Intrathecal catheter insertion

We provide coverage for this procedure for adult members who meet medical necessity criteria.

**For Medicare Plus Blue members:** Submit authorization requests through the e-referral system.

**For BCN HMO and BCN Advantage members:**

- For dates of service **on or after July 1, 2020**, submit authorization requests to TurningPoint Healthcare Solutions, LLC. 
  You can submit authorization requests to TurningPoint starting on June 1, 2020. See the BCN Musculoskeletal Services page for more information.

- For dates of service **before July 1, 2020**, submit authorization requests through the e-referral system.

For requests submitted through the e-referral system, the submitter will receive a prompt to complete a questionnaire to determine the appropriateness of the requested service. The questions are listed below. If all questions are answered, e-referral will either approve or pend the case. If the case pends and we cannot authorize it, we will contact the provider for additional clinical information.

Authorization is not a guarantee of payment. Payment is based on established claim edits. We will retrospectively monitor compliance with this authorization requirement.

Applicable procedure codes: *62350, *62360, *62361, *62362

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**See below for the questions you’ll encounter in the e-referral system.**

**Q** Does the patient have COMPLEX REGIONAL PAIN SYNDROME with a history of pain or burning in the affected area that is disproportionate to the inciting event and may be continuous, occur without painful stimulus or the sensitivity to pain is abnormal?

**A** Possible answers: ☐ Yes ☐ No ☐ N/A
Preview questionnaire
Intrathecal catheter insertion
For Medicare Plus BlueSM PPO, BCN HMOSM (commercial) and BCN AdvantageSM members
Effective March 17, 2020

Q Does the patient have COMPLEX REGIONAL PAIN SYNDROME and TWO or more of the following symptoms of the affected area (A-F)? A. Swelling or tenderness. B. Cyanotic, red or pale digit or extremity. C. Increased sweating. D. Alteration of temperature. E. Trophic skin changes appearing as thinning of the overlying skin, with shiny, smooth appearance. F. Flexion contractures.

A □ Yes □ No □ N/A

Q Does the patient have COMPLEX REGIONAL PAIN SYNDROME and continued symptoms after treatment with ALL of the following (A-C)? A. Nerve block with an anesthetic agent. B. Physical or occupational therapy OR physician directed home exercise FOR AT LEAST 6 months. C. Treatment with antidepressant drugs (for example, amitriptyline, nortriptyline, doxepin, duloxetine, venlafaxine) or antiepileptic drugs (for example, gabapentin, oxcarbazepine, pregabalin) FOR AT LEAST 4 weeks.

A □ Yes □ No □ N/A

Q Does the patient have FAILED BACK SURGERY as evidenced by ONE of the following (A-C)? A. Two or more back surgeries at the same level. B. One or more back surgeries at more than one level. C. Prior spinal fusion surgery at any level.

A □ Yes □ No □ N/A

Q Does the patient have FAILED BACK SURGERY pain that is interfering with activities of daily living AND NO spinal cord compression identified by BOTH physical examination and imaging that would obstruct placement?

A □ Yes □ No □ N/A

Q Does the patient have FAILED BACK SURGERY pain that continues after ALL of the following (A-D)? A. Additional corrective back surgery (unless the patient is not a candidate or would not benefit from additional back surgery). B. Medication (for example, oral, injectable, topical). C. Physical or occupational therapy or physician directed home exercise. D. Passive modalities (for example, heat, cold).

A □ Yes □ No □ N/A
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Q Does the patient have SEVERE CANCER PAIN WITH a life expectancy of at least 3 months AND NO epidural metastatic lesion(s) or tumor encroachment of the thecal sac by imaging?
A  
Possible answers:  □ Yes  □ No  □ N/A

Q Does the patient have SEVERE CANCER PAIN with NO infection at the catheter insertion site AND NO intracranial pressure?
A  
Possible answers:  □ Yes  □ No  □ N/A

Q Does the patient have SEVERE CANCER PAIN that continues after treatment with opioids (unless contraindicated or not tolerated)?
A  
Possible answers:  □ Yes  □ No  □ N/A

Q Is this request for a trial of epidural or intrathecal drug infusion?
A  
Possible answers:  □ Yes  □ No  □ N/A

Q Is this request for a permanent implantation of an epidural or intrathecal drug infusion catheter and BOTH (A-B)? A. A trial of epidural or intrathecal drug infusion has been completed. B. The patient’s medical record documents AT LEAST 50 percent reduction in pain after the trial.
A  
Possible answers:  □ Yes  □ No  □ N/A

Q Did the patient have a psychological evaluation that reveals ALL significant psychiatric, psychosocial and substance abuse issues have been adequately addressed?
A  
Possible answers:  □ Yes  □ No  □ N/A