Blue Cross Blue Shield Blue Care Network of Michigan

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

TurningPoint Healthcare Solutions

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: _____ /_____ /_____	**Member name:**
Provider contact name:	**Date of birth:** _____ /_____ /_____
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):
_____ /_____ /_____

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

- ☐ Diabetes that requires medication or insulin (Type I or Type II)
  A1C 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
- ☐ Unaddressed psychosocial and/or substance abuse issues
- ☐ Other (please specify) _____
- ☐ None

2. 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)

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

- ◯ Independent
- ◯ Partially dependent
- ◯ Totally dependent

Patient's weight: _____ **Patient's height:** _____

Patient's BMI: _____

4. For BMI over 30, which weight loss activities are documented?

- ◯ Weight loss discussion documented
- ◯ Weight loss plan documented
- ◯ Patient has lost at least 15-20% of initial body weight
- ◯ No weight loss, or weight loss of less than 15-20% of initial body weight
- ◯ None of the above

5. Which conservative treatments have been attempted? ***Select all that apply.***

- ☐ Oral medication (NSAIDs, analgesics)
- ☐ Topical medication
- ☐ Injection(s)
- ☐ Ice or heat
- ☐ Activity modification
- ☐ Physical therapy
- ☐ Home exercise program
- ☐ Chiropractic treatment
- ☐ Assistive device (cane, crutches, brace, walker, etc.)
- ☐ TENS unit
- ☐ Other (please specify)

_____

- ☐ None of the above

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6. How long has conservative treatment been attempted?
- ◯ Less than 4 weeks
- ◯ 4-5 weeks
- ◯ 6-11 weeks
- ◯ 3-5 months
- ◯ 6-12 months
- ◯ More than 1 year
- ◯ No conservative treatment has been attempted

7. Which types of imaging are included?
- ☐ MRI
- ☐ X-ray
- ☐ CT
- ☐ Ultrasound
- ☐ Other (please specify) _____

8. What are the imaging findings?
Select all that apply.
- ☐ Disc herniation with nerve impingement and correlating symptoms
- ☐ Stenosis with nerve impingement and correlating symptoms
- ☐ Severe degenerative disc disease or central disc herniation/ central spinal stenosis
- ☐ Disc bulge or annular tear/fissure with low back pain only
- ☐ Stenosis or disc herniation with impingement with non-correlating symptoms
- ☐ Spinal cord impingement or other compromised epidural space
- ☐ Other (please specify) _____

9. What are the history and exam findings?
Select all that apply.
- ☐ Acute radicular pain present for more than 3 months that interferes with daily activities
- ☐ Acute radicular pain present for less than 3 months
- ☐ Acute radicular pain present that does not interfere with daily activities
- ☐ Axial neck or back pain with no radiculopathy
- ☐ Chronic radicular pain
- ☐ Pain due to herpes zoster
- ☐ Neurogenic claudication
- ☐ Low back pain rated at least 3/10 on a numeric pain rating scale that interferes with daily activities
- ☐ Other (please specify) _____

10. Is this an initial or a repeat injection?
- ◯ Initial injection at one level
- ◯ Repeat/subsequent injection at one level *(please also complete question 10a below)*
- ◯ Initial injection at more than one level
- ◯ Repeat/subsequent injection at more than one level

10a. What was the result of the prior injection?
- ◯ At least 50% improvement in pain and function for at least 2 months
- ◯ Improvement in pain and function for less than 2 months
- ◯ Less than 50% improvement in pain and function

11. Will the injection be performed with fluoroscopic guidance?
- ◯ Yes
- ◯ No

12. How many injection sessions in the last 6 months?
- ◯ 0-2
- ◯ 3 or more

13. Are any of the following present?
Select all that apply.
- ☐ Patient has bleeding disorder or is on anticoagulant therapy
- ☐ Allergy to any part of injectate
- ☐ Infection or tumor at planned needle trajectory
- ☐ Presence of conditions that may be exacerbated by steroids (uncontrolled diabetes, hypertension, congestive heart failure, etc.)
- ☐ Insufficient epidural space due to prior surgery, compression or congenital condition
- ☐ A third injection when the first two have failed to improve symptoms
- ☐ None of the above

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:** _____ /_____ /_____