PRIOR AUTHORIZATION for SACROILIAC JOINT FUSION

For authorization, please complete this form, include patient chart notes to document information and FAX to the PEHP Prior Authorization Department at (801) 366-7449 or mail to: 560 East 200 South Salt Lake City, UT 84102. If you have prior authorization or benefit questions, please call PEHP Member & Provider Services at (801) 366-7555 or toll free at (800) 753-7490.

Section I: PATIENT INFORMATION

Date Requested:	Name (Last, First MI):	DOB:	Age:	PEHP ID #:

Section II: PROVIDER INFORMATION

***Rendering* Provider:**			***Rendering* Provider Address:**		
Provider NPI #:	**Provider TIN #:**	**Contact Person:**	**Phone:** ( )	**Facsimile:** ( )	**Email Address:**
***Facility/Hospital*:**			***Facility/Hospital* Address:**		
Provider NPI #:	**Provider TIN #:**	**Contact Person:**	**Phone:** ( )	**Facsimile:** ( )	**Email Address:**

Section III: PRE-AUTHORIZATION REQUEST

Nature of Request: *Please check.*	**Requested Date of Service:**	**Place of Service:** *Please check.*
☐ Auth Extension ☐ Pre-Auth ☐ Retro Auth ☐ Urgent	**From:** **To:**	☐ Ambulatory Surgical Center ☐ Inpatient ☐ Office ☐ Outpatient

Primary Diagnosis/ICD-10 Code:	**Secondary Diagnosis/ICD-10 Code:**

Service (s) Requested: ***Please list all requested services regardless of pre-authorization requirement. Unlisted codes cannot be pre-authorized.***

Service: _____ CPT/HCPCS code: _____ ☐ Bilateral ☐ Left ☐ Right

Service: _____ CPT/HCPCS code: _____ ☐ Bilateral ☐ Left ☐ Right

Service: _____ CPT/HCPCS code: _____ ☐ Bilateral ☐ Left ☐ Right

Service: _____ CPT/HCPCS code: _____ ☐ Bilateral ☐ Left ☐ Right

***(Please check surgical approach and answer questions in the corresponding section.)* QUESTION**	**YES**	**NO**	**COMMENTS/NOTES**
A. ☐ Minimally Invasive / Percutaneous Fusion (Arthrodesis) of the Sacroiliac (SI) Joint:			
1. Will an FDA-approved transfixing titanium implant (i.e., triangular shaped implant or "pontoon-like" implant) via an inferior-posterior, lateral transarticular, or posterior-oblique approach, and intended to promote bone fusion be utilized?	☐	☐	
2. Does the patient have low back/buttock pain that has been present for at least 6 months and is due to degenerative sacroiliitis or sacroiliac joint disruption, or dysfunction?	☐	☐	
3. Does the patient have non-radicular unilateral pain that is worse below the L5 vertebra, is localized over the posterior sacroiliac joint, and is consistent with sacroiliac joint pain?	☐	☐	
4. Does the patient have localized tenderness with palpitation of the posterior sacroiliac joint in the absence of tenderness of similar severity elsewhere (e.g., greater trochanter, lumbar spine, coccyx) and no other obvious sources for the pain exists?	☐	☐	
5. Does the patient have persistent moderate to severe SI joint pain (pain rated > 5 on 10-point VAS/Visual Analog Scale) that limits activities of daily living (ADLs) and/or has resulted in functional disability?	☐	☐	
6. Has the pain/symptoms failed to respond to at least six (6) months of physician-supervised conservative management (e.g., active physical therapy targeted at the lumbar spine, pelvis, SI joint, and hip, activity lifestyle modification, exercise, and medication escalation [unless contraindicated])?	☐	☐	
7. Is there a statement or documentation from a licensed behavioral and/or medical health care provider confirming the absence of generalized pain behavior (e.g., somatoform disorder)untreated, generalized pain disorder (e.g., fibromyalgia), and underlying mental health conditions/issues (e.g., depression, drug, alcohol abuse)?	☐	☐	***Please submit copy of documentation.***
8. Is the patient a nonsmoker, or will they refrain from tobacco use for at least six (6) weeks prior to surgery if they do not have progressive neurological compromise (e.g., changes in reflexes, difficulty with bowel or bladder control, loss of sensation, weakness or paralysis)?	☐	☐	
9. Did the patient have a positive response to at least three of the following provocative tests? ***Please check all that apply.*** a. ☐ Compression Test c. ☐ FABER (Patrick's) Sign e. ☐ Thigh Thrust Test b. ☐ Distraction Test d. ☐ Gaenslen's Maneuver	☐	☐	

