PAIN MANAGEMENT
FACET JOINT INJECTION
AUTHORIZATION REQUEST FORM

Utilization Management local phone: 866-747-0586
Utilization Management fax: 423-800-5302

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.

*Requests can be submitted online at any time through Availity.com.
*Contact the eBusiness Marketing team for all your Availity® registration and training needs by calling 423-535-5717 option 2 or emailing eBusiness_marketing@bcbst.com.

BlueCross BlueShield of Tennessee: Commercial Members Only

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

**** Codes 64491, 64492, 64494, and 64495 use LT, and/or RT modifiers only, not 50 (bilateral)***

Today's date (mm/dd/yyyy): __ / __ / ____

MEMBER INFORMATION		
Member name:		**Date of birth (mm/dd/yyyy): __ / __ / ____**
Member ID:	**Suffix:**	**Health plan:**

RENDERING PROVIDER INFORMATION	
Contact name:	
Contact phone:	**Contact fax:**
Provider name:	
Provider NPI:	**Provider Mailing address or fax number:**
Provider TIN:	
BCBSTN Provider ID:	
Practice/group name:	
Notes:	**Provider physical address:**
	Notification method preference: ○ Postal mail ○ Fax

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TurningPoint

of Tennessee

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Where will the procedure take place?			
○ Provider office	○ Outpatient	○ Observation	○ Inpatient hospital
Facility name:		**BCBSTN Provider ID:**	
Facility TIN:		**Facility contact name:**	
Facility NPI:		**Facility contact phone:**	
Facility physical address:		**Facility contact fax:**	

Requested procedure code	**Modifier: LT, RT or 50 (bilateral)**	**Quantity**	**Spine level**
Primary Diagnosis code:		**Anticipated date of service (mm/dd/yyyy): __ / __ / ____**	
Additional Diagnosis code(s):			
Patient's height:	**Patient's weight:**	**Patient's BMI:**	

What procedure is being requested? Select one.	**Which side of the spine are the injections planned for? Select One.**
○ Diagnostic nerve root block(s) ○ Therapeutic Facet Joint (intraarticular) or medical branch injection	○ Left ○ Right ○ Bilateral

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

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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

Will the injection be done with fluoroscopic guidance? Select one.

- ◯ Yes
- ◯ No

How long have conservative treatments been attempted? Select one.

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

Which of the following apply? Select all that 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

What conservative treatments have been attempted? Select all that apply.

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

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

◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10

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

***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:

***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

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

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By submitting this request, you are confirming that you have provided all clinical information available pertinent to this request and you are requesting the decision be made based on information provided in your submission.	
Form completed by:	**Date:**

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