

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