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:**	**Patient Date of Birth:**	
Date of Service:	**ICD 10 Diagnosis:**	**Procedure Code(s):**	

ORDERING PROVIDER INFORMATION		
Ordering Provider Name:	**Ordering Provider Signature:**	**NPI:**
Clinic Name:		**NPI:**
Clinic Address:		
City:	**State:**	**Zip:**
Phone:	**Fax:**	

SERVICING PROVIDER INFORMATION		
Servicing Provider Name:		**NPI:**
Facility 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, but not limited to, the member's physical stats is classified as ASA III-VI, per the American Society of 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 ☐				
Structure Home Exercise Program ☐	Weight Loss, if indicate ☐	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 ☐
Structured Home Exercise Program ☐	Weight Loss, if indicated ☐	Activity Modification ☐	Spinal Manipulation ☐

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 ☐ Structured Home Exercise Program ☐ Weight Loss, if indicated ☐	
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 has a history of TKA for osteoarthritis and is equal to or greater than 6 months post-op.	☐

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.							☐