PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Medical Necessity Criteria for Pain Management Procedures

MCUP3049 Pain Management Specialty Services – Attachment A
MCUG3007 Authorization of Ambulatory Procedures and Services - Attachment C
11/13/2024

22510, 22511, 22512, 22513, 22514, 22515 Percutaneous vertebroplasty and percutaneous vertebral augmentation	**InterQual® criteria followed.** **Subset:** *Vertebroplasty or Kyphoplasty* **Exception(s) to InterQual criteria:** None Well-controlled study shows no benefit over placebo for longstanding vertebral fractures/pain. (Reference: Treatment of Symptomatic Osteoporotic Spinal Compression Fractures, *Journal of the American Academy of Orthopedic Surgeons*, March 2011; Spine J. 2012 Nov; 12(11): 998-1005)
27096 SI joint injection	**InterQual® criteria followed.** **Subset:** *Sacroiliac (SI) Joint Injection* **Exception(s) to InterQual criteria:** • Imaging to confirm sacroiliac joint disease is not required
62263, 62264 Percutaneous lysis of epidural adhesions	**Requests are reviewed on a case-by-case basis** upon review of clinical information provided.
62290, 62291 Discography, Lumbar and Cervical	**InterQual® criteria followed.** **Subset:** *Discography, Spine, Lumbar* InterQual criteria shows limited evidence to support this procedure.
62360, 62362 Implantable or replacement device for intrathecal or epidural drug infusion; subcutaneous reservoir	**InterQual® criteria followed.** **Subset:** *Epidural or Intrathecal Catheter Placement* **Exception(s) to InterQual criteria:** • Physician review required
63650, 63655, 63662, 63664, 63685 Insertion, revision, or removal of spinal neurostimulator	**InterQual® criteria followed.** **Subset:** *Spinal Cord Stimulator (SCS) Insertion* **Exception(s) to InterQual criteria:** None **Note:** Revisions/Replacements may be considered when the Elective Replacement Indicator (ERI) reflects that replacement is required in ≤ 6 months.

64479, 64480, 64483, 64484 Transforaminal epidural injection	**InterQual® criteria followed.** **Subset:** *Epidural Steroid Injection* **Exception(s) to InterQual criteria:** 1. A minimum of 30 days conservative treatment is required before eligible for epidural steroid injection. 2. TFESI may be considered for cervical radicular pain with nerve root impingement confirmed by imaging or testing. 3. Repeat injections require a minimum of 50% improvement in pain symptoms lasting a minimum of 8 weeks from previous injection. 4. The interval between injections per site must be no more frequent than every 3 months, and the maximum number of injections per site is 3 per year.
64490, 64491, 64492, 64493, 64494, 64495 Paravertebral facet injections and medial branch blocks	**InterQual® criteria followed.** **Subset:** *Facet Joint Injection* **Exception(s) to InterQual criteria:** 1. The progress note should document a physical examination of the back, including pain elicited with movement. 2. Trial of physical therapy & NSAIDS/ acetaminophen is not required. 3. Imaging required only to rule out nerve root impingement for any radicular complaints. 4. No more than 3 levels will be approved, either 3 levels unilaterally or 3 levels bilaterally.
64633, 64634, 64635, 64636 Destruction by neurolytic agent, paravertebral facet joint	**InterQual® criteria followed.** **Subset:** *Neuroablation, Percutaneous* **Exception(s) to InterQual criteria:** None
72285, 72295 Cervical, Thoracic, Lumbar discography	*Same as 62290 and 62291 above.* **InterQual® criteria followed.** **Subset:** *Discography, Spine, Lumbar* InterQual criteria shows limited evidence to support this procedure.