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
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 (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 contact email:	**Notification method preference:** ☐ Postal mail ☐ Fax
Provider name:	
Provider TIN:	**Mailing address or fax number:**
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 diagnostic SI joint injection** (answer a – h)	a. Has SI joint pain, without radiculopathy (burning, tingling, cramping), been present for at least 3 months?	☐ Yes ☐ No
	b. Does the exam confirm tenderness to touch over the SI joint (below lumbar spine), consistent with SI joint pain?	☐ Yes ☐ No
	c. Does the exam show positive responses to at least 3 different SI joint tests (thigh thrust, sacral compression or thrust, Gaenslen's, distraction, Patrick's, and/or posterior provocation)?	☐ Yes ☐ No
	d. Has conservative treatment been attempted for at least 4 weeks/1 month?	☐ Yes ☐ No
	e. Has medication been attempted as part of conservative treatment?	☐ Yes ☐ No
	f. Has chiropractic care, physical therapy, and/or home exercise program been attempted as part of conservative treatment?	☐ Yes ☐ No
	g. Does imaging show any other possible causes of pain (hip or lumbar degeneration, stenosis, etc.)?	☐ Yes ☐ No
	h. Is the total amount of anesthetic being used less than 3cc per joint?	☐ Yes ☐ No
☐ **Second diagnostic SI joint injection** (answer a – c)	a. Were criteria met for initial diagnostic injection?	☐ Yes ☐ No
	b. Does the medical record show at least 75% reduction in pain and improvement in function with initial diagnostic injection?	☐ Yes ☐ No
	c. Have at least 2 weeks passed since first diagnostic injection?	☐ Yes ☐ No
☐ **Third or greater diagnostic SI joint injection**	No questions related to this procedure; proceed to next section.	

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☐ **Initial therapeutic SI joint injection** (answer a – b)	a. Were 2 diagnostic SI joint injections performed on the same side(s) as the planned therapeutic injection in the past year?	☐ Yes ☐ No
	b. Does the medical record show at least 75% reduction in pain and improvement in function with both diagnostic injections?	☐ Yes ☐ No
☐ **Second or greater therapeutic SI joint injection** (answer a – c)	a. Was the prior therapeutic injection performed on the same side(s) within the past year?	☐ Yes ☐ No
	b. Does the medical record show at least 50% reduction in pain and improvement in function for at least 3 months after the prior procedure?	☐ Yes ☐ No
	c. Have 3 or more SI joint injections containing steroid (including diagnostic) been done in this joint in the past 12 months?	☐ Yes ☐ No

Do any of the following apply? (Answer a – d)	
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. Other pain management interventions planned same day (i.e. epidural steroid injection, SI joint injection, trigger point injection, etc.)	☐ Yes ☐ No
d. 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:**