Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

TurningPoint Healthcare Solutions

PAIN MANAGEMENT NEUROABLATION AUTHORIZATION REQUEST FORM

Utilization management toll-free phone: 1-833-217-9670
Utilization management local phone: 313-908-6040
Utilization management fax: 313-483-7323

Today's date: _____ /_____ /_____	**Member name:**
Provider contact name:	**Date of birth:** _____ /_____ /_____
Provider contact phone:	**Member ID (including any alpha prefix):**
Provider contact fax:	**Health plan:**
Provider name:	**Notification method preference:** ◯ **Postal mail** ◯ **Fax** **Mailing address or fax number:**
Provider TIN:	
Provider NPI:	
Practice/group name:	**Notes:**
Provider physical address:	
Provider mailing address (if different):	

Where will the procedure take place?

◯ **Provider office** ◯ **Outpatient facility** ◯ **Inpatient hospital** ◯ **Ambulatory surgical center**

Facility name:	**Facility contact name:**
Facility TIN:	**Facility contact phone:**
Facility NPI:	**Facility contact fax:**
Facility physical address:	**Facility mailing address (if different):**

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Requested procedure code	Modifier: LT, RT, or 50 (bilateral)	Quantity	Spine level

Diagnosis code(s):

Anticipated date of service (mm/dd/yyyy):
_____ / _____ / _____

1. Does the patient have any of the following comorbidities?
Select all that apply.

- ☐ Diabetes that requires medication or insulin (Type I or Type II) A1C Level: _____
- ☐ Hypertension requiring medication
- ☐ Previous cardiac event
- ☐ Congestive heart failure
- ☐ Dyspnea
- ☐ Current smoker within past 12 months
- ☐ History of severe COPD
- ☐ Dialysis
- ☐ Acute renal failure
- ☐ Ascites within past 30 days
- ☐ Steroid use for chronic condition
- ☐ Disseminated cancer
- ☐ Unaddressed psychosocial and/or substance abuse issues
- ☐ Other (please specify) _____
- ☐ None

Patient's height: _____

Patient's weight: _____

Patient's BMI: _____

4. For BMI over 30, which weight loss activities are documented?

- ○ Weight loss discussion documented
- ○ Weight loss plan documented
- ○ Patient has lost at least 15-20% of initial body weight
- ○ No weight loss or weight loss of less than 15-20% of initial body weight
- ○ None of the above

2. What is the patient's current health status?

- ○ Normal healthy patient
- ○ Mild or moderate disease that does not limit activity (ex: controlled HTN or DM, mild obesity)
- ○ Severe disease that limits activity (ex: controlled CHF, history of MI, uncontrolled HTN or DM)
- ○ Severe life-threatening disease (ex: symptomatic CHF or COPD, renal failure, unstable angina)

3. Patient's activities of daily living (ADL) functional status:

- ○ Independent
- ○ Partially dependent
- ○ Totally dependent

5. Which procedure is planned?

- ○ Thermal radiofrequency ablation
- ○ Pulsed radiofrequency denervation
- ○ Endoscopic ablation
- ○ Cooled/low grade thermal energy (< 80° Celsius)
- ○ Intraosseous radiofrequency ablation
- ○ Cryoablation, cryoneurolysis or cryodenervation
- ○ Chemical ablation (e.g., alcohol, phenol, high-concentration local anesthetics)
- ○ Laser denervation

6. Why is the procedure being done? ***Select all that apply.***

- ☐ Cerebral palsy with spastic diplegia
- ☐ Spinal cord injury with inability to void or voiding dysfunction
- ☐ Severe pain related to cancer that is not relieved by opioids
- ☐ Trigeminal neuralgia that has failed at least 8 weeks of antiepileptic medications and/or baclofen, when microvascular decompression or stereotactic radiosurgery has failed or is not indicated
- ☐ Series of 2 ablations for chronic pain in limited dermatomal distribution, with at least one week between *(please also complete questions 6a-d)*
- ☐ Other (please specify) _____

6a. Which of the following indications are present? ***Select all that apply.***

- ☐ Primarily axial pain without radiculopathy or neurological deficits that has been present for at least 3 months
- ☐ Primarily axial pain without radiculopathy or neurological deficits that has been present for less than 3 months
- ☐ Radiating pain/radiculopathy or pain with neurological deficits, regardless of onset
- ☐ Two prior diagnostic facet joint injections resulting in at least 80% pain relief after each injection
- ☐ Two prior diagnostic facet joint injections resulting in less than 80% pain relief after one or both injections
- ☐ No prior diagnostic facet joint injections done
- ☐ Imaging shows other possible explanation for pain
- ☐ Imaging rules out all other possible explanations for pain

6b. Which conservative treatments have been attempted? ***Select all that apply.***

- ☐ Oral medication (NSAIDs, analgesics)
- ☐ Topical medication
- ☐ Injection(s)
- ☐ Ice or heat
- ☐ Activity modification
- ☐ Physical therapy
- ☐ Home exercise program
- ☐ Chiropractic treatment
- ☐ Assistive device (cane, crutches, brace, walker, etc.)
- ☐ TENS unit
- ☐ Other (please specify) _____
- ☐ None of the above

6c. How long has conservative treatment been attempted?

- ◯ Less than 6 weeks
- ◯ 6-11 weeks
- ◯ 3-5 months
- ◯ 6-12 months
- ◯ More than 1 year
- ◯ No conservative treatments attempted

6d. Is this an initial series or a subsequent series of ablations?

- ◯ Initial series
- ◯ Subsequent series *(Please also answer question 6e)*
- ◯ Not provided

6e. Which of the following indications for subsequent ablation(s) are present? ***Select all that apply.***

- ☐ Original pain has returned
- ☐ Ablations done for new/different pain
- ☐ Prior ablations occurred greater than 6 months prior
- ☐ Prior ablations occurred less than 6 months prior
- ☐ Procedure is planned for the same site(s)
- ☐ Procedure is planned for different site(s)
- ☐ Achieved at least 50% pain relief from baseline for 6 months after prior series
- ☐ Achieved less than 50% pain relief from baseline, or pain relief lasted for less than 6 months
- ☐ None of the above

7. Are any of the following present? ***Select all that apply.***

- ☐ Infection, tumor or prior spinal fusion at site planned for procedure
- ☐ Procedure is planned for 3 or more spinal levels/4 or more individual facet joints
- ☐ Coagulopathy or systemic infection
- ☐ None of the above

NOTE: Include imaging reports, surgical plan and clinical documentation of ALL conservative therapies that have been attempted as well as the duration of each type of conservative treatment.

Form completed by: **Date:** _____ /_____ /_____