Regence

1800 Ninth Avenue
Seattle, WA 98111-9115

Regence BlueShield serves select counties in the state of Washington
and is an Independent Licensee of the Blue Cross and Blue Shield Association

SPINAL INJECTION ADDITIONAL INFORMATION FORM

Note: This form must be completed and submitted at the time of claims submission to ensure timely and accurate claims processing. If this information is not submitted with the claim(s), services will be denied until the information is received.

Fax completed form to: 1 (877) 357-3418 **Questions or Assistance:** 1 (888) 849-3682

Patient Information:

Last Name	First Name	Middle Initial
UMP Identification Number		Date of Birth (mm/dd/yyyy)
Date(s) of Service		
Procedure Codes		

Therapeutic Cervical, Thoracic and Lumbar Epidural Injections and Sacroiliac Joint Injections are a covered benefit for the treatment of chronic pain. Go to **www.hca.wa.gov/about-hca/health-technology-assessment/health-technology-reviews** to view the entire Health Technology Assessment.

Limitations of Coverage:
Therapeutic Epidural Injections in the lumbar or cervical-thoracic spine for chronic pain are a covered benefit when all of the following conditions are met:

- For treatment of radicular pain
- Performed with fluoroscopic or CT guidance
- After failure of conservative therapy
- No more than two without clinically meaningful improvement in pain and function, and
- Maximum of 3 in 6 months

Therapeutic Sacroiliac Joint Injections for chronic pain is a covered benefit when all of the following conditions are met:

- Performed with fluoroscopic or CT guidance
- After failure of conservative therapy, and
- No more than one without clinically meaningful improvement in pain and function, subject to plan review

Non-Covered Indications:

Therapeutic Medial Branch Nerve injections, Intradiscal injections and Intraarticular Facet injections are not a covered benefit.

The following services are not addressed by HTA coverage policy: diagnostic spinal injections and radiofrequency nerve ablations. Regence reserves the right to audit these claims and request medical records

This coverage policy does not apply to those with a known systemic inflammatory disease such as: ankylosing spondylitis, psoriatic arthritis or enteropathic arthritis.

I certify that these services, for the above UMP patient, do not violate the guidelines set forth in the Health Technology Assessment for Spinal Injections and that diagnostic injections are not related to and/or used as a means to subsequently perform non-covered therapeutic injections inclusive of Therapeutic Medial Branch Nerve injections, Intradiscal injections and Intraarticular Facet injections.

► _____ _____ (mm/dd/yyyy)
Provider Signature Date

_____ _____ (xxx) xxx-xxxx
Provider Name (please print) Office Phone Number