PLEASE DO NOT USE STAPLES FOR ANY DOCUMENTATION!

JURISDICTION 15 PART A

PRIOR AUTHORIZATION OPD: FACET JOINT INTERVENTIONS

PAR 573

All fields are REQUIRED unless otherwise noted.
Incomplete or illegible handwritten requests will be returned.

Note: Use of this request document will require submission via fax, mail, or the electronic submission of Medical Documentation (esMD). To save time, use the myCGS web portal to submit your request, upload your documentation electronically, track the status of your request, and receive a quicker response.

Request Type

Expedited Reason

Note: *Provide reason for expediting request if Expedited Initial or Expedited Resubmission Request Type is selected above.*

UTN

Only required for Resubmissions & Expedited Resubmissions. Enter the UTN of most recent submission.

Requested HCPCS

Primary Diagnosis Code

Date of Service

Related HCPCS Codes (up to 2)

*All related codes require a primary code **AND** any possible additional related codes at the facet level(s) and region of the back.*

FACILITY INFORMATION

Facility Name

PTAN

NPI

Region

Note: Facility information should be the Hospital Outpatient Department information.

Fax Number

Note: **If submitting by fax, fax number is required. The fax number must be the fax number of the Hospital Outpatient Department.** *If submitting by mail or esMD, fax number is optional. If you want to also receive the decision letter via fax, provide a fax number. A decision letter will be sent by mail to the provider address on file.*

BENEFICIARY INFORMATION (ONLY ONE BENEFICIARY PER FORM)

Beneficiary Name

Medicare ID

ATTENDING PHYSICIAN INFORMATION

Physician Name

NPI

Fax Number

Address

REQUESTOR INFORMATION

Requestor Name

Email

Date

Phone Number

Disclaimer: The documents accompanying this facsimile transmittal are intended only for the use of the individual or entity to which it is addressed. It contains information that is privileged, confidential, and exempt from disclosure under law. If the recipient of this document is not the intended recipient, you are notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you are not the intended recipient, you are hereby notified that by law you are strictly prohibited to disclose, copy, distribute, or take any action in reliance on the contents of this document. If you have received this fax in error please call 1.866.590.6703.

FOR OFFICE USE ONLY

file:///C|/Users/6z18/Downloads/j15_parta_pior_auth_opd_facet_joint_interventions_2024_v2.pdf

For Kentucky, fax to: 1.615.782.4486
For Ohio, fax to: 1.615.782.4498

Mail to: CGS
PO Box 20203
Nashville, TN 37202

For additional information, please visit our website at: https://www.cgsmedicare.com/parta/mr/opd.html

Originated March 13, 2023
Revised August 9, 2024

CGS®
A CELERIAN GROUP COMPANY

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

PLEASE DO NOT USE STAPLES FOR ANY DOCUMENTATION!

JURISDICTION 15 PART A

PRIOR AUTHORIZATION OPD: FACET JOINT INTERVENTIONS

Please answer and follow the instructions for each question below.

QUESTIONS

Q1. Does the documentation indicate there are plans for anesthesia beyond local anesthesia and anxiolytics? **Yes** ☐ **or No** ☐

Note: If the answer is Yes, the procedure may not be medically necessary for prior authorization.

Comments:

Q2. Will the procedure be performed using fluoroscopy (CT-guidance)? **Yes** ☐ **or No** ☐

Note: If the answer is No, the procedure may receive a non-affirmed decision.

Comments:

Q3. Does the documentation show the use of the same pain scale and functional assessment scale such as numerical rating scale, visual analog scale, PDAS, PROMIS profile domains, etc.? – Need to have both a pain assessment scale and functional assessment scale. **Yes** ☐ **or No** ☐

Note: If the answer is No, the request may receive a non-affirmed decision.

Comments:

Q4. Have conservative therapies been tried such as NSAIDS, analgesics, home exercise program, or cognitive therapy, etc.? **Yes** ☐ **or No** ☐

Note: If the answer is No, the request may receive a non-affirmed decision.

Comments:

Q5. For subsequent therapeutic procedures – does the documentation support at least 50% pain relief for at least 3 months or at least 50% consistent improvement in the ability to perform previously painful movements and ADLs as compared to baseline using the same scales? **Yes** ☐ **or No** ☐

Note: If the answer is No, the request may receive a non-affirmed decision.

Comments:

Note: Attach supporting documentation for condition and associated symptoms, rationale for treatment procedure, etc. and/or comment..

DOCUMENTATION

Condition and Associated Symptoms/ Rationale for Treatment Procedure

