Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Preview questionnaire: Spinal cord stimulator or epidural or intrathecal catheter (trial or permanent placement)

For BCN HMO℠ (commercial) and BCN Advantage℠ members

For Blue Cross Medicare Plus Blue℠ PPO members

Spinal cord stimulator or epidural or intrathecal catheter (trial or permanent placement)

Services must meet medical necessity criteria. Submit prior authorization requests 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 the plan cannot authorize it, the plan will contact the provider for additional clinical information. Authorization is not a guarantee of payment.

Payment is based on established claim edits. Compliance with this prior authorization requirement will be monitored retrospectively.

Applicable procedure codes: *62350, 62360, 62361, 62362, *63650, *63655, *63663, *63685

See below for the questions you'll encounter for this procedure in the e-referral system.

1.*The Spinal cord stimulator or epidural or intrathecal catheter (trial or permanent placement) Questionnaire is required Questionnaire Assessment.
2.Please attach any clinical information you would like BCBSM to consider for this request from the patients medical record up in the Case Communication field.

You must answer each question by choosing either Yes, No, Not Applicable or another appropriate option.

Spinal Cord Stimulator Insertion and Trial

Answering the question(s) below will provide additional information needed to process your request.

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

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

A [ ] Possible answers: ☐ Yes ☐ No ☐ N/A

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See below for the questions you'll encounter for this procedure in the e-referral system. (cont'd.)

You must answer each question by choosing either Yes, No, Not Applicable or another appropriate option.

Q Does the patient have COMPLEX REGIONAL PAIN SYNDROME and continued symptoms after treatment with ALL of the following: Nerve block with an anesthetic agent. Physical or occupational therapy OR physician directed home exercise FOR AT LEAST 6 months. Treatment with antidepressant drugs (for example, amitriptyline, nortiptyline, doxepin, duloxetine, venlafaxine) or antiepileptic drugs (for example, gabapentin, oxcarbazepine, pregabalin) FOR AT LEAST 4 weeks. A ☐ Possible answers: ☐ Yes ☐ No ☐ N/A
Q Does the patient have FAILED BACK SURGERY as evidenced by ONE of the following? Two or more back surgeries at the same level. One or more back surgeries at more than one level. Prior spinal fusion surgery at any level. A ☐ Possible answers: ☐ 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 that would obstruct placement identified by BOTH physical examination and imaging? A ☐ Possible answers: ☐ Yes ☐ No ☐ N/A
Q Does the patient have FAILED BACK SURGERY pain that continues after ALL of the following? Additional corrective back surgery (unless the patient is not a candidate or would not benefit from additional back surgery). Medication (for example, oral, injectable, topical). Physical or occupational therapy or physician directed home exercise. Passive modalities (for example, heat, cold). A ☐ Possible answers: ☐ Yes ☐ No ☐ N/A

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See below for the questions you'll encounter for this procedure in the e-referral system. (cont'd.)

You must answer each question by choosing either Yes, No, Not Applicable or another appropriate option.

Q Does the patient have CANADIAN CLASS III (angina with mild exertion) or IV (angina at rest) angina? A ⌄ Possible answers: ☐ Yes ☐ No ☐ N/A
Q Does the patient have CANADIAN CLASS ANGINA III or IV that continues after treatment with anti-anginal medications (for example, long-acting nitrates, beta-adrenergic blockers, or calcium-channel antagonists)? A ⌄ Possible answers: ☐ Yes ☐ No ☐ N/A
Q Does the patient have CANADIAN CLASS ANGINA III or IV that continues after percutaneous coronary intervention or coronary artery bypass graft (unless patient is not a candidate or would not benefit from PCI or CABG)? A ⌄ Possible answers: ☐ Yes ☐ No ☐ N/A
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

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. **See below for the questions you'll encounter for this procedure in the e-referral system. (cont'd.)**

You must answer each question by choosing either Yes, No, Not Applicable or another appropriate option.

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 trial of a temporary electrode spinal cord stimulator? A ⌄ Possible answers: ☐ Yes ☐ No ☐ N/A
Q Is this request for a permanent implantation of a spinal cord stimulator WITH ALL of the following? The patient completed at least a 3 day trial of a temporary electrodes. The patient's medical record documents AT LEAST a 50% reduction in pain documented? The medical record documents the patient's understanding of use of the stimulator and equipment during the trial. A ⌄ Possible answers: ☐ Yes ☐ No ☐ N/A
Q Is this request for a permanent implantation of an epidural or intrathecal drug infusion catheter WITH BOTH a trial of epidural or intrathecal drug infusion has been completed AND the patient's medical record documents AT LEAST 50% reduction in pain after the trial? A ⌄ Possible answers: ☐ Yes ☐ No ☐ N/A

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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