

## Interventional Pain Management Quick Reference Guide

### Diagnosis/Procedure Information

- Primary Diagnosis Code(s)
- CPT code(s) and/or modifiers , units, spinal region (cervical, thoracic, lumbar), spinal level (e.g. C2-C3, L5-S1) and side of procedure (right, left, bilateral)

### Specific Information Related to Requested Procedure

- **Indicate the following information:**
  - **Image Guidance:** Fluoroscopy, Ultrasound, CT, no image guidance required
  - Diagnostic or therapeutic
  - Initial or subsequent
- **Signs/Symptoms:**
  - Indicate the most recent reported level of pain using the Visual Analog Scale (VAS)
  - Indicate the duration of pain
  - Indicate that the pain radiates to a specific anatomical site including the specific dermatomal distribution if there is pain radiation.
  - Indicate if there are any associated signs or symptoms such as numbness, tingling, weakness, alterations in bowel/bladder function, relieving/aggravating factors, fever, abdominal pain, etc.
- **Physical Exam:**
  - Indicate:
    - Reduced spinal range of motion
      - Graded muscle strength (0-5) of named muscle groups
    - Pain to palpation in a specified spinal region and/or spinal level
    - Altered sensation to light touch, pain, temperature and position in a specific dermatome distribution
    - Absent/asymmetrical/diminished deep tendon reflexes by named tendon
    - Pathological reflexes
    - Nerve root tension signs
    - Any other substantive/relevant physical examination findings
  - Note: Radiculopathy ***must*** be supported by objectively verifiable physical examination findings. If radiculopathy is not supported by physical examination findings, and only by patient-reported subjective symptoms, results of a concordant electro-diagnostic study and/or radiologist's report of a concordant advanced diagnostic imaging study is required documentation.

## Interventional Pain Management Quick Reference Guide (con't)

- **Past Medical and/or Surgical History:**
  - Outcome of prior spinal surgical procedures and prior interventional pain procedures
  - Spinal trauma including spinal fractures
  - Herpes Zoster
  - Multiple Sclerosis
  - Cauda Equina Syndrome
  - Suspicion of primary or metastatic spinal malignancy
  - Suspicion of epidural abscess, discitis or vertebral osteomyelitis
  - Any other pertinent history
- **Treatment:**
  - Since the onset of pain or prior spinal surgical/interventional pain procedure, indicate the following:
    - Length of time the patient has continually participated in a physician-directed physical therapy or home exercise program
    - Medications prescribed for the pain condition and duration of use
    - Indicate response to **physician-directed conservative treatment using the Visual Analog Scale**: Unknown, no decrease in pain, 1 point decrease in pain, 2 point decrease in pain, or 3+ point decrease in pain
    - Indicate response to and date of **prior named interventional pain procedure and/or spinal surgical procedure using the Visual Analog Scale**: Unknown, no decrease in pain, 1 point decrease in pain, 2 point decrease in pain, or 3+ point decrease in pain
- **Prior Imaging:**
  - Results and date of prior imaging studies
    - Disc pathology
    - Fracture deformity
    - Spinal deformity
    - Central or lateral foraminal stenosis
    - Spinal cord abnormalities
    - Spinal implants/instrumentation
    - Pseudoarthrosis
    - Any other pertinent results

## Interventional Pain Management Quick Reference Guide (con't)

### Additional Clinical Information

- **Ablation:**
  - Indicate the method to be used
    - Thermal radiofrequency
    - Cooled radiofrequency
    - Pulsed radiofrequency
    - Electrocautery
- **Co-management:**
  - Current management of comorbid medical and behavioral health issues
  - Use and/or abuse of controlled substances—especially opiates
- **Objective Evidence:**
  - The objective clinical evidence supporting interventional pain procedures at additional spinal levels
- **Posterior Fusion:**
  - The presence of and levels of posterior spinal fusion with/without spinal instrumentation and decompression
- **For Anesthesia Requests:**
  - Indicate the procedure for which prior authorization is being requested
    - Epidural steroid injection
    - Facet injection/medial branch block
    - Radiofrequency ablation
    - SI joint injection
    - Sympathetic block
    - Implantation of spinal cord stimulator or drug pump
  - Indicate any medical issues related to this request
    - Spasticity making it difficult for the patient to lie still
    - Severe sleep apnea
    - Inability to follow commands due to dementia or severe developmental delay
    - Severity of a behavioral health disorder
    - Inability to tolerate the procedure previously without anesthesia
    - Any other pertinent medical issues
  - Indicate the specialty of the physician providing the anesthesia services
  - Indicate the type of anesthesia services being provided
    - Minimum, moderate or deep sedation or general anesthesia
  - Attendance by the anesthesiologist and/or nurse anesthetist for the entire interventional pain procedure

## Interventional Pain Management Quick Reference Guide (con't)

- **Subsequent Injections:**
  - Indicate how many injections were previously performed ***and*** the response to each of the previous injection procedures
    - Date performed
    - Injection procedure
    - Percent of improvement, if any, based on a Visual Analog Scale and the duration of improvement
    - Improvement, if any, in functional capacity and performance of activities of daily living
    - Decreased utilization of controlled substances for pain management
    - Decreased utilization of massage therapy, chiropractic care, acupuncture

**\*\*\*Please note this document is to be used as a tool to assist with prior authorization requests. Providing all of the information listed on this tool does not guarantee approval of the requested procedure(s). All prior authorization requests are reviewed for medical necessity based upon evidence-based medical policies.\*\*\***