

Epidural Injection Criteria Form

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| Patient Name: DOB: / / Phone:  |
| **R E Q U I R E****D** | * Pain duration has lasted at least 4 weeks? Yes No
* Patient has completed 4 weeks of non-invasive conservative care (physical therapy, oral meds, etc.)? Yes No

\*If no, please list why the patient didn't complete conservative care: * Patient has radicular pain? Yes No
* Pain affects patient’s quality of life or function? Yes No

\*If yes, please list specific living activities affected: \*Note: Medicare does not recognize sleeping, standing, sitting or walking as daily living activities. * First request for pain management injection? Yes No

\*If yes, is the pain duration greater than or equal to 4 weeks? Yes No\*Note: Medicare limits the number of injections a patient can receive. For more information on the limitations, please visit the CMS website for details. |
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**\*\*\*ALL OF THE FOLLOWING ARE REQUIRED AND MUST BE FAXED TOGETHER\*\*\*:**

1. Completed Epidural Injection Criteria Form.
2. History, physical examination and imaging dated within **one** year of the request stating:
	* Pain level and scale.
	* The intention to send patient for pain management injection.
	* ICD-10 codes that support medical necessity.
3. Order for epidural steroid injection including spine level.

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| Ordering Provider Signature: Date: / /  |
| **R E Q U I R****E D** | Ordering Provider (Print Name): Office Phone: Office Fax:  |
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Created: 07/08/2022