Required Medical Information Check List

Program		Required Medical Information
Radiology		
	☐	Rule out/diagnosis
	☐	Symptoms
	☐	Physical Exam findings
	☐	Treatment such as medications, physical therapy, surgery; chemotherapy
	☐	Re-evaluation post treatment for some indications
	☐	Recent relevant imaging
	☐	Recent relevant laboratory work
	☐	Pertinent medical history and family history
	☐	For imaging exam requests for cancer, indicate if the exam is requested for initial staging or restaging following treatment or surveillance. Please provide the type and stage of cancer, date of diagnosis, type of treatment and date of treatment completion.
Cardiology		
	☐	Current office notes with complete history and physical exam
	☐	Lipid panels
	☐	Reports (or copies) of current electrocardiograms (EKGs) signed by doctors
	☐	Reports of previously performed left heart catheterizations, nuclear stress tests, routine exercise stress tests, echocardiograms and stress echocardiograms (as applicable) previous cardiac imaging studies (CT, MR, PET)
	☐	For Cardiac Implantable Devices (CRID), reports of EKGs, EP studies, rhythm strips and/or rhythm monitoring reports, cardiac device interrogations, current office notes with complete history and physical
Radiation Therapy Program		
	☐	Please fill out the appropriate Clinical Worksheet/Guide
	☐	Site of treatment and/or cancer type
	☐	Radiation Prescription
	☐	Will IGRT be needed?
	☐	Reason for treatment
	☐	Staging of the cancer, if applicable
	☐	Technique to be used, and start date which should be the first day of treatment, not simulation
	☐	Number of phases of treatment if more than one, and number of fractions
	☐	Diagnosis codes
	☐	Pertinent clinical information to substantiate medical necessity for requested treatment plan
	☐	Radiation Oncologists consultation note
	☐	Recent imaging if applicable
Medical Oncology		
	☐	Patient's clinical presentation
	☐	Diagnosis codes
	☐	Type and duration of treatments performed to date for the diagnosis
	☐	Disease-Specific Clinical Information

Required Medical Information Check List

	☐	Diagnosis at onset
	☐	Stage of disease
	☐	Clinical presentation
	☐	Histopathology
	☐	Comorbidities
	☐	Patient risk factors
	☐	Performance status
	☐	Genetic alterations
	☐	Line of treatment
	☐	Regimen/drugs
Musculoskeletal Program for Spine Surgery		
	☐	**Prior Authorization requests should be submitted at least two weeks prior to the anticipated date of an elective spine surgery.**
	☐	Signs/Symptoms
	☐	Date of first office visit related to this condition and/or after symptoms began
	☐	Last office visit including re-evaluation
	☐	Physical exam findings
	☐	Previous medical history
	☐	Duration and type of physician-directed treatment
	☐	Outcomes of prior surgical/non-surgical physician-directed treatment and prior surgical/non-surgical interventions
	☐	Results of relevant prior imaging related to the request including the radiologists report of advanced diagnostic imaging studies
Musculoskeletal Program for Joint Surgery		
	☐	**Prior Authorization requests should be submitted at least two weeks prior to the anticipated date of an elective joint surgery**
	☐	Date of most recent physical exam along with physical exam findings and patient complaints
	☐	Medical history/duration of complaints
	☐	Other pertinent medical history/comorbidities
	☐	Dates/duration/response to conservative treatment such as medication and various therapies (please specify)
	☐	Prior imaging films/reports with date of service (MRI, CT, X-ray or bone scan)
	☐	Severity of pain and details of functional disabilities interfering with activities of daily living.
	☐	Physician's treatment plan
Musculoskeletal Program for Pain Management		
	☐	CPT codes and diagnosis codes/ICD10
	☐	CPT codes and specific levels of injection and/or specific muscle groups to be injected. Specific prior injection history with dates/level/side/response to injection, especially if it is an injection into the same vertebral region (e.g., cervical, thoracic or lumbar spine)
	☐	Total number of injections/procedures in the past 12 months for the diagnoses (to include all prior doctors)

