RADIOFREQUENCY ABLATION (INITIAL AND REPEAT) AUTHORIZATION FORM

This form must be completed by a person with thorough clinical knowledge of the member's current clinical presentation and clinical evaluation history. Please attach clinical records or clinic progress notes. 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/medical-policy/.

Please fax this form and other relevant documents to (763) 847-4014.

Indicate level/s where treatment is being considered: _____________________

Check Box

Right  Left  Bilateral

INITIAL REQUEST FOR NON-PULSED RADIOFREQUENCY ABLATION FOR NECK AND BACK PAIN

The member has chronic (at least 6 months) cervical or lumbosacral pain suggestive of facet or sacroiliac origin (must be documented in the medical record on history and physical exam).

MRI or other imaging suggests that the primary source of the pain is not a condition such as, but not limited to, disc herniation, foraminal stenosis, fracture, malignancy, spinal instability, or spinal stenosis.

No prior fusion surgery at the level where treatment is being considered.

The member has failed at least 3 months of conservative therapy. Please indicate below the type of conservative therapy (check all that apply) and the date(s) of service(s) (mm/dd/yy):

☐ Comprehensive back therapy treatment, including:
  □ Pharmacotherapies - Date/s of service/s: __ / __ / __ to __ / __ / __; List medications below:

  □ Steroid injections - Quantity: ___; Date of first injection __ / __ / __; Date of last injection __ / __ / __

  □ Physical therapy - Date(s) of service/s: __ / __ / __ to __ / __ / __

  □ Other (e.g., activity modification, structured home exercise program, weight loss, spinal manipulation)
    (Please specify below) - Date/s of service/s: __ / __ / __ to __ / __ / __

☐ Chronic back program - Date(s) of service/s: __ / __ / __ to __ / __ / __

☐ Other (Please specify below) - Date/s of service/s: __ / __ / __ to __ / __ / __

The member has undergone at least 2 anesthetic blocks of the involved facet, medial, primary dorsal-rami, or sacral lateral branch nerves.

  First anesthetic block: __ / __ / __ (mm/dd/yy) _____% pain reduction

  Second anesthetic block: __ / __ / __ (mm/dd/yy) _____% pain reduction

The procedure will be done in an office or ambulatory surgery center setting.

REPEAT REQUEST FOR THE SAME SITE

Date of prior radiofrequency treatment at the same site: __ / __ / __ (mm/dd/yy)

Prior radiofrequency treatment resulted in at least a 50% reduction in pain for a minimum of 10 weeks following the previous treatment.

Prior radiofrequency treatment demonstrated an improvement in functional status and decreased use of analgesics.

The procedure will be done in an office or ambulatory surgery center setting.