Blue Cross Blue Shield Blue Care Network of Michigan

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

TurningPoint

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 (mm/dd/yyyy): ____ / ____ / _____	**Member name:**
Provider contact name:	**Date of birth (mm/dd/yyyy):** ____ / ____ / _____
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): ____ / ____ / _____

Case urgency

☐ Standard ☐ Expedited

In keeping with guidelines from the National Committee for Quality Assurance and Centers for Medicare & Medicaid Services, prior authorization requests qualify for expedited review when the standard review time frame could do one of the following:

- Seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state.
- In the opinion of a practitioner with knowledge of the member's medical or behavioral health condition, subject the member to adverse health consequences without the care or treatment that is the subject of the request.

Patient's height:	Patient's weight:	Patient's BMI:

What type of procedure is planned? (Select one and answer all adjacent questions.)

☐ **Initial cervical/thoracic or lumbar thermal radiofrequency ablation** (answer a – i)	a. Has moderate to severe pain (rated at least 3 out of 10), primarily axial in nature, been present for 3 months?	☐ Yes ☐ No
	b. Are any radiculopathy or claudication symptoms (burning, tingling, cramping) present?	☐ Yes ☐ No
	c. Are more than 2 levels (either unilateral or bilateral) planned for the procedure?	☐ Yes ☐ No
	d. Has conservative treatment been attempted for at least 12 weeks/3 months?	☐ Yes ☐ No
	e. Has medication been attempted as part of conservative treatment?	☐ Yes ☐ No
	f. Has chiropractic care, physical therapy, and/or home exercise program been attempted as part of conservative treatment?	☐ Yes ☐ No
	g. Does imaging show any other possible causes of pain (such as stenosis, nerve impingement, fracture, or infection)?	☐ Yes ☐ No
	h. Were two medial branch blocks performed at the same location as planned radiofrequency ablation?	☐ Yes ☐ No
	i. Does the medical record show that BOTH medial branch blocks resulted in at least 80% reduction in pain and improvement in function?	☐ Yes ☐ No
☐ **Repeat cervical/thoracic or lumbar thermal radiofrequency ablation** (answer a – d)	a. Were criteria met for initial ablation?	☐ Yes ☐ No
	b. Does the medical record confirm at least 50% reduction in pain and improvement in function for at least 6 months after the prior procedure?	☐ Yes ☐ No
	c. Have 2 or more radiofrequency ablation sessions been done in this same spine region in the past 12 months (cervical/thoracic or lumbar/sacral)?	☐ Yes ☐ No
	d. Have 4 or more total medial branch block sessions for the entire spine been done in the past 12 months?	☐ Yes ☐ No

☐ **Initial sacroiliac thermal radiofrequency ablation** (answer a – f)	a. Is there presence of moderate to severe pain (rated at least 3 out of 10) that interferes with daily activities?	☐ Yes ☐ No
	b. Has conservative treatment been attempted for at least 12 weeks/3 months?	☐ Yes ☐ No
	c. Has medication been attempted as part of conservative treatment?	☐ Yes ☐ No
	d. Has chiropractic care, physical therapy, and/or home exercise program been attempted as part of conservative treatment?	☐ Yes ☐ No
	e. Were 2 diagnostic injections performed on the L5 primary dorsal ramus and the 1st – 3rd sacral dorsal rami branches?	☐ Yes ☐ No
	f. Does the medical record show at least 75% reduction in pain and improvement in function with both diagnostic injections?	☐ Yes ☐ No
☐ **Repeat sacroiliac thermal radiofrequency ablation** (answer a – c)	a. Does the medical record confirm at least 50% reduction in pain and improvement in function for at least 6 months after the prior procedure?	☐ Yes ☐ No
	b. Have 2 or more radiofrequency ablation sessions been done in this same spine region in the past 12 months (cervical/thoracic or lumbar/sacral)?	☐ Yes ☐ No
	c. Have 4 or more total medial branch block sessions for the entire spine been done in the past 12 months?	☐ Yes ☐ No
☐ **Intraosseous radiofrequency ablation (basivertebral nerve)**	No questions related to this procedure; proceed to next section.	
☐ **Pulsed radiofrequency ablation**	No questions related to this procedure; proceed to next section.	
☐ **Cooled radiofrequency ablation**	No questions related to this procedure; proceed to next section.	
☐ **Endoscopic radiofrequency ablation**	No questions related to this procedure; proceed to next section.	
☐ **Chemical ablation**	No questions related to this procedure; proceed to next section.	
☐ **Laser ablation**	No questions related to this procedure; proceed to next section.	
☐ **Cryoablation, cryoanalgesia, or cryoneurolysis**	No questions related to this procedure; proceed to next section.	
☐ **Procedure planned for any area other than the spine**	No questions related to this procedure; proceed to next section.	

Do any of the following apply? (Answer a – d)	
a. Systemic or localized infection at planned injection site	☐ Yes ☐ No
b. Radiofrequency ablation is planned at a fused spine level	☐ Yes ☐ No
c. Other pain management interventions planned same day (i.e. epidural steroid injection, SI joint injection, trigger point injection, etc.)	☐ Yes ☐ No
d. Pain management procedures planned in multiple regions (i.e. cervical/thoracic AND lumbar or sacral)	☐ Yes ☐ No
Will the procedure be performed with fluoroscopic guidance?	☐ Yes ☐ No
Is general anesthesia, conscious sedation, or monitored anesthesia care planned?	☐ Yes ☐ No

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Is this request for lovera (cryoablation)?	☐ Yes ☐ No
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:**