PRIOR AUTHORIZATION for RADIOFREQUENCY ABLATION 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

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

Section II: PROVIDER INFORMATION

Date Requested:		Service Provider Name:
Service Provider NPI #:	Service Provider Tax ID #:	Service Provider Address:

Contact Person:	Phone: ( )	Facsimile: ( )

Section III: PRE-AUTHORIZATION REQUEST

Nature of Request: *Please check.* ☐ Auth Extension ☐ Pre-Auth ☐ Retro Auth ☐ Urgent	**Requested Date of Service:**	**Place of Service:** *Please check.* ☐ Ambulatory Surgical Center ☐ Inpatient ☐ Office ☐ Outpatient

Facility Name:	**Facility NPI #:**	**Facility Tax ID #:**
Facility Address:	**Facility Phone:** ( )	**Facility Facsimile:** ( )
Primary Diagnosis/ICD-10 Code:	**Secondary Diagnosis/ICD-10 Code:**	

Service (s) Requested: *Please list all requested services/CPT codes regardless of pre-auth requirement.*

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

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

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

A. Pain onset:	**B. Was there a precipitating event?** ☐ Yes ☐ No	**C. Was event a Motor Vehicle Accident?** ☐ Yes ☐ No	**D. Was event work related?** ☐ Yes ☐ No

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

1. ☐ Chemical Neurolysis (Facet Joint)
2. ☐ Cooled Radiofrequency
3. ☐ Cryoneurolysis (Cryoablation, Cryotherapy, Cryoanalgesia)
4. ☐ Laser Neurolysis (Facet Joint)
5. ☐ Percutaneous Non-Pulsed Radiofrequency Neurolysis of Cervical (C3-4 and below) and/or Lumbar Facet Joints
6. ☐ Percutaneous Non-Pulsed Radiofrequency Neurolysis of Cervical (C2-3), Thoracic Facet Joints, and/or Sacroiliac Joints
7. ☐ Pulsed Radiofrequency Neurolysis
8. ☐ Radiofrequency Lesioning of Dorsal Root Ganglia or Terminal (Peripheral) Nerve Endings

(Please check service being requested.) **QUESTION**	**YES**	**NO**	**COMMENTS/NOTES**
1. ☐ Percutaneous Non-Pulsed Radiofrequency Neurolysis:			
a. Will neurolysis be performed on cervical facet joints (C3-4 and below) or lumbar facet joints?	☐	☐	
b. Has the patient had a prior spinal fusion surgery in the vertebral level being treated (except for cervical fusion, if done by anterior approach)?	☐	☐	*Please submit operative report.*
c. Does the patient have disabling low back (lumbosacral) or neck (cervical) pain, suggestive of facet joint origin as evidenced by absence of nerve root compression on radiographic evaluation?	☐	☐	*Please submit all imaging reports.*
d. Is the patient's pain non-radicular (pain may radiate but is not dermatomal)?	☐	☐	
e. Has the patient's pain failed to respond to at least three (3) months of conservative management (e.g., nonsteroidal anti-inflammatory medications, acetaminophen, manipulation, physical therapy, and/or a home exercise program)?	☐	☐	
f. Has there been a successful medial branch block with local anesthetic (≥ 60% pain relief at the same anatomic location as the proposed percutaneous radiofrequency neurolysis?	☐	☐	*Please submit copy of diagnostic block report and pain diary.*
g. Will radiofrequency neurolysis be performed with fluoroscopic guidance?	☐	☐	
2. ☐ Repeat Percutaneous Non-Pulsed Radiofrequency Neurolysis: ***Date of Last Procedure:*** _____	☐	☐	*Please submit reports of prior neurolysis procedures.*
a. Did the patient have a prior successful radiofrequency (RF) neurolysis?			
b. Has it been a minimum of nine (9) months since prior RF treatment (per side, per anatomical level of the spine)?	☐	☐	

Additional Comments:

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