

Patient Name _____ Medicaid ID # _____

CPT Codes: 62310, 62311, 62318, 62319, 64479, 64480, 64483, 64484, 0228T, 0229T, 0230T, 0231T

1. **NOTICE:** Medicaid's Fee for Service program does not require review via Qualis for patient with: Medicaid Managed Care (Healthy Options), Medicare, other primary carriers, Take Charge/FPO, Detox Only, unmet Spend-down OR injections in the inpatient or ED setting.
2. Have you confirmed the Medicaid client's eligibility for the planned date of service of this spinal injection procedure?
 Yes = Go to #3
 No = STOP. Need to confirm eligibility before submitting
3. Is the client's primary medical coverage Emergency Related Services Only (ERSO)?
 Yes = **go to #4**
 No = **go to #5**
4. If client has ERSO coverage, is this spinal injection to treat cancer?
 Yes = Go to #5
 No = Call Medical Assistance Customer Service Center (MACSC) at 1-800-562-3022
5. **(Mandatory) DISCLAIMER:** This guideline based review will result in a recommendation to Health Care Authority. HCA makes the final determination regarding authorization & payment. Services are not authorized until HCA has issued an authorization number.
 Acknowledge
6. **NOTE:** MRI is not a prerequisite to perform an Epidural Steroid Injection (ESI).
7. **INSTRUCTIONAL NOTE: NO MORE THAN TWO (2) LEVELS AND ONE SIDE ALLOWED PER DATE OF SERVICE. FOURTH INJECTION AT ANY LEVEL REQUIRES FULL REVIEW; DO NOT COMPLETE QUESTIONNAIRE.**
8. **(Mandatory)** Indicate if Epidural Steroid Injection or Selective Nerve Root Block is planned.
 Epidural Steroid Injection
 Selective Nerve Root Block
9. **(Mandatory)** Indication for the Epidural Steroid Injection or Selective Nerve Root Block. (Select ONE)
 Diagnostic
 Therapeutic
10. **(Mandatory)** Side of Body/Approach: (Select ONE)
 Interlaminar
 Left
 Right
 Caudal

11. **(Mandatory)** Select injection. **INSTRUCTIONAL NOTE: 3rd injection may require submission of medical records. 4th injection – MUST submit medical records.** (Select ONE)
- 1st injection: answer 8-19 ONLY
- 2nd injection: answer ALL questions
- 3rd injection: answer ALL questions
- 4th injection: Do NOT complete
12. **(Mandatory)** Epidural Spinal Injection(s) to be done on the following nerves/levels: (Enter up to TWO)
- 1) _____ 2) _____
13. **(Mandatory)** Please indicate which imaging guidance will be used. (Select ONE).
- CT guidance
- Fluoroscopic guidance
- Ultrasound guidance
- None of the above
14. Has patient had conservative care?
- Yes = go to #15
- No = go to #17
15. How many weeks of conservative care has the patient had? (Select ONE)
- Less than 2 weeks
- 2 – 5 weeks
- 6 or more weeks
16. Please indicate conservative approaches used: (Select all that apply)
- Chiropractic care
- Home exercise
- Massage therapy
- Narcotic therapy
- NSAIDs
- Steroids
- Structured PT
17. **OBJECTIVE PHYSICAL EXAM** findings? **NOTE: Patient complaint/report of symptoms NOT adequate.** (Select all that apply)
- Normal exam
- Dermatomal sensory loss
- Motor weakness
- Reflex asymmetry or loss
18. Has the patient had a prior diagnostic selective nerve root block?
- Yes = go to #19
- No = go to #21
19. How was the selective nerve root block performed? (Select all that apply)
- Low-volume
- Post-block patient generated pain diary
- Single level
- Steroid-free

20. **(Mandatory)** Have prior injection(s) been given at the same level & side as this request? **NOTE: 2 or more prior injections may require submission of medical records. 4th injection requires medical records.** (Select ONE)

- No prior injections
- Only one prior injection
- 2 prior injections
- 3 or more prior injections (see NOTE)

21. Please enter dates for ANY prior injections for same level & side as this request.
(Date format: mm/dd/yyyy)

- 1) ___ / ___ / _____
- 2) ___ / ___ / _____
- 3) ___ / ___ / _____

22. How much improvement in function & pain was realized after the injection? (Select ONE)

- None
- Less than 30%
- Greater than 30%

23. How was the percentage of improvement determined? (Select all that apply)

- Documented decrease in use of pain medications
- Documented improvement in **objective** findings on PE
- Documented increased activity
- Patient generated pain diary
- Verbal report from patient