SCS Prior Authorization Submission List

Use this checklist every time your team prepares a prior authorization request for Spinal Cord Stimulation (SCS), whether it's for a trial or a permanent implant.

1. Verify Payer Timelines & Pre-Submission Requirements
Before initiating anything, confirm:

Timeline Expectations

- Payer's standard review timeframe verified (most require ~2 weeks for review).
- Patient not scheduled for the procedure for at least 3 weeks from submission date to avoid cancellations or rescheduling.

Payer-Specific Requirements

- Any special payer processes identified (e.g., UnitedHealthcare often requires peer-to-peer reviews for SCS).
- Required forms, portals, and submission formats reviewed.
- Payer's medical necessity policy for SCS reviewed for recent updates.

2. Gather & Validate All Required Clinical Documentation
Ensure the documentation package is complete and internally validated before submission.
Diagnostic & Clinical Evidence

- Imaging reports related to the pain condition (MRI, CT, X-ray, as applicable).
- Pain diagram clearly mapping the patient's pain distribution.
- Pain history including onset, progression, and prior impacts.
- Functional limitations documented (ADLs, work limitations, mobility issues).

Conservative Therapy Documentation

- Record of all conservative therapies tried.
- Duration of each therapy (e.g., PT, medications, injections).
- Documented clinical outcomes or lack of improvement.

Psychological Evaluation

- Completed psychological evaluation included (required by most payers).
- Any contraindications addressed.

Provider Attestation

- Clear provider statement explaining why the patient is an appropriate candidate for neuromodulation.
- Attestation includes medical necessity rationale aligned with payer policy.

- Provider signature and date included.

3. Confirm Coding & Submission Accuracy

Coding Review

- Correct CPT/HCPCS codes selected (trial vs permanent).
- Diagnosis codes support medical necessity.
- SCS device type and lead configuration documented correctly.

Submission Validation

- All required attachments uploaded.
- Prior authorization form completed accurately.
- Clinical summary uploaded with correct formatting and clarity.
- Submission date documented for tracking.

4. Ensure Internal Operational Alignment
This step minimizes downstream denials and improves communication.

Cross-Team Checkpoint

- Front desk understands the expected timeline and avoids premature scheduling.
- Medical assistants are aware of their documentation responsibilities.
- Providers notified if additional documentation or clarification is needed.
- Billing team pre-reviews for downstream claim implications.

Communication Loop

- A designated team member assigned to track the request.
- Payer follow-up dates entered into task system.
- Alerts set for peer-to-peer requests if applicable.

5. Final Approval & Pre-Procedure Verification

Approval Confirmation

- Authorization approval received in writing.
- Authorization number saved in EHR and billing system.
- Validity dates verified to ensure no lapse.

Scheduling Readiness

- Only schedule the patient once approval is confirmed.
- Patient notified of approval and next steps.
- Team prepared for any payer-specific pre-procedure requirements.