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QUESTION (*cont'd*)	YES	NO	COMMENTS/NOTES
10. Does imaging of the SI joint show evidence of injury and/or degeneration?	☐	☐	
11. Did plain radiograph of the ipsilateral hip (the same side as the affected SI joint) show evidence of osteoarthritis?	☐	☐	***Please submit imaging reports.***
12. Did imaging (plain radiographs and a CT/computerized tomography or MRI/magnetic resonance imaging) of the SI joint show evidence of destructive lesions (e.g., tumor, infection) or inflammatory arthropathy?	☐	☐	***Please submit imaging reports.***
13. Did imaging of the lumbar spine (CT or MRI) show evidence of neural compression or any other degenerative condition that could be causing the low back or buttock pain?	☐	☐	***Please submit imaging reports.***
14. Was there confirmation that the SI joint is the cause of the pain as evidenced by at least a 75% reduction in pain for the expected duration of the anesthetic used following an image-guided, contrast-enhanced intra-articular sacroiliac joint injection on 2 separate occasions that are at least two (2) months apart?	☐	☐	***Please submit procedure reports & post-procedure pain diary.***
15. Did the patient have a trial of at least one therapeutic intra-articular SI joint injection (i.e., corticosteroid)?	☐	☐	
16. Is percutaneous SI joint fusion being requested for a patient who has any of the following present? ***Please check all that apply.*** a. ☐ Acute, traumatic instability of the SI joint b. ☐ Back pain present for less than 6 months c. ☐ Existence of other pathology that could explain the patient's pain d. ☐ Failure to pursue conservative treatment of SI joint (unless contraindicated) e. ☐ Generalized Pain Behavior (e.g., somatoform disorder) f. ☐ Generalized Pain Disorder (e.g., Fibromyalgia) g. ☐ Infection, tumor, or fracture h. ☐ Mechanical low back pain i. ☐ Neural compression as seen on an MRI or CT that correlates with the patient's symptoms or other more likely source for their pain (e.g., radicular pain) j. ☐ Osteopenia or osteoporosis (e.g., T-score < - 1.0) k. ☐ Pain that has not been confirmed with a diagnostic SI joint injection l. ☐ Systemic Arthropathy (e.g., ankylosing spondylitis or rheumatoid arthritis) m. ☐ Untreated or underlying mental health conditions/issues (e.g., depression, drug, alcohol abuse) that is a major contributor to the patient's chronic back pain.	☐	☐	
17. Will a posterior or dorsal approach be used to access the SI joint with use of only bone grafts and no internal fixation for SI joint fusion?	☐	☐	
17. Will implants other than those which are placed across the joint (transfixing) to promote fusion (e.g., allograft, synthetic, nonmetallic implants [e.g., CornerLoc, LinQ]) be used for SI joint fusion?	☐	☐	
18. Will both a lateral transfixing and intra-articular (non-transfixing) device be inserted during the same operative session (e.g., Hybrid SI joint fusion)?	☐	☐	
19. Will a percutaneous intra-articular implant be used for SI joint fusion?	☐	☐	
20. Will a 3D printed SI joint fusion implant be used?	☐	☐	
B. ☐ Open Fusion of the Sacroiliac (SI) Joint:			
1. Does appropriate imaging studies demonstrate localized SI joint pathology?	☐	☐	***Please submit imaging reports.***
2. Is the patient a nonsmoker, or will they refrain from tobacco use for at least six (6) weeks prior to surgery if they do not have progressive neurological compromise (e.g., changes in reflexes, difficulty with bowel or bladder control, loss of sensation, weakness or paralysis)?	☐	☐	
3. Is open SI joint fusion being requested for any of the following? ***Please check all that apply.*** a. ☐ As an adjunct to the medical treatment of sacroiliac joint infection (e.g., osteomyelitis, pyogenic sacroiliitis)/sepsis b. ☐ As an adjunct to sacrectomy or partial sacrectomy related to tumors involving the sacrum c. ☐ Post-traumatic injury of the SI joint (e.g., following pelvic ring fracture) d. ☐ When performed as part of multisegmental long fusions for the correction of spinal deformity (e.g., idiopathic scoliosis, neuromuscular scoliosis).	☐	☐	
4. Is open SI joint fusion being requested for a patient who has any of the following present? ***Please check all that apply.*** a. ☐ Degenerative sacroiliac joint b. ☐ Mechanical low back pain c. ☐ Presence of neural compression on an MRI or CT that corresponds with the patient's symptoms or other more likely source for their pain (e.g., radicular pain) d. ☐ Sacroiliac joint syndrome	☐	☐	
Additional Comments:			

By submitting this form, I attest that the information provided is true and accurate to the best of my knowledge.

Please fax completed form and medical records to 801-366-7449.