BlueCross BlueShield of North Carolina

Facet Joint Denervation

PRIOR REVIEW/CERTIFICATION

Request for Services Form

Submission of this form is solely a notification for request for services and does not guarantee approval. All requests must be reviewed using authorization requirements by the prospective review area/department before authorization is granted.
Incomplete forms may delay processing. All NC Providers must provide their 5-digit BCBSNC provider ID# below.

*****PLEASE NOTE: Additional Records are NOT REQUIRED at this time IF FAX FORM CLINICAL IS COMPLETE *****

Patient Name	BCBSNC Member ID number	Patient Date of Birth

Requesting Provider Information		**Servicing Provider Or Facility Location (for services to be performed outside of the physician office)**	
Provider Name		Servicing Provider	
Provider #, Tax ID # or NPI		Facility Name	
Street, Bldg., Suite #		Servicing provider or Facility #,Tax ID # or NPI	
City/State/Zip code		Street, Bldg., Suite #	
Phone #		City/State/Zip code	
Fax #			

Primary Diagnosis		ICD-10 Code	
Other Diagnosis		ICD-10 Code	

CPT code/# of Units		Levels to be treated		Treatment side	
CPT code/# of Units		Levels to be treated		Treatment side	
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CPT code/# of Units		Levels to be treated		Treatment side	

Initial Treatment:

Fill in the appropriate response: Y= Yes, N =No, NA =Not Applicable	
	Patient has no prior spinal fusion surgery in the vertebral level being treated?
	The medical record documents the all the below:
	(a) History, consisting of mainly axial or non-radicular pain
	(b) Physical examination confirms positive provocative signs of facet disease
	(c) Is there radiographic imaging that excludes other causes of cervical or lumbar pain prior to treatment with spinal injections?
	Pain has failed to respond to three (3) months of conservative management which must consist of **therapies that include all the below:**
	(a) oral analgesics; (e.g., nonsteroidal anti-inflammatory medications, acetaminophen)
	(b) manipulation or physical therapy
	(c) home exercise program
	Has a trial of controlled diagnostic medial branch blocks or facet joint injections consisting of two (2) separate positive blocks/injections or placebo controlled series of blocks under fluoroscopic guidance been completed and each resulted in at least a 70% or greater reduction in pain?
	MBB #1 date Levels treated % pain relief
	MBB #2 date Levels treated % pain relief

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Prior Review Fax Form (page 2)

Patient Name	BCBSNC Member ID number	Patient Date of Birth

Repeat Requests:

Fill in the appropriate response: Y= Yes, N =No, NA =Not Applicable	
	Has there been prior successful radiofrequency (RF) denervation?
	Has a minimum of six months elapsed since the prior RF denervation treatment?
	Is the repeat treatment being requested for symptoms and presentation similar to that of the initial treatment location(s) or spinal level(s)?
	Was the percentage of relief from previous RFA at least 50%?
	Has a trial of two separate diagnostic medial branch blocks or facet joint injections under fluoroscopic guidance been completed and has **each resulted in a 50% or greater reduction in pain.**

Please Note ***

Repeat medial branch blocks are not necessary after 6 months or more have elapsed since prior RF denervation treatment, if symptoms and treatment are at the same location(s) or spinal level(s), and presentation is similar to that of initial or prior treatment.
If no prior diagnostic medial branch blocks have been done, even if the patient responded well to prior RF denervations, those denervations are NOT a substitute for an initial trial of nerve blocks and therefore medial branch nerve blocks would be necessary before a repeat RF denervation is done.

PHYSICIAN ATTESTATION: By signing below, I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.

Please certify the following by signing and dating below:

Physician signature:		Date:	

Fax this form with required documentation to the appropriate fax number below:

Department	Fax Number	Department	Fax Number
Discharge Services	800.228.0838	Medical Drugs	800.795.9403
PPA/Case Mgmt/Acute Inpt	800.571.7942	ST PPO PPA/UM	866.225.5258
	800.672.6587	ST PPO Transplant	919.765.1553
	800.459.1410	-	-