



**Blue Cross
Blue Shield
Blue Care Network**
of Michigan

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: ____ / ____ / ____
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: ____ / ____ / ____
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):



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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? <i>Select all that apply.</i> <input type="checkbox"/> Diabetes that requires medication or insulin (Type I or Type II) A1C Level: _____ <input type="checkbox"/> Hypertension requiring medication <input type="checkbox"/> Previous cardiac event <input type="checkbox"/> Congestive heart failure <input type="checkbox"/> Dyspnea <input type="checkbox"/> Current smoker within past 12 months <input type="checkbox"/> History of severe COPD <input type="checkbox"/> Dialysis <input type="checkbox"/> Acute renal failure <input type="checkbox"/> Ascites within past 30 days <input type="checkbox"/> Steroid use for chronic condition <input type="checkbox"/> Disseminated cancer <input type="checkbox"/> Unaddressed psychosocial and/or substance abuse issues <input type="checkbox"/> Other (please specify) _____ <input type="checkbox"/> None		Patient's weight: _____	Patient's height: _____
		Patient's BMI: _____	
2. What is the patient's current health status? <input type="checkbox"/> Normal healthy patient <input type="checkbox"/> Mild or moderate disease that does not limit activity (ex: controlled HTN or DM, mild obesity) <input type="checkbox"/> Severe disease that limits activity (ex: controlled CHF, history of MI, uncontrolled HTN or DM) <input type="checkbox"/> Severe life-threatening disease (ex: symptomatic CHF or COPD, renal failure, unstable angina)		4. For BMI over 30, which weight loss activities are documented? <input type="checkbox"/> Weight loss discussion documented <input type="checkbox"/> Weight loss plan documented <input type="checkbox"/> Patient has lost at least 15-20% of initial body weight <input type="checkbox"/> No weight loss, or weight loss of less than 15-20% of initial body weight <input type="checkbox"/> None of the above	
		5. Which conservative treatments have been attempted? <i>Select all that apply.</i> <input type="checkbox"/> Oral medication (NSAIDs, analgesics) <input type="checkbox"/> Topical medication <input type="checkbox"/> Injection(s) <input type="checkbox"/> Ice or heat <input type="checkbox"/> Activity modification <input type="checkbox"/> Physical therapy <input type="checkbox"/> Home exercise program <input type="checkbox"/> Chiropractic treatment <input type="checkbox"/> Assistive device (cane, crutches, brace, walker, etc.) <input type="checkbox"/> TENS unit <input type="checkbox"/> Other (please specify) _____ <hr/> <input type="checkbox"/> None of the above	
3. Patient's activities of daily living (ADL) functional status: <input type="checkbox"/> Independent <input type="checkbox"/> Partially dependent <input type="checkbox"/> Totally dependent			



<p>6. How long has conservative treatment been attempted?</p> <p><input type="checkbox"/> Less than 6 weeks</p> <p><input type="checkbox"/> 6-11 weeks</p> <p><input type="checkbox"/> 3-5 months</p> <p><input type="checkbox"/> 6-12 months</p> <p><input type="checkbox"/> More than 1 year</p> <p><input type="checkbox"/> No conservative treatment has been attempted</p>	<p>8a. How many injection sessions has the patient had in the last 12 months?</p> <p><input type="checkbox"/> 0-2</p> <p><input type="checkbox"/> 3 or more</p>
<p>7. What are the history and exam findings? <i>Select all that apply.</i></p> <p><input type="checkbox"/> Presence of non-radicular SI joint pain for at least 3 months</p> <p><input type="checkbox"/> SI joint pain that radiates/has radiculopathy component</p> <p><input type="checkbox"/> Pain is localized over SI joint (typically one sided)</p> <p><input type="checkbox"/> Pain is located below lumbar spine</p> <p><input type="checkbox"/> Localized tenderness over SI joint that does not involve lumbar spine, hip or coccyx</p> <p><input type="checkbox"/> Presence of pain on exam in lumbar spine, hip or coccyx</p> <p><input type="checkbox"/> Positive thigh thrust test</p> <p><input type="checkbox"/> Positive sacral compression/sacral thrust test</p> <p><input type="checkbox"/> Positive Gaenslen's test</p> <p><input type="checkbox"/> Positive distraction test</p> <p><input type="checkbox"/> Positive Patrick's test</p> <p><input type="checkbox"/> Positive provocation test</p> <p><input type="checkbox"/> All other causes of pain ruled out</p> <p><input type="checkbox"/> Imaging or exam suggests other causes for pain</p> <p><input type="checkbox"/> Other (please specify) _____</p>	<p>8b. Were dual diagnostic injections performed?</p> <p><input type="checkbox"/> Yes; dual diagnostic injections resulted in at least 50% improvement in pain and function for at least 2 months</p> <p><input type="checkbox"/> Yes; dual diagnostic injections resulted in at least 50% improvement in pain and function for less than 2 months</p> <p><input type="checkbox"/> Yes; dual diagnostic injections resulted in less than 50% improvement in pain and function</p> <p><input type="checkbox"/> No; 0-1 diagnostic injections performed</p>
<p>8. What is the purpose of the injection?</p> <p><input type="checkbox"/> Diagnosing sacroiliac joint pain</p> <p><input type="checkbox"/> Treating sacroiliac joint pain (<i>please also complete questions 8a-b</i>)</p>	<p>9. Will the injection be performed with fluoroscopic guidance?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p>10. Are any of the following present? <i>Select all that apply.</i></p> <p><input type="checkbox"/> Patient on anticoagulant therapy</p> <p><input type="checkbox"/> Allergy to any part of injectate</p> <p><input type="checkbox"/> Infection or tumor at planned needle trajectory</p> <p><input type="checkbox"/> Presence of conditions that may be exacerbated by steroids (uncontrolled diabetes, hypertension, congestive heart failure, etc.)</p> <p><input type="checkbox"/> None of the above</p>
<p>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.</p>	
<p>Completed by: _____ Date: ____ / ____ / ____</p>	