Interventional Pain Management

Prior Authorization Tip Sheet

This tip sheet is intended to assist you in the prior authorization process, but it is not a substitute for the clinical guidelines for individual pain management procedures. The information below is in reference to the National Imaging Associates, Inc. (NIA)[1] Standard Clinical Guidelines. Medicare LCDs and Health Plan Specific Guidelines may have different requirements for approval.

Initial Injection

All initial injection requests should include the following documentation:

History and duration of pain

- Facet Joint Injections and Sacroiliac Joint Injections require at least 3 months of pain
- Epidural steroid injections have different requirements for chronic pain (≥ 3 months) vs. acute pain (< 3 months)

Example Documentation:
- Patient complains of chronic low back pain for several years
- Patient reports new onset low back pain after heavy lifting a month ago

Location and character of pain

- Details regarding what aggravates the pain, where does the pain radiate, etc.
- Facet interventions require mainly axial, non-radicular pain

Example Documentation:
- Axial low back pain aggravated by bending and twisting
- Low back pain radiating to the left leg and foot

Exam findings (SIJ Injection only)

- Documentation of one of the following positive provocative tests for SIJ pain is required:
  - Gaenslen's test
  - FABER (Patrick's test)
  - Pelvic distraction test
  - Pelvic compression test
  - Thigh thrust test

Pain score on a 0-10 scale or functional disability

- Pain score of at least 6/10 **OR** functional disability
- Functional disability should include ***specific*** examples of limited function due to pain

Example Documentation:
- Pain is a 4/10 at best and 8/10 at worst
- Pain is currently rated 7/10
- Patient can no longer golf due to pain
- Patient unable to lift child due to pain

[1] *Effective 1/20/2023, National Imaging Associates, Inc. is now a subsidiary of Evolent Health. Evolent Health and its affiliates and subsidiaries collectively referred to as "Evolent."*

Conservative Treatment

- All injections (except ESIs for acute pain) require at least 6 weeks of active conservative treatment within the last 6 months
- Active conservative treatment consists of physical therapy, a physician-supervised home exercise program, or chiropractic care
- Dates and duration are extremely important (actual PT/Chiro records are not required)

Example Documentation:
- Office visit 12/15/22: Patient completed 2 months of physical therapy in May and continues prescribed HEP
- Office visit 11/1/22: Patient attended physical therapy 6/1/2022-7/18/2022
- Patient has had weekly chiropractic visits for the last 3 months without relief

- Documentation of a medical reason the patient cannot complete conservative treatment within the last 6 months is also acceptable (inability to tolerate PT in the distant past would not be sufficient)

Example Documentation:
- Patient is unable to complete prescribed HEP at this time due to severe pain
- Patient attempted physical therapy 2 weeks ago but was discharged due to significant worsening pain

- Document the spinal region targeted for active conservative treatment if there are multiple pain complaints

Example Documentation:
- The patient has received numerous cervical injections in the past and all previous office notes mostly focus on the cervical spine, but a new request is submitted for a lumbar injection. The conservative treatment would need to be specific to the lumbar spine (and should be documented as such)

Injection plan

- Include approach and levels
- A specific plan is not an outright guideline requirement, but for certain injections, it is necessary for approval (i.e., transforaminal ESIs have a level limit, previously targeted levels for diagnostic medial branch blocks must be consistent with the planned radiofrequency ablation, etc.)

Example Documentation:
- Left L3-5 transforaminal ESI
- Bilateral MBBs at L4, L5, and SA

Repeat Injection

All repeat injection requests should include the following documentation*:
** In-person visit not required; Telephone note is acceptable*

Response to the previous injection

- Include percent of pain relief **OR** specific examples of functional improvement due to injection (required percentages vary based on injection type)
- Documentation of duration of relief is also very important (required durations vary based on injection type)

Example Documentation:
- Patient reports 100% relief lasting for 2 days after the MBBs
- Patient reports they were able to play in their weekly golf game for the last 3 months after the previous ESI

Updated pain score after the last injection

- Pain should return to at least 6/10 **OR** a return of functional disability

Example Documentation:
- Pain is rated 7/10 today
- The pain has returned, and patient states they can no longer play golf

Ongoing conservative treatment

- Actively engaged in active conservative treatment since the last injection (in the same region) or medical reason the patient cannot participate

Example Documentation:
- Patient continues daily prescribed home exercise program since the last injection
- Patient did HEP for a few weeks after the injection, but was unable to continue when the pain returned

Injection plan

- "Repeat injection" is sufficient if the same approach, levels, and medication will be used
- If the first injection was not successful, it is important to specifically note what will be changed for the follow-up injection

Example Documentation:
- Repeat MBBs
- Last TFESI performed at right L4, now targeting right L5 due to ongoing pain radiating into lateral leg and foot

Important Notes

- All injections have frequency limits and yearly maximums that are dependent upon the injection type
- Radiofrequency Neurolysis requires diagnostic medial branch blocks (not therapeutic facet blocks)
- For chronic pain patients who have a lengthy injection history, it is helpful to have a section of the EMR that lists the following: injection type/levels, date performed, % relief, and duration of relief
- Submitted clinical documentation must be part of the patient's official medical record – all notes should have the patient's name, date of birth (or second patient identifier), and clinician signature with date