PreferredOne®

# RADIOFREQUENCY ABLATION (INITIAL AND REPEAT) PRIOR AUTHORIZATION FORM

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<br>(nearest office of ambulatory surgery center capable of providing service is 60 miles or more from member's home) | ☐ |
| Outpatient Hospital<br>(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) | ☐ |
| Outpatient Hospital<br>(Documentation supports that the servicing provider does not hold privileges at an office or ambulatory surgery center within 60 miles driving distance from the member's home) | ☐ |

| **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: | | | | | |

| **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 ☐ |

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**RADIOFREQUENCY ABLATION (INITIAL AND REPEAT)**
**PRIOR AUTHORIZATION FORM**

| **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 ☐ |
| The member has undergone at least 1 anesthetic blocks of the genicular nerve with 50% 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. | | | ☐ |

| **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. | | | | | | | ☐ |