SecurityHealth Plan℠
Promises kept, plain and simple.®

1515 North Saint Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000

1.800.472.2363 | 715.221.9555
TTY: 711

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: ☐ Ambulatory Surgery Center ☐ Hospital outpatient ☐ Hospital inpatient ☐ Provider's office ☐ 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. Security Health Plan 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:	Security Health Plan Health Services Department PO Box 8000 Marshfield, WI 54449-8000 Fax 715-221-6616	**Marshfield Clinic providers route to:** Health Services Department Routing location, SHP

If you have any questions, please contact Customer Service at 1-800-548-1224.

