



# Epidural Injection Questionnaire

## Epidural Injections

Blue Care Network provides coverage for epidural injections for members who meet medical necessity criteria. Prior authorization requests should be submitted through e-referral. The submitter will be prompted to complete a questionnaire to determine the appropriateness of the requested service. The questions that will be asked are listed below. Quantity limits apply. The maximum number of units that can be requested is four. Note: A “unit” is equivalent to 1 trip to the fluoroscopy suite during which one or more spinal injection for pain management may be administered. Requests for greater than four units will pend and the questionnaire will not display for submitters to complete. Submitters will receive a message if the limit has been exceeded and will have an opportunity to modify the request if needed prior to submitting. If all questions are answered and the number of units is four or less, e-referral will either approve or pend the case. If the case pends and BCN cannot authorize it, BCN will contact the provider for additional clinical information. Requests for visits can be requested for up to 12 months. BCN Care Management should be contacted for services beyond 12 months. \*\*\*Authorization is not a guarantee of payment. Payment is based on established claim edits. Compliance with this prior authorization service will be monitored retrospectively.

Code	Description
* 62281	Injection/infusion of neurolytic substance (e.g., alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, cervical or thoracic
* 62282	Injection/infusion of neurolytic substance (e.g., alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, lumbar, sacral (caudal)
* 62310	Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic
* 62311	Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)
* 62318	Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic
* 62319	Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)
* 64479	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level
* 64480	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional level (list separately in addition to code for primary procedure)
* 64483	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level
* 64484	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional level (list separately in addition to code for primary procedure)

### Diagnosis Codes:

353.0	353.1	353.2	353.4	355.0	722.0	722.10	722.2	722.4
722.52	722.6	722.81	722.83	722.91	722.93	723.0	723.4	723.7
723.8	723.9	724.00	724.02	724.09	724.3	724.5	724.8	724.9
728.85	728.9	729.1	738.4	738.5	953.0	953.2	953.3	

1.	Does the patient have:	
2.	Any of the following conditions? NOTE: If the patient does not have any of these conditions, you MUST select "None of the above apply."	<input type="checkbox"/> Coagulopathy <input type="checkbox"/> Injection site infection <input type="checkbox"/> Spinal infection <input type="checkbox"/> Increased intracranial pressure <input type="checkbox"/> Cancer of the spine <input type="checkbox"/> Septicemia <input type="checkbox"/> None of the above apply
3.	Psychogenic pain (pain that is caused, increased, or prolonged by mental, emotional, or behavioral factors)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Pain that is present in a specific nerve root distribution? Examples: **Neck, shoulder and upper arm pain (C5); **Neck, shoulder and radial forearm pain (C6); **Hip, thigh and knee pain (L3); **Hip, lateral thigh and leg pain (L5)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
5.	Pain rating on a scale of 1-10, with 10 being the worst?	<input type="checkbox"/> 0-5 No pain/Mild pain <input type="checkbox"/> 6-8 Moderate pain <input type="checkbox"/> 9-10 Severe pain
6.	Pain is MODERATE OR SEVERE (6-10 on a 10 point scale) AND is relieved with changes in body position?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
7.	Pain is SEVERE (9-10 on a 10 point scale) AND interferes with completion of activities of daily living (e.g. not able to go to work or may be able to work but needs to take frequent breaks due to pain)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
8.	Pain is SEVERE (9-10 on a 10 point scale) WITH failure of conservative treatment of appropriate anti-inflammatory drugs for at least three days (or; anti-inflammatory drugs are contraindicated/not tolerated)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
9.	Pain is SEVERE (9-10 on a 10 point scale) WITH failure of conservative treatment of Opiates (e.g. morphine, codeine, oxycodone, hydrocodone, etc.) for at least three days (or; opiates are contraindicated/not tolerated)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
10.	Pain is MODERATE (6-8 on a 10 point scale) and WORSENS after failure of conservative treatment of appropriate anti-inflammatory drugs for at least 1 week (or; contraindicated/not tolerated) AND activity modification for at least 1 week?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
11.	Pain is MODERATE (6-8 on a 10 point scale) and CONTINUES after failure of conservative treatment of appropriate anti-inflammatory drugs for at least 3 weeks (or; contraindicated/not tolerated) AND activity modification for at least 6 weeks?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

12.	Evidence of NERVE ROOT COMPRESSION generally identified by imaging (MRI or CT or CT myelogram), OR less commonly by electromyogram (EMG) or nerve conduction studies (NCS)? NOTE: If no imaging or testing was performed, you MUST select "N/A."	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
13.	For ongoing injections, did the patient receive AT LEAST a 50% reduction in pain with the most recent injection?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A (diagnostic injection)
14.	For ongoing injections, did the patient receive relief of pain for at least 6 weeks with most recent injections?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A (diagnostic injection)
15.	In the past 12 months, did the member have 4 or less VISITS for injections to the cervical/thoracic region?	<input type="checkbox"/> 4 or less visits <input type="checkbox"/> 5 or more visits <input type="checkbox"/> N/A (diagnostic injection) <input type="checkbox"/> N/A (lumbar/sacral region)
16.	In the past 12 months, did the member have 4 or less VISITS for injections to the lumbar/sacral region?	<input type="checkbox"/> 4 or less visits <input type="checkbox"/> 5 or more visits <input type="checkbox"/> N/A (diagnostic injection) <input type="checkbox"/> N/A (cervical/thoracic region)
17.	Are there 8 weeks or more between planned injections?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A (diagnostic injection)

**Reference:**

InterQual® 2012 Procedures Adult Criteria, Epidural Injection.

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