox"/> Other _____		
Facility where services will be provided (include address if the provider provides services at more than one practice location)		
Contact person name (print)	Telephone number	Fax number
Procedure information		
Scheduled date of service (month/day/year)	Requested service/procedure	Procedure code(s)
Diagnosis	Diagnosis code(s)	

Answer all of the following questions.

What type of placement is this spinal cord stimulator for:

- Temporary..... Yes No
 If yes, date placed (month/day/year) _____ / _____ / _____
- Permanent..... Yes No

Conventional conservative medical management have been tried for greater than or equal to 6 consecutive months and did not prove satisfactory, or are judged to be unsuitable or contraindicated. Must include **1 or more** of the following:

- For limb ischemia, failed surgical or endovascular revascularization, or inoperable vascular disease..... Yes No
- For neuropathic pain, stellate ganglion or lumbar sympathetic block..... Yes No
- Pharmacotherapy Yes No
- Physical therapy Yes No
- Psychotherapy or cognitive behavioral therapy Yes No

Patients have undergone careful screening, evaluation, and diagnosis by a multi-disciplinary team prior to implantation. This screening must include psychological and physical evaluation... Yes No

The facilities, equipment, and professional and support personnel required for the proper diagnosis, treatment training, and follow-up of the patient, including that required to satisfy the preceding requirement, must be available Yes No

Demonstration of pain relief with a temporarily implanted electrode precedes permanent implantation (significant pain reduction [greater than or equal to 50%] with a 3 – 7 day trial of percutaneous spinal stimulator) Yes No

Patient capable of operating stimulating device Yes No

No cardiac pacemaker or implantable defibrillator Yes No

No coagulopathy, severe thrombocytopenia, or anticoagulant or antiplatelet therapy Yes No

No current or chronic infection Yes No

Member does not have any untreated existing drug addiction problems, per American Society of Addiction Medicine (ASAM) guidelines Yes No

By signing this form, the provider attests that the above information is accurate and documented in the medical record. CGHC may, at its discretion, request medical records to make a final coverage determination.

Provider signature

Date

Pre-service decisions: Initial review is received and a coverage determination is made within fourteen (14) calendar days of receipt of request. The member and/or provider are notified in writing of a denial decision within fourteen (14) calendar days of receipt of the request.

Urgent pre-service decisions: Initial review is received and a coverage determination is made within seventy-two (72) hours of receipt of request.

Mail or fax form to: **Common Ground Healthcare Cooperative**
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If you have any questions, please contact Customer Service at 1.877.514.2442.