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 Radiofrequency Ablation (Neurotomy, Denervation, Rhizotomy) Neck and Back (MC/F024) located at https://www.aspirushealthplan.com/.

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)	☐
Outpatient Hospital (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.							☐