



Nonprofit corporations and independent licensees
of the Blue Cross and Blue Shield Association



**PAIN MANAGEMENT
SACROILIAC JOINT INJECTIONS
AUTHORIZATION REQUEST FORM**

Utilization management toll-free phone: 1-833-217-9670
Utilization management local phone: 313-908-6040
Utilization management fax: 313-483-7323

Today's date (mm/dd/yyyy): ___ / ___ / ___
Provider contact name:
Provider contact phone:
Provider contact fax:
Provider name:
Provider TIN:
Provider NPI:
Practice/group name:
Provider physical address:
Provider mailing address (if different):

Member name:
Date of birth (mm/dd/yyyy): ___ / ___ / ___
Member ID (including any alpha prefix):
Health plan:
Notification method preference: <input type="checkbox"/> Postal mail <input type="checkbox"/> Fax
Mailing address or fax number:
Notes:

Where will the procedure take place? <input type="checkbox"/> Provider office <input type="checkbox"/> Outpatient facility <input type="checkbox"/> Inpatient hospital <input type="checkbox"/> Ambulatory surgical center	
Facility name:	Facility contact name:
Facility TIN:	Facility contact phone:
Facility NPI:	Facility contact fax:
Facility physical address:	Facility mailing address (if different):

Requested procedure code	Modifier: LT, RT or 50 (bilateral)	Quantity	Spine level
Diagnosis code(s):		Anticipated date of service (mm/dd/yyyy): ___ / ___ / ___	
Case urgency <input type="checkbox"/> Standard <input type="checkbox"/> Expedited In keeping with guidelines from the National Committee for Quality Assurance and Centers for Medicare & Medicaid Services, prior authorization requests qualify for expedited review when the standard review time frame could do one of the following: <ul style="list-style-type: none"> • Seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state. • In the opinion of a practitioner with knowledge of the member's medical or behavioral health condition, subject the member to adverse health consequences without the care or treatment that is the subject of the request. 			
Patient's height:	Patient's weight:	Patient's BMI:	

What type of procedure is planned? (Select one and answer all adjacent questions.)		
<input type="checkbox"/> Initial diagnostic SI joint injection (answer a – h)	a. Has SI joint pain, without radiculopathy (burning, tingling, cramping), been present for at least 3 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	b. Does the exam confirm tenderness to touch over the SI joint (below lumbar spine), consistent with SI joint pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	c. Does the exam show positive responses to at least 3 different SI joint tests (thigh thrust, sacral compression or thrust, Gaenslen's, distraction, Patrick's, and/or posterior provocation)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	d. Has conservative treatment been attempted for at least 4 weeks/1 month?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	e. Has medication been attempted as part of conservative treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	f. Has chiropractic care, physical therapy, and/or home exercise program been attempted as part of conservative treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	g. Does imaging show any other possible causes of pain (hip or lumbar degeneration, stenosis, etc.)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	h. Is the total amount of anesthetic being used less than 3cc per joint?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Second diagnostic SI joint injection (answer a – c)	a. Were criteria met for initial diagnostic injection?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	b. Does the medical record show at least 75% reduction in pain and improvement in function with initial diagnostic injection?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	c. Have at least 2 weeks passed since first diagnostic injection?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Third or greater diagnostic SI joint injection	No questions related to this procedure; proceed to next section.	

<input type="checkbox"/> Initial therapeutic SI joint injection (answer a – b)	a. Were 2 diagnostic SI joint injections performed on the same side(s) as the planned therapeutic injection in the past year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	b. Does the medical record show at least 75% reduction in pain and improvement in function with both diagnostic injections?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Second or greater therapeutic SI joint injection (answer a – c)	a. Was the prior therapeutic injection performed on the same side(s) within the past year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	b. Does the medical record show at least 50% reduction in pain and improvement in function for at least 3 months after the prior procedure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	c. Have 3 or more SI joint injections containing steroid (including diagnostic) been done in this joint in the past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do any of the following apply? (Answer a – d)	
a. Injection with steroid planned with uncontrolled diabetes, uncontrolled hypertension, or congestive heart failure present	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Systemic or localized infection at planned injection site	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Other pain management interventions planned same day (i.e. epidural steroid injection, SI joint injection, trigger point injection, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Pain management procedures planned in multiple regions (i.e. cervical/thoracic AND lumbar or sacral)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Will the procedure be performed with fluoroscopic guidance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is general anesthesia, conscious sedation, or monitored anesthesia care planned?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Include imaging reports, surgical plan and clinical documentation of all conservative therapies that have been attempted as well as the duration of each type of conservative treatment.	
Form completed by:	Date: