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 FACET 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:** _____ /_____ /_____ | **Member name:** |
| **Provider contact name:** | **Date of birth:** _____ /_____ /_____ |
| **Provider contact phone:** | **Member ID (including any alpha prefix):** |
| **Provider name:** | **Health plan:** |
| **Provider TIN:** | **Notification method preference:**<br>◯ **Postal mail**<br>◯ **Fax**<br><br>**Please provide mailing address or fax number.** |
| **Provider NPI:** | |
| **Practice/group name:** | |
| **Provider contact fax:** | **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

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

**Patient's BMI:** _____

**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

**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 procedure is planned?**

- ◯ Selective nerve root block to diagnose symptomatic level in presence of multi-level disease
- ◯ Selective nerve root block to diagnose symptomatic level when physical exam does not correlate with imaging
- ◯ Selective nerve root block to diagnose symptomatic level with imaging evidence of disc herniation/bulging, or stenosis
- ◯ Diagnostic facet joint or z-joint injection *(please also complete questions 5a-c)*
- ◯ Therapeutic facet joint or z-joint injection *(please also complete question 5d)*

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**5a. 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

**5b. How long has conservative treatment been attempted?**

- ◯ Less than 6 weeks
- ◯ 6-11 weeks
- ◯ 3-5 months
- ◯ 6-12 months
- ◯ More than 1 year
- ◯ No conservative treatment attempted

**5c. Which of the following indications are present?**
***Select all that apply.***

- ☐ Primarily axial pain without radiculopathy or neurological deficits that has been present for at least 3 months
- ☐ Primarily axial pain without radiculopathy or neurological deficits that has been present for less than 3 months
- ☐ Radiating pain/radiculopathy or pain with neurological deficits, regardless of onset
- ☐ Imaging shows other possible explanation for pain
- ☐ Imaging rules out all other possible explanations for pain
- ☐ Procedure planned for up to 2 levels/4 individual facet joints
- ☐ Procedure planned for 3 or more levels/5 or more individual facet joints
- ☐ Other (please specify) _____
- ☐ None of the above

**5d. Is this an initial or a repeat therapeutic injection?**

- ◯ Initial; 0-1 diagnostic injections performed prior
- ◯ Initial; 2 diagnostic injections performed prior with less than 80% relief of pain
- ◯ Initial; 2 diagnostic injections performed prior with 80% relief of pain or more
- ◯ Repeat; prior therapeutic injection resulted in less than 50% relief of pain
- ◯ Repeat; prior therapeutic injection resulted in less than 3 months relief of pain
- ◯ Repeat; prior therapeutic injection resulted in at least 50% relief of pain for at least 3 months

**6. Will the injection be performed with fluoroscopic guidance?**

- ◯ Yes
- ◯ No

**7. Are any of the following present?**
***Select all that apply.***

- ☐ Infection, tumor or prior spinal fusion at site planned for procedure
- ☐ Procedure is planned for 3 or more spinal levels
- ☐ Coagulopathy or systemic infection
- ☐ Planned therapeutic facet injection
- ☐ None of the above

**8. How many facet joint interventions have been performed in the last 12 months in this spinal region (cervical/thoracic or lumbar)?**

- ◯ 0-4 medial branch blocks, intraarticular injections, facet cyst rupture, and/or radiofrequency ablations
- ◯ 5 or more medial branch blocks, intraarticular injections, facet cyst rupture, and/or radiofrequency ablations

**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:** _____ /_____ /_____