REIMBURSEMENT POLICY STATEMENT
INDIANA MEDICAID

Original Issue Date	Next Annual Review		Effective Date
01/01/2017	07/15/2019		07/15/2018
Policy Name			**Policy Number**
Pain Management			PY-0127
Policy Type			
Medical	Administrative	Pharmacy	**REIMBURSEMENT**

Reimbursement Policies prepared by CSMG Co. and its affiliates (including CareSource) are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

CSMG Co. and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

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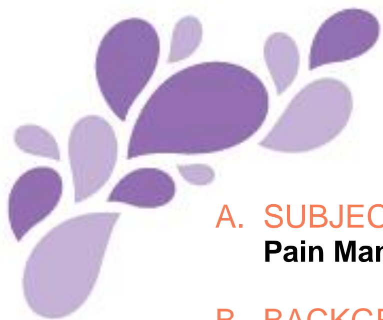


A. SUBJECT

Pain Management

B. BACKGROUND

Reimbursement policies are designed to assist you when submitting claims to CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and their office staff are encouraged to use self-service channels to verify member's eligibility.

It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT/HCPCS code(s) for the product or service that is being provided. The inclusion of a code does not imply any right to reimbursement or guarantee claims payment.

Pain management is a branch of medicine employing an interdisciplinary approach for easing the suffering and improving the physical function and quality of life of those living with chronic pain. Treatment approaches to chronic pain include, but are not limited to, pharmacological measures, interventional procedures, physical therapy, physical exercise, application of ice and/or heat, and psychological measures, such as biofeedback and cognitive behavioral therapy. Pain management, regarding this policy, is the utilization of different types of injections, stimulator or infusion pump for the relief of chronic pain.

C. DEFINITIONS

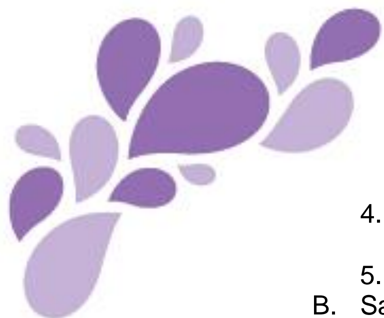
- Medically necessary - health services that are necessary for the diagnosis or treatment of disease, illness, or injury and meet accepted standards of medical practice.
- 12 Month Rolling Year- a 12 month period starting from the initial date of service and renewing every 12 months from that date, regardless of calendar year.
- Calendar Year- January 1st to December 31st of the same year

D. POLICY

I. Prior Authorization (PA): CareSource requires prior authorization for selected pain management injections as described below, for all places of service.

II. Trigger Point Injections (CPT codes 20552 and 20553)
   A. CareSource will reimburse up to a maximum of no more than eight dates of service per calendar year per patient, regardless of location, duration of symptoms, rendering provider, or interval between injections.
   B. CareSource will not reimburse for localization by any technique for trigger point injections.
   C. No prior authorization is required for participating providers, prior authorization is required for nonparticipating providers.

III. Sacroiliac Procedures
   A. Sacroiliac joint injections (CPT code 27096, G0260, G0259)
      1. CareSource will reimburse injections for diagnosis or treatment that are given no less than 14 calendar days apart, with no more than four injections total, 2 per side, in a rolling 12 months.
      2. Neural blockade, if applied to different regions or sides, cannot be performed within one week, or 7 calendar days. (either before or after) of the sacroiliac injection.
      3. Image guidance and/or injection of contrast for sacroiliac joint injections for pain will be denied for coverage as not medically necessary.



4. Monitored anesthesia and conscious sedation will be denied as not medically necessary.
5. Prior authorization is required for all providers.

B. Sacroiliac neurotomy
1. Thermal or pulsed, cooled neurotomy by Radio-Frequency Ablation (RFA) or other techniques for sacroiliac pain are not covered.
2. Sacral injections, identified on the claim by the ICD-10 codes M43.27, M43.28, M46.1, M53.2X7, M53.2X8, M53.3, M53.87, M53.88, are not covered when submitted with a claim for facet medial branch nerve block.

C. Sacroiliac Joint Fusion, or Arthrodesis (CPT code 27279)
1. Sacroiliac joint fusion procedures are not covered.

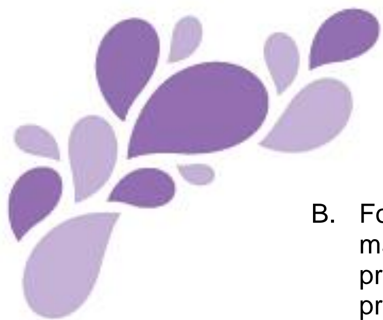
IV. Facet medial branch nerve procedures.

