

Wesley Healthcare Check List: Total Knee Medical Necessity For patients with Medicare as primary or secondary payer

Fax completed form with all required pre-surgical medical record documents at the time of scheduling (7 days before surgery) and for all add on cases to Wesley Medical Center eFax (316) 962-3018 or Wesley Woodlawn Hospital eFax (316) 858-2788 eSurgical Services.

Scheduled Surgery Date: _____

Today's Date: _____ Completed By: _____ Direct Phone #: _____ E-mail: _____

Indications: <ul style="list-style-type: none"> At least 3 of the following 5 indications specified below must be checked Within each checked indication, check at least 1 applicable condition/diagnoses box and corresponding pre-surgical medical record documentation type/location provided 		Pre-surgical Medical Record Provided: <i>Results must be separate report or H&P heading</i>
<input type="checkbox"/> 1. Advanced joint disease as demonstrated by radiological supported evidence:		Documentation Location:
<input type="checkbox"/> Subchondral cysts <input type="checkbox"/> Joint subluxation <input type="checkbox"/> Distortion of the joint surfaces <input type="checkbox"/> Subchondral sclerosis <input type="checkbox"/> Joint space narrowing <input type="checkbox"/> Fracture or deterioration <input type="checkbox"/> Periarticular osteophytes <input type="checkbox"/> Avascular necrosis		<input type="checkbox"/> MRI <input type="checkbox"/> X-ray report <input type="checkbox"/> H&P heading
<input type="checkbox"/> 2. Unsuccessful conservative treatment for 3+ months		Documentation Location:
Treatment type: <input type="checkbox"/> NSAIDS <input type="checkbox"/> Analgesics <input type="checkbox"/> Physical Therapy for flexibility and muscle strengthening	Start Date: ___ / ___ / ____ ___ / ___ / ____ ___ / ___ / ____	<input type="checkbox"/> H & P <input type="checkbox"/> Consult <input type="checkbox"/> PT notes <input type="checkbox"/> Office notes <input type="checkbox"/> Other: _____
<input type="checkbox"/> 3. Pain and functional disability from injury due to trauma or arthritis of the knee joint:		Documentation Location:
<input type="checkbox"/> Assistive device use <input type="checkbox"/> Appropriate weight reduction <input type="checkbox"/> Appropriate therapeutic injections into knee <input type="checkbox"/> Activities of daily living diminished despite compliance with plan of care including activity restrictions	Additional Documentation: <input type="checkbox"/> Distance patient can walk/stairs <input type="checkbox"/> Type of assistive device or brace <input type="checkbox"/> Activity modification	<input type="checkbox"/> H & P <input type="checkbox"/> Consult <input type="checkbox"/> Office notes <input type="checkbox"/> Pain and disability summary: _____
<input type="checkbox"/> 4. Distinct structural abnormalities:		Documentation Location:
<input type="checkbox"/> Distal femur fracture <input type="checkbox"/> Proximal tibia fracture <input type="checkbox"/> Rheumatologic changes precluding or inconsistent with rehab <input type="checkbox"/> Malignancy of the distal femur, proximal tibia, knee joint or adjacent soft tissues <input type="checkbox"/> Avascular or other form of osteonecrosis of the knee		<input type="checkbox"/> MRI <input type="checkbox"/> X-ray report <input type="checkbox"/> Path report <input type="checkbox"/> Oncologist consult
<input type="checkbox"/> 5. Failed previous joint replacement necessitating revision indicated by any of the following:		Documentation Location:
<input type="checkbox"/> Infection/inflammatory response <input type="checkbox"/> Tibiofemoral or extensor mechanism instability <input type="checkbox"/> Previous osteotomy/partial arthroplasty <input type="checkbox"/> Bearing surface wear leading to symptomatic synovitis <input type="checkbox"/> Periprosthetic fracture or bone loss of distal femur, proximal tibia or patella; Implant or knee malalignment <input type="checkbox"/> Loosening, fracture or mechanical failure of one or more components <input type="checkbox"/> Technical or functional failure of previous knee surgery, e.g. unicompartmental knee replacement <input type="checkbox"/> Knee stiffness, arthrofibrosis or other destructive conditions that render the knee impaired to the extent to preclude employment or functional activities.		<input type="checkbox"/> MRI <input type="checkbox"/> X-ray report <input type="checkbox"/> Lab report <input type="checkbox"/> Revision supporting documentation: _____

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Total Knee Replacement Medical Necessity Check List

MRPPS
H10137 (11/2015)

Patient Information/Label

Patient name: _____

DOB: _____

Anticipated admit date: _____

Wesley Healthcare Pre-Surgical Fax Cover Sheet

Fax completed form with all required documents at the time of scheduling (4-30 days before surgery) and for all add on cases
OR eFax: Wesley Medical Center (316) 962-3018 or Wesley Woodlawn Hospital (316) 858-2788

Date: _____ Time: _____

Total Number of Pages: _____

Completed By: _____

Phone #: _____

Scheduled Surgery Date: _____

Pre-Surgical Check List: *In an effort to prevent unnecessary case cancellations and delays for your surgeon and patient, please use the following check list to ensure all necessary pre-surgical documentation is received prior to surgery.*

- | | |
|-----------------------------|--|
| <input type="checkbox"/> 1. | Pre-authorization Check List with included supporting documentation (if required) |
| <input type="checkbox"/> 2. | Pre-Surgical documentation (if not submitted with Pre-authorization Check List) |
| | <input type="checkbox"/> PAT Order |
| | <input type="checkbox"/> EKG |
| | <input type="checkbox"/> Lab |
| | <input type="checkbox"/> Clinic Note |
| | <input type="checkbox"/> Preoperative Order |
| | <input type="checkbox"/> H & P |
| | <input type="checkbox"/> Surgical Consent |

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