PRIOR AUTHORIZATION for NEUROLYSIS AND PAIN MANAGEMENT PROCEDURES

For authorization, please complete this form, include patient chart notes to document information and FAX to the PEHP Prior Authorization Department at (801) 366-7449 or mail to: 560 East 200 South Salt Lake City, UT 84102. If you have prior authorization or benefit questions, please call PEHP Member & Provider Services at (801) 366-7555 or toll free at (800) 753-7490.

Section I: PATIENT INFORMATION

Date Requested:	Name (Last, First MI):	DOB:	Age:	PEHP ID #:

Section II: PROVIDER(S) INFORMATION

***Rendering* Provider:**			***Rendering* Provider Address:**		
Provider NPI #:	**Provider TIN #:**	**Contact Person:**	**Phone:** ( )	**Facsimile:** ( )	**Email Address:**

***Facility/Hospital*:**			***Facility/Hospital* Address:**		
Facility NPI #:	**Facility TIN #:**	**Contact Person:**	**Phone:** ( )	**Facsimile:** ( )	**Email Address:**

Section III: PRE-AUTHORIZATION REQUEST

A. Nature of Request: ***Please check.***
☐ Auth Extension ☐ Pre-Auth ☐ Retro Auth

B. Requested Date(s) of Service:
From: **To:**

C. Place of Service: ***Please check.***
☐ Ambulatory Surgical Center ☐ Inpatient ☐ Office ☐ Outpatient

D. Primary Diagnosis/ICD-10 Code:

E. Secondary Diagnosis/ICD-10 Code:

F. Pain onset:

G. Was there a precipitating event? ☐ Yes ☐ No

H. Was event a Motor Vehicle Accident? ☐ Yes ☐ No

I. Was event work related? ☐ Yes ☐ No

J. What type of neurolysis procedure is being requested? ***Please check all that apply.***

1. ☐ Chemical Ablation (Facet Joint)
2. ☐ Cooled Radiofrequency Ablation
3. ☐ Cryoneurolysis (Lumbar Facet Joint)
4. ☐ Laser Facet Neurolysis
5. ☐ *Pulsed* Radiofrequency Neurolysis
6. ☐ *Non-Pulsed* Radiofrequency Neurolysis of ***Cervical*** *(**C2 -3 and below**)*, ***Thoracic,*** *and/or* ***Lumbar*** *Facet Joints*
7. ☐ *Non-Pulsed* Radiofrequency Neurolysis of ***Sacroiliac*** *Joints*
8. ☐ Radiofrequency Lesioning of *Dorsal Root Ganglia* or *Terminal (Peripheral) Nerve Endings*

K. Service (s) Requested: ***Please list all requested services regardless of pre-authorization requirement. Unlisted codes cannot be pre-authorized.***

Service/Spine Levels: _____ CPT/HCPCS code: _____ ☐ Bilateral ☐ Left ☐ Right ☐ Repeat

Service/Spine Levels: _____ CPT/HCPCS code: _____ ☐ Bilateral ☐ Left ☐ Right ☐ Repeat

Service: _____ CPT/HCPCS code: _____ ☐ Bilateral ☐ Left ☐ Right ☐ Repeat

Service: _____ CPT/HCPCS code: _____ ☐ Bilateral ☐ Left ☐ Right ☐ Repeat

(Please check device being requested.) **QUESTION**	YES	NO	COMMENTS/NOTES
L. ☐ <u>Percutaneous Non-Pulsed Radiofrequency Neurolysis:</u>			
1. Will neurolysis be performed on cervical facet joints (C2-3 and below), thoracic facet joints, or lumbar facet joints?	☐	☐	***Please submit operative report.***
2. Does imaging show no significant spinal canal narrowing or instability that would require surgery?	☐	☐	
3. Has the patient failed at least three months of conservative therapy, including treatments such as medications, physical therapy, postural correction, rest, or bracing?	☐	☐	
4. Is the pain pattern non-radicular, meaning symptoms may radiate but do not follow a dermatomal or nerve-root distribution?	☐	☐	
5. Is the pain pattern consistent with a facet-mediated origin, with disabling cervical, thoracic, or lumbosacral pain and no evidence of nerve-root compression on imaging?	☐	☐	
6. Did a diagnostic facet joint injection or medial branch block at the targeted level(s) produce at least 80% relief of facet-mediated pain for the minimum expected duration of the anesthetic used?	☐	☐	***Please submit copy of procedure report/pain diary.***
7. Is there no prior fusion at the target level, except in cases where anterior cervical fusion or lumbar fusion still allows accurate medial branch localization?	☐	☐	
8. Has the patient experienced severe, function-limiting pain for at least six months that significantly restricts activities of daily living despite conservative care?	☐	☐	
9. Will non-pulsed radiofrequency facet denervation be performed using fluoroscopic guidance to ensure accurate needle placement?	☐	☐	
M. ☐ <u>Repeat Percutaneous Non-Pulsed Radiofrequency Neurolysis:</u>			
1. Did the patient receive greater than 50% pain relief for at least twelve (12) weeks following procedure?	☐	☐	***Please submit prior procedures report(s).***
2. Has it been at least six (6) months since prior neurolysis procedure (per level per side)? Date: _____	☐	☐	

Additional Comments:

By submitting this form, I attest that the information provided is true and accurate to the best of my knowledge.

Please fax completed form and medical records to 801-366-7449.