Blue Cross Blue Shield Blue Care Network of Michigan

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

TurningPoint

PAIN MANAGEMENT EPIDURAL STEROID 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): ____ / ____ / _____	**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):	

Where will the procedure take place?

☐ 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):**

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Requested procedure code	Modifier: LT, RT or 50 (bilateral)	Quantity	Spine level

Diagnosis code(s):	Anticipated date of service (mm/dd/yyyy): ____ / ____ / _____

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:

What type of procedure is planned? (Select one and answer all adjacent questions.)

☐ **Initial epidural steroid injection** (answer a – h)	a. Is there presence of moderate to severe pain (rated at least 3 out of 10) that interferes with daily activities?	☐ Yes ☐ No
	b. Are any radiculopathy or claudication symptoms (burning, tingling, cramping) present?	☐ Yes ☐ No
	c. Does imaging show stenosis or disc herniation/bulging that seems to match up with radiculopathy?	☐ Yes ☐ No
	d. Is the procedure planned for one caudal or interlaminar, or one bilateral or two unilateral transforaminal levels?	☐ Yes ☐ No
	e. Will more than the recommended amount of steroid be injected? (80mg of Triamcinolone, 80mg of methylprednisolone, 12mg of betamethasone, or 15mg of dexamethasone)	☐ Yes ☐ No
	f. Has conservative treatment been attempted for at least 4 weeks/1 month?	☐ Yes ☐ No
	g. Has medication been attempted as part of conservative treatment?	☐ Yes ☐ No
	h. Has chiropractic care, physical therapy, and/or home exercise program been attempted as part of conservative treatment?	☐ Yes ☐ No

☐ **Repeat epidural steroid injection** (answer a – h)	a. Is this injection being done in the same location/for the same episode of pain as the prior injection(s)?	☐ Yes ☐ No
	b. Have at least 2 weeks passed since first injection?	☐ Yes ☐ No
	c. Is the procedure planned for one caudal, one interlaminar, one bilateral transforaminal, or two unilateral transforaminal levels?	☐ Yes ☐ No
	d. Will more than the recommended amount of steroid be injected? (80mg of Triamcinolone, 80mg of methylprednisolone, 12mg of betamethasone, or 15mg of dexamethasone)	☐ Yes ☐ No
	e. Does the medical record confirm at least 50% reduction in pain and improvement in function after all prior procedures for this episode of pain?	☐ Yes ☐ No
	f. Does the medical record show ongoing participation in non-operative treatment, including chiropractic/physical therapy and/or a home exercise program?	☐ Yes ☐ No
	g. Have 4 or more epidural steroid injection sessions been done in this same spine region in the past 12 months (cervical/thoracic, or lumbar)?	☐ Yes ☐ No
	h. Have 6 or more epidural steroid injection sessions for the entire spine been done in the past 6 months?	☐ Yes ☐ No
☐ **Selective nerve root block** (answer a – b)	a. Is the selective nerve root block being done as a diagnostic aid to confirm which spinal level corresponds with symptoms (such as multi-level degeneration, physical exam doesn't match imaging, or confirmation of disc herniation/bulge as cause of pain)?	☐ Yes ☐ No
	b. Are 2 or more levels planned for the procedure?	☐ Yes ☐ No

Do any of the following apply? (Answer a – g)	
a. Injection with steroid planned with uncontrolled diabetes, uncontrolled hypertension, or congestive heart failure present	☐ Yes ☐ No
b. Systemic or localized infection at planned injection site	☐ Yes ☐ No
c. Axial neck or back pain with no or minimal radiculopathy or claudication (burning, tingling, cramping)	☐ Yes ☐ No
d. Planned interlaminar ESI into insufficient epidural space (due to prior surgery, compression, or congenital condition)	☐ Yes ☐ No
e. Presence of cauda equina syndrome, spinal cord compression, or spinal tumor	☐ Yes ☐ No
f. Other pain management interventions planned same day (i.e. epidural steroid injection, SI joint injection, trigger point injection, etc.)	☐ Yes ☐ No
g. Pain management procedures planned in multiple regions (i.e. cervical/thoracic AND lumbar or sacral)	☐ Yes ☐ No
Will the procedure be performed with fluoroscopic guidance?	☐ Yes ☐ No
Is general anesthesia, conscious sedation, or monitored anesthesia care planned?	☐ Yes ☐ 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:**