

This form must be completed by a person with thorough clinical knowledge of the member's current clinical presentation and his/her clinical evaluation history. **Clinical documentation supporting the medical necessity of this request is required.** For more information, please refer to the medical policy document MC/F024 Radiofrequency Ablation (Neurotomy, Denervation, Rhizotomy) Neck and Back located at <https://www.preferredone.com/MedicalPolicy/>.

Please email this form and clinical documentation to Intake@PreferredOne.com or fax to (763) 847-4014.

PATIENT INFORMATION		
Patient Name:	Member ID:	DOB:
ICD 10 Diagnosis:	Ordering Provider Signature:	Procedure Code(s):
ORDERING PROVIDER		
Ordering Provider First and Last Name:		NPI:
Clinic Name:		NPI:
Address:		
City:	State:	Zip:
Phone:	Fax:	
SERVICING PROVIDER		
Servicing Provider First and Last Name:		NPI:
Clinic Name:		NPI:
Address:		
City:	State:	Zip:
Phone:	Fax:	
THE PROCEDURE WILL BE DONE IN ONE OF THE FOLLOWING SITES OF CARE:		
Office or Ambulatory Surgery Center		
Outpatient Hospital (nearest office of ambulatory surgery center capable of providing service is 60 miles or more from member's home)		
Outpatient Hospital (Documentation supports that the member is considered at high risk for complications that require a hospital setting, such as classified as ASA III-VI per Anesthesiologists Physical Classification System)		

INITIAL REQUEST FOR NON-PULSED RADIOFREQUENCY ABLATION FOR FACET-MEDIATED CERVICAL, THORACIC, LUMBOSACRAL, OR SACROILIAC JOINT PAIN

Level of Procedure:		Left		Right		Bilateral	
The member has chronic (at least 6 months) cervical, thoracic, or lumbosacral pain suggestive of facet or sacroiliac joint origin (must be documented in the medical record on history and physical exam).							
The member has failed at least 3 months of conservative therapy. Please indicate below the type of conservative therapy (check all that apply). Clinical documentation should indicate dates of services.							
Chronic Back Program	Physical Therapy	Steroid Injections		Pharmacotherapies			
Home Exercise	Weight Loss	Activity Modification		Spinal Manipulation			
The member has not had prior fusion surgery at the level where treatment is being considered.							
The member has undergone at least one anesthetic block of the involved facet, medial, primary dorsal-rami, or sacral lateral branch nerves.							
Anesthetic block date:		% Pain Reduction:					

REPEAT REQUEST FOR RFA ON THE SAME NERVE (SITE)

Level of Procedure:		Left		Right		Bilateral	
A minimum of six (6) months has elapsed since prior ablative treatment of the same nerve.							
Date of Prior Radiofrequency Treatment of the Same Nerve (MM/DD/YY):							
Prior ablative treatment resulted in at least a 50% reduction in pain for a minimum of 10 weeks following the previous treatment.							

INITIAL REQUEST FOR INTRAOSSEOUS ABLATION (e.g., INTRACEPT[®]) OF THE BASIVERTBRAL NERVE (BVN) FOR LOW BACK PAIN

The member has chronic (at least 6 months) isolated low back pain suggestive of skeletal endplate inflammation (must be documented in the medical record on history and physical exam).

MRI shows Type 1 or Type 2 Modic changes of the vertebral endplates at 3 or less contiguous levels, L3-S1.

The member has failed at least 3 months of conservative therapy. Please indicate below the type of conservative therapy (check all that apply). Clinical documentation should indicate dates of services.

Chronic Back Program	Physical Therapy	Steroid Injections	Pharmacotherapies
Home Exercise	Weight Loss	Activity Modification	Spinal Manipulation

The member has undergone at least one anesthetic block of the involved facet, medial, primary dorsal-rami, or sacral lateral branch nerves.

Anesthetic block date:		% Pain Reduction:		
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INITIAL REQUEST FOR NON-PULSED RADIOFREQUENCY ABLATION OF THE GENICULAR NERVE (ARTICULAR NERVE BRANCHES) FOR KNEE PAIN

The member has chronic (at least 6 months) knee pain

The member has failed at least 3 months of conservative therapy. Please indicate below the type of conservative therapy (check all that apply). Clinical documentation should indicate dates of services.

Pharmacotherapies	Physical Therapy	Activity Modification	Home Exercise
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The member has undergone at least 1 anesthetic blocks of the genicular nerve with 50% pain reduction.

Anesthetic block date: _____ % Pain Reduction: _____

The member has no history of total knee arthroplasty (TKA) – knee pain is due to knee osteoarthritis (OA) and member is not a good surgical candidate for TKA due to medical comorbidities and/or a high body mass index (BMI).

OR

The member is status post-TKA for osteoarthritis.