

Review Request for
Implanted Spinal Cord Stimulators (SCS)

Please fax the completed form to **1-800-823-5520**.

If you have questions, call **1-866-902-1689** during regular business hours.

Provider Data Collection Tool Based on Medical Policy SURG.00060



Policy Last Review Date: 02/26/2 Policy Effective Date: 04/22/2 Provider Tool Effective Date: 01/27/2

Member Name:	Date of Birth:
Insurance Identification Number:	Member Phone Number:
Ordering Provider Name and Specialty:	Provider ID Number:
Office Address:	
Office Phone Number:	Office Fax Number:
Rendering Provider Name and Specialty:	Provider ID Number:
Office Address:	
Office Phone Number:	Office Fax Number:
Facility Name:	Facility ID Number:
Facility Address:	
Date/Date Range of Service:	Place of Service: <input type="checkbox"/> Home <input type="checkbox"/> Inpatient
Service Requested (CPT if known):	<input type="checkbox"/> Outpatient <input type="checkbox"/> Other: _____
Diagnosis (ICD-9) if known:	

Please check all that apply to the member:

- Request is for a spinal cord stimulator for (check all that apply):
 - Temporary implantation
 - Permanent implantation
- Member has (check all that apply):
 - Chronic (greater than 6 months duration), intractable neuropathic pain
 - Critical limb ischemia
 - Other (Please specify/describe): _____

Member meets the following criteria (check all that apply):

- There is documentation in the medical record of the failure of 6 months of conservative treatment modalities (pharmacologic, surgical, psychological or physical), if appropriate and not contraindicated
- Further surgical intervention is not indicated
- Psychological evaluation has been obtained
- There is documentation clearly stating the pain is not psychological in origin

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0810 SCW2950 09/28/10

- No contraindications for implantation exist such as (check all that apply):
- Member has sepsis
 - Member has a coagulopathy
 - Other (Please list): _____
- There is objective documentation of pathology in the medical record
- A temporary trial of spinal cord stimulation has been successful as defined by a 50% reduction in pain for at least 2 days
- Improvement in function documented in the medical record
- Other Please list): _____
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This request is being submitted:

- Pre-Claim
- Post-Claim. If checked, please attach the claim or indicate the claim number: _____

I attest the information provided is true and accurate to the best of my knowledge. I understand that BlueChoice HealthPlan Medicaid may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

Name and Title of Provider or Provider Representative
Completing Form and Attestation (Please Print)*

Date

*** The attestation fields must be completed by a provider or provider representative in order for the tool to be accepted.**