Blue Cross Blue Shield Blue Care Network of Michigan

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

TurningPoint

JOINT AND SPINE PROCEDURES AUTHORIZATION REQUEST FORM

Utilization management toll-free phone: 1-833-217-9670
Utilization management local phone: 313-908-6040
Utilization management fax: 313-879-5509

Today's date (mm/dd/yyyy): ____ / ____ / _____	**Member name:**
Provider contact name:	**Date of birth (mm/dd/yyyy):** ____ / ____ / _____
Provider contact phone:	**Member ID (including any alpha prefix):**
Provider contact fax:	**Health plan:**
Provider name:	**Notification method preference:** ☐ Postal mail ☐ Fax **Mailing address or fax number:**
Provider TIN:	
Provider NPI:	
Practice/group name:	**Notes:**
Provider physical address:	
Provider mailing address (if different):	

Requested procedure:	**Anticipated surgery date (mm/dd/yyyy)**
CPT/HCPCS or ICD procedure code(s):	
Diagnosis code(s):	
Facility setting: ☐ Provider office ☐ Outpatient facility ☐ Inpatient hospital ☐ 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):**

Blue Cross Blue Shield Blue Care Network of Michigan

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

TurningPoint

JOINT AND SPINE PROCEDURES AUTHORIZATION REQUEST FORM

Utilization management toll-free phone: 1-833-217-9670
Utilization management local phone: 313-908-6040
Utilization management fax: 313-879-5509

Case urgency

☐ Standard ☐ 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:

- 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:** _____

Does the patient have any of the following comorbidities? Select all that apply.

☐ Diabetes that requires medication or insulin (Type I or Type II) AIC Level: _____
☐ Hypertension requiring medication
☐ Previous cardiac event
☐ Congestive heart failure
☐ Dyspnea
☐ Current smoker within past 12 months
☐ History of severe COPD
☐ Dialysis
☐ Acute renal failure
☐ Ascites within past 30 days
☐ Steroid use for chronic condition
☐ Disseminated cancer
☐ None of the above

NOTE: For policies with smoking and BMI criteria, the requesting provider must include signed documentation stating that they have discussed the risks and benefits of the procedure related to smoking and elevated BMI, as appropriate.

Patient's activities of daily living (ADL) functional status:

☐ Independent
☐ Partially independent
☐ Totally dependent

What is the patient's current health status?

☐ Normal healthy patient
☐ Mild or moderate disease that does not limit activity (ex: controlled HTN or DM, mild obesity)
☐ Severe disease that limits activity (ex: controlled CHF, history of MI, uncontrolled HTN or DM)
☐ Severe life-threatening disease (ex: symptomatic CHF or COPD, renal failure, unstable angina)

Does the patient have psychosocial and/or substance use issues?

☐ Absent – no psychosocial and/or substance use issues
☐ Address – psychosocial and/or substance use issues present but addressed

Will any of the following be used?

☐ Allograft
☐ Autograft – patient's own tissue
☐ Bone Morphogenetic Protein
☐ Stem cells
☐ None of the above

If requesting procedure code *20930, please indicate tissue type:

Vendor: _____

Name/type of product: _____

Will a co-surgeon or assistant be utilized?

☐ Orthopedic
☐ Physician's Assistant/Nurse Practitioner
☐ RN Surgical Assistant
☐ Other: _____
☐ No planned co-surgeon or assistant

Other products intended to be used:

Manufacturer: _____

Product line: _____

NOTE: 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:**