Radiofrequency Ablation (Initial and Repeat) Prior Authorization Form

ASPIRUS HEALTH PLAN

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) Cervical, Thoracic, Lumbosacral, Sacroiliac or Knee Pain (MC/F024) located at https://www.aspirushealthplan.com. Please contact Customer Service at 866.631.5404 if there are questions.

Return completed form and clinical documentation to: Aspirus Health Plan, Attn: Integrated Health Services, PO Box 1062, Minneapolis, MN 55440 or Fax to 763.847.4014.

PATIENT INFORMATION

Patient Last Name	Patient First 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	**Clinic Phone Number**	**Clinic Fax Number**	**NPI**
Clinic Address	**City**	**State**	**Zip Code**

SERVICING PROVIDER INFORMATION

Servicing Provider Name			NPI
Facility Name	**Facility Phone Number**	**Facility Fax Number**	**NPI**
Facility Address	**City**	**State**	**Zip Code**

THE PROCEDURE WILL BE DONE IN ONE OF THE FOLLOWING SITES OF CARE

- ☐ Office or Ambulatory Surgery Center
- ☐ Outpatient Hospital. *Nearest office or 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 status is classified as ASA III-VI, per the American Society of Anesthesiologists Physical Status 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 ☐ Structured Home Exercise Program
☐ Weight Loss, if indicated ☐ 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 block 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	Date of Prior Radiofrequency Treatment of the Same Nerve

☐ A minimum of six (6) months has elapsed since prior ablative treatment of the same nerve.

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