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 Customer Service 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*** *(**C3-4 and below**)*, ***Thoracic,*** *and/or* ***Lumbar*** *Facet Joints*
7. ☐ *Non-Pulsed* Radiofrequency Neurolysis of ***Cervical*** *(**C2-3**) and/or* ***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 and for unlisted codes, please provide comparable code(s).***

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. ☐ Percutaneous Non-Pulsed Radiofrequency Neurolysis:			
1. Will neurolysis be performed on cervical facet joints (C3-4 and below), thoracic facet joints, or lumbar facet joints?	☐	☐	***Please submit operative report.***
2. Has the patient experienced severe pain limiting activities of daily living for at least 6 months?	☐	☐	
3. Has the patient had a prior spinal fusion surgery at the level to be treated (except for cervical fusion, if done by anterior approach)?	☐	☐	
4. Are neuroradiologic studies negative or fail to confirm disc herniation?	☐	☐	
5. Does the patient have disabling low back (lumbosacral, thoracic) or neck (cervical) pain, suggestive of facet joint origin as evidenced by absence of nerve root compression on radiographic evaluation?	☐	☐	
6. Is the patient's pain non-radicular (pain may radiate but is not dermatomal)?	☐	☐	
7. Does the patient have significant narrowing of the vertebral canal or spinal instability that will require surgery?	☐	☐	
8. Has the patient's pain failed to respond to at least three (3) months of conservative management such as bed rest, back supports, physiotherapy, correction of postural abnormality, as well as pharmacotherapies (e.g., anti-inflammatory agents, analgesics, and muscle relaxants)?	☐	☐	
9. Did the patient have a positive diagnostic facet joint injection (intraarticular or medial branch blocks) at the level to be treated, as evidenced by at least 80% relief of facet mediated pain for at least the expected minimum duration of the effect of the local anesthetic used?	☐	☐	***Please submit copy of procedure report/pain diary.***
10. Will radiofrequency neurolysis be performed with fluoroscopic guidance?	☐	☐	
M. ☐ Repeat Percutaneous Non-Pulsed Radiofrequency Neurolysis:			
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.