A. Facet medial branch nerve blocks (CPT codes 64490, 64491, 64492, 64493, 64494, 64495, 0213T, 0214T, 0215T, 0216T, 0217T, 0218T)
1. A maximum of 5 facet injection sessions inclusive of medial branch blocks, intraarticular injections, facet cyst rupture and facet medial branch neurotomies may be performed in a rolling 12 month, in the cervical/ thoracic spine and a maximum of 5 in the lumbar spine. A “session” is defined as all injections/ blocks/ RF procedures performed on one day and includes medial branch blocks, intraarticular injections, facet cyst ruptures and radiofrequency ablations.
2. CareSource will review for prior authorization and reimbursement of Facet medial branch nerve blocks up to the targeted joint itself, one joint above and one joint below on the same side, or bilaterally per treatment session if medical necessity criteria are substantiated in the medical record.
3. Facet joint interventions (diagnostic and/or therapeutic) must be performed under fluoroscopic or computed tomographic (CT) guidance. Facet joint interventions performed under ultrasound guidance will not be reimbursed (CPT code 76942)
4. Prior authorization is required for all providers.

B. Facet Neurotomy (CPT codes 64633, 64634, 64635, 64636)
1. A maximum of 2 Facet Medial Branch Neurotomies in a rolling 12 months will be reimbursed.
2. Facet Neurotomy should be performed with imaging guidance. Coverage for image guidance and any injection of contrast are inclusive components and are not reimbursed separately.
3. Conscious sedation, if required for co-morbidities or patient/physician preference, may be provided without prior authorization but services will be considered part of the procedure and are not eligible for additional reimbursement if administered by a second provider.
4. Prior authorization is required for all providers.

V. Epidural Steroid Injections

A. Includes: Interlaminar, Transforaminal, or Caudal Epidural Injections (For CPT codes 62320, 62321, 62322, 62323, 0228T, 0229T, 0230T, 0231T).
1. Only 1 Interlaminar or Caudal Epidural Injection will be authorized per treatment date.
2. Bilateral injections and modifiers will not be reimbursed (For CPT codes 62320, 62321, 62322, 62323).
3. Transforaminal Epidurals (CPT codes 64479, 64480, 64483, 64484) provided to more than 2 vertebral levels per treatment date, whether unilateral or bilateral will not be reimbursed.
4. Repeat injections sooner than 3 weeks will not be reimbursed.
5. The maximum epidurals of all types of epidural injections a member can receive in a rolling 12 months is a total of 6, regardless of the number of levels involved.
6. Prior authorization is required for all epidural steroid injections.



B. For conscious sedation, if required for co-morbidities or patient/physician preference, may be provided without prior authorization but services will be considered part of the procedure and are not eligible for additional reimbursement if administered by a second provider.
C. Image guidance and any injection of contrast are inclusive components of epidural injections.

VI. Spinal Cord Stimulator
A. A prior authorization is required both for a trial of SCS and a second prior authorization is required for implantation of a permanent SCS. (CPT codes 63650, 63655, 63865)
B. CPT, HCPCS, and ICD-10 codes for inclusion and exclusion in coverage determinations at the claims level are listed below.

VII. Implantable Pain Pump
A. A prior authorization is required for each proposed preliminary trial injection and for each proposed placement of an Implantable Infusion Pain Pump for pain management. (CPT codes 62350-62351 and 62360-62362)

E. CONDITIONS OF COVERAGE

Reimbursement is dependent on, but not limited to, submitting CMS approved HCPCS and CPT codes along with appropriate modifiers. Please refer to the appropriate Indiana Medicaid fee schedule.

F. RELATED POLICIES/RULES

- See Medical policy ‘Epidural Steroid Injections’
- See Medical policy ‘Facet medial branch nerve blocks’
- See Medical policy ‘Facet Neurotomy’
- See Medical policy ‘Trigger Point Injections’
- See Medical policy ‘Sacroiliac Joint Injections’

G. REVIEW/REVISION HISTORY

	DATE	ACTION
Date Issued	01/01/2017	New Policy.
Date Revised		
Date Effective	07/15/2018	

H. REFERENCES

1. Indiana Health Coverage Programs Fee Schedule. (2016, October 23).

The Reimbursement Policy Statement detailed above has received due consideration as defined in the Reimbursement Policy Statement Policy and is approved.