ADMINISTRATIVE POLICY AND PROCEDURE		
Policy #:	**1416**	
Subject:	**Pain Management - Injections**	
Section:	**Care Management**	
Effective Date:	**05/01/2016**	
Revision Date(s):	**05/17, 07/17**	
Review Date(s):	**10/16**	
Responsible Parties:	**Patryce Toye, MD Danielle Gerry, MD**	
Responsible Department(s):	**Case Management, Utilization Management**	
Regulatory References:		
Approved:		
	Theresa Bittle, RN **AVP Clinical Operations**	**Patryce A. Toye, MD** **Chief Medical Officer**

Purpose: **It is the purpose of this policy to define the conditions under which MedStar Family Choice will approve pain management injections. This policy will also define the conditions under which Utilization Management Staff (Pre-certification Nurses) may authorize pain management injections (epidural, facet joint, and sacroiliac joint injections) without Medical Director review. Injections may be authorized by the Pre-certification Nurse when specified criteria are met (see next page).**

Scope: **MedStar Family Choice, MD; MedStar Family Choice, District of Columbia Healthy Families, and District of Columbia Alliance**

Policy: **It is the policy of MedStar Family Choice to cover pain management injections for appropriate members.**

Procedure:

Submission of Requests:

1. Requests for pain management injections should be submitted by the practitioner along with a completed Prior Authorization Form and the supporting clinical information (ex: office notes, imaging, physical therapy notes, etc.) in accordance with the MedStar

Family Choice Prior Authorization Policy. The clinical information will be gathered and a Referral entered by pre-certification nurses.

Indications:

1. Injections may be authorized by the Pre-certification Nurse when InterQual Criteria Procedures: Specialized Procedures Epidural Injection, Facet Joint Injection, Percutaneous neuroablation or Sacroiliac (SI) Joint Injection are met **AND** all of the following criteria are met:
   a. No more than 1 injection is being requested. Additional injections will be authorized per InterQual criteria depending on the patient's clinical response to his/her previous injection.
   b. Injections are being performed to treat chronic pain (pain present for more than 3 months).
   c. The member has received conservative treatments [ex: Physical Therapy (duration as per InterQual Guidelines for the specific procedure being requested), TENS, pain medications (as per InterQual Guidelines for the specific procedure being requested), muscle relaxers, oral steroids] for his/her chronic pain for at least 3 months.
   d. The member continues to have pain despite conservative treatments. Supporting documentation is required. Office notes should clearly state prior treatments and results. Additionally, Physical Therapy records must be submitted.
   e. The request is for the first injection– **OR** – the patient has experienced pain relief with past injections (documentation MUST be provided that demonstrates this element as per InterQual Guidelines for the specific procedure being requested).
   f. The requesting practitioner specializes in Anesthesia, Pain Management, Orthopedics, or Neurosurgery.

2. Requests that do not meet these criteria will be forwarded to the Medical Director for review. The Medical Director will review the clinical information and take into consideration any extenuating circumstances related to each particular case and provide a decision based on his/her best clinical judgment of medical necessity.

Summary of Changes:	**07/17:** • Added Percutaneous neuroablation • Changed Physician Advisor to Medical Director **05/17:** • Revised to reflect only one injection at a time may be requested, insertion of InterQual references where appropriate, and requirement for supporting documentation strengthened and clarified. **10/16:** • No changes **05/16:** • New policy

MedStar Family Choice

Caring For You. Caring About You.

MedStar Health

Fax completed form to MFC MD 1-888-243-1790 or 410-933-2274

INTERVENTIONAL PAIN MANAGEMENT PRIOR AUTHORIZATION FORM

Please attach copies of the patient's record.

****Please review our clinical criteria before submitting this form. ****

Patient Information

Patient Name:____

MFC Member ID #: _______________________________

Date of Birth: ________/________/________

Procedure Requested

Contact Person Name:____

Contact Phone w/ext:______________________________ **Contact Fax:**______________________

Date(s) of Service:____

Facility name:____

CPT Code(s) and Quantities Requested: ____

____

ICD 10 Codes: ____

□ **Epidural Steroid Injection**: vertebral location(s) requested ______________________________

□ **Facet Joint Injection**: vertebral location(s) ____

□ **Percutaneous Neuroablation**: vertebral location(s) ___________________________________

□ **Sacroilliac Joint Injection**

Diagnosis: □ cervical radiculopathy □ lumbar radiculopathy □ non-specific low back pain

□ cervical facet joint pain □ lumbar facet joint pain □ sacroiliac joint pain

□ other- specify:____

MedStar Family Choice

Caring For You. Caring About You.

MedStar Health

Fax completed form to MFC MD 1-888-243-1790 or 410-933-2274

Additional history:

Has the patient had a trial of **Activity Modification**? □ no □ yes - If yes, length of trial: _______weeks

Dates of Activity Modification: _____________ to _____________

Has the patient participated in **Physical Therapy**? □ no □ yes - If yes, length of therapy: _______weeks

Dates of Physical Therapy: _____________ to _____________

Physical Therapy location/office name:

____

(Please note: Physical Therapy notes must be submitted with this request)

Injection history:

□ initial injection

□ repeat injection (please complete table below)

Date(s) of prior injection(s)	**Type of Injection (epidural, facet, SI joint, ablation)**	**Vertebral location(s)**	**Percent pain relief**	**Duration of pain relief**

MedStar Family Choice

Caring For You. Caring About You.

MedStar Health

Fax completed form to MFC MD 1-888-243-1790 or 410-933-2274

I certify that the information provided is accurate. Supporting documentation is available for audits.

Provider's signature ____

Provider's name ____

Provider NPI# ____

Date _____________________

Practice specialty: ____