Facet Joint Injection(s): Prior Authorization Request Form

Please download and complete form in Adobe or Fax. Do not complete in browser.

Please Note: For non-urgent pain management injection requests, please complete form and submit with all appropriate and relevant medical records (imaging, office visit notes, attempted conservative treatments, etc.). Failure to submit appropriate relevant medical records may result in determination delays and denials.

BlueCross BlueShield of Tennessee: Commercial Members Only

Use for CPT codes 0213T, 0214T, 0215T, 0216T, 0217T, 0218T, 64490, 64491, 64492, 64493, 64494, 64495

Requested CPT Code	Quantity	Modifier: LT, RT, or 50 (bilateral)
Primary Diagnosis Code	Anticipated Date of Service (mm/dd/yyyy)	

Patient/Member Information			
First Name	Last Name	DOB (mm/dd/yyyy)	
Health Plan	Member ID	Member ID Suffix	

Requesting Provider			
Contact First Name:	Last Name:		
Contact Phone:	Contact Fax:		
Providers First Name:	Providers Last Name:		
TIN:	NPI:		
BCBSTN Provider ID #:			
Address:		Suite #:	
City:	State:	Zip:	
Notification Method Preference:	☐ Postal Mail	☐ Fax	☐ Portal

Facility/Place of Service

Is Facility Setting same as practice? ☐ Yes ☐ No ***If yes, do not complete facility information below.**			
Facility Setting: ☐ In-Office ☐ Outpatient ☐ Observation ☐ Inpatient Hospital			
Facility Name:			
TIN:	NPI:		
BCBSTN Facility ID #:			
Address:		Suite #:	
City:	State:	Zip:	
Contact First Name:	Last Name:		
Contact Phone:	Contact Fax:		
Notification Method Preference: ☐ Postal Mail ☐ Fax ☐ Portal			

Patient Clinical Information

I. What procedure is being requested?

- ☐ Diagnostic nerve root block(s)
- ☐ Therapeutic Facet Joint (intraarticular) or medical branch injection

II. Which side of the spine are the injections planned for?

- ☐ Left
- ☐ Right
- ☐ Bilateral

III. Which levels will be treated (unilateral or bilateral)? (Select all that apply)

☐ C1-C2	☐ C4-C5	☐ C7-T1	☐ T3-T4	☐ T6-T7	☐ T9-T10	☐ T12-L1	☐ L3-L4
☐ C2-C3	☐ C5-C6	☐ T1-T2	☐ T4-T5	☐ T7-T8	☐ T10-T11	☐ L1-L2	☐ L4-L5
☐ C3-C4	☐ C6-C7	☐ T2-T3	☐ T5-T6	☐ T8-T9	☐ T11-T12	☐ L2-L3	☐ L5-S1

IV. Has the patient had a previous spinal fusion at any levels? (Select all that apply)

☐ C1-C2	☐ C4-C5	☐ C7-T1	☐ T3-T4	☐ T6-T7	☐ T9-T10	☐ T12-L1	☐ L3-L4
☐ C2-C3	☐ C5-C6	☐ T1-T2	☐ T4-T5	☐ T7-T8	☐ T10-T11	☐ L1-L2	☐ L4-L5
☐ C3-C4	☐ C6-C7	☐ T2-T3	☐ T5-T6	☐ T8-T9	☐ T11-T12	☐ L2-L3	☐ L5-S1

V. Will the injection be done with fluoroscopic guidance?

- ☐ Yes
- ☐ No

VI. Which of the following apply?

- ☐ Procedure is being done for back or neck pain, occurring daily
- ☐ The patient does not have radiculopathy
- ☐ All other sources of pain have been ruled out
- ☐ Pain causes significant functional limitations

VII. How long have conservative treatments been attempted?

- ☐ Less than three (3) months
- ☐ Three (3) months or longer

VIII. What conservative treatments have been attempted?

- ☐ Medication – NSAIDs
- ☐ Medication - analgesics
- ☐ Medication – other (steroids, muscle relaxants, nerve pain medication, etc.)
- ☐ Rest or activity modification
- ☐ Physical therapy
- ☐ Manipulation
- ☐ None of the above

IX. What is the patient's pain level? [Select applicable]

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

X. Are any of the following present? [Select all that apply]

- ☐ Allergy to medication being administered
- ☐ Infection (either systemic or at the injection site)
- ☐ Uncontrolled hypertension
- ☐ Congestive Heart Failure
- ☐ Diabetes
- ☐ Bleeding disorder or anticoagulant use
- ☐ Planned injection for pain treatment (e.g., epidural, sacroiliac joint injection or lumbar sympathetic block and/or trigger point injections) given within three (3) days of facet joint injection
- ☐ Neurogenic Claudication
- ☐ Radiculopathy (unless caused by facet joint synovial cyst in lumbar spine)
- ☐ None

XI. ***If therapeutic injection only:*** How much pain relief was received from diagnostic nerve block?

- ☐ No diagnostic nerve block completed
- ☐ 0-24% pain relief
- ☐ 25-49% pain relief
- ☐ 50-74% pain relief
- ☐ 75-100% pain relief

XII. ***If therapeutic injection only:*** Has a previous facet joint injection been performed within the past twelve (12) months? If so, how many?

- ☐ No previous injection – first treatment
- ☐ One (1) previous facet joint injection
- ☐ Two (2) previous facet joint injections
- ☐ Three (3) previous facet joint injections
- ☐ Four (4) or more previous facet joint injections

Dates and Levels of All Previous Injections: _____

XIII. If repeat therapeutic injection, was there greater than 50% improvement in pain and function for ten (10) weeks or longer with the previous injection?

- ☐ Yes, there was greater than 50% improvement in pain and function for ten (10) weeks or longer
- ☐ No, there was not greater than 50% improvement in pain and function and/or it was not achieved for at least ten (10) weeks

ADDITIONAL COMMENTS:

To submit the following form electronically, please select the submit button:

To clear all the above fields in the form, please select clear button:

To print the above form with your, select the print button:

To submit this request via fax, you may submit this form to TurningPoint Healthcare Solutions at (423) 800-5302