Required Medical Information Check List

	☐	Date of most recent physical exam along with physical exam findings and patient complaints
	☐	Medical history/duration of complaints
	☐	Other pertinent medical history/comorbidities
	☐	Name of injectate(s)
	☐	Specify imaging guidance type
	☐	Type or method of radiofrequency ablation
	☐	Dates/duration/response to conservative treatment such as medication and various therapies (please specify)
	☐	Date of MRI and other imaging with findings
	☐	Proposed date of service for current request
	☐	Any anesthesia requirements

PT/OT		
	☐	Primary and Secondary Diagnosis/ICD10
	☐	Co-morbidities/Complexities that will impact the therapy plan of care
	☐	Surgery – Date and type
	☐	Functional Outcome Measures/Patient Reported Outcome Scores
	☐	Standardized test scores (a minimum of annually for pediatric neurodevelopmental conditions

Chiropractic		
	☐	Primary and Secondary Diagnosis/ICD10
	☐	Primary and Secondary area of treatment (i.e., neck, back, upper/lower extremity)
	☐	Co-morbidities/Complexities that will impact the therapy plan of care
	☐	Functional Outcome Measures/Patient Reported Outcome Scores (i.e., Oswestry, Neck Disability)
	☐	Results of physical performance tests relevant to the condition

Acupuncture		
	☐	Primary and Secondary diagnosis code/ICD10
	☐	Start date for Acupuncture
	☐	New condition not previously treated or previous condition
	☐	Date of current findings
	☐	What is the acupuncture being used to treat?
	☐	Average level of pain (Rate 1 - 10)
	☐	List of activities the patient isn't able to perform within the last week (Rate level of difficulty 1 - 10)
	☐	Provide current pain medication
	☐	How many new re-occurrences has the patient experienced in last 12 months?
	☐	Patient's response to care
	☐	Reasons for patient not responding to care
	☐	Patient's status to Provider prescribed pain medication
	☐	Additional information for non-MSK conditions: date of most recent medical evaluation, current medical co-management, condition-specific outcome measures.

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Massage	
☐	Primary and Secondary diagnosis code/ICD10
☐	Start date for Massage Therapy
☐	New condition not previously treated or previous condition
☐	Date of current findings
☐	Average level of pain (Rate 1 - 10)
☐	List of activities the patient isn't able to perform within the last week (Rate level of difficulty 1 - 10)
☐	Provide current pain medication
☐	How many new re-occurrences has the patient experienced in last 12 months?
☐	Patient's response to care
☐	Reasons for patient not responding to care
☐	Patient's status to Provider prescribed pain medication
☐	Additional information for non-MSK conditions: date of most recent medical evaluation, current medical co-management, condition-specific outcome measures.

Molecular and Genomic Testing Program	
☐	Specimen Collection or Shelf Retrieval Date if known
☐	Test Name
☐	Laboratory Performing Test
☐	CPT Codes and Units
☐	ICD Codes relevant to requested test
☐	Test Indication (Personal history of condition being tested, age at initial diagnosis, relevant signs and symptoms (if applicable)
☐	Relevant past test results
☐	Member or patient's ethnicity
☐	Relevant Family history if applicable (maternal or paternal relationship, medical history including ages at diagnosis, genetic testing)
☐	Is there a known familial mutation? If yes, what is the specific mutation?
☐	How will the test results be used in the member or patient's care?

Post-Acute Care	
☐	Therapy notes within the last (24/48) (including home set up; baseline LOF; and current LOF)
☐	Facility demographic information
☐	Face sheet, history and physical, past history, clinical notes, lab results
☐	Primary ICD-10 code
☐	H&P, Consultant notes, and progress notes
☐	Medication list
☐	Diagnostic testing
☐	Discharge summary and working DRG (if applicable)
☐	wound evaluation and wound care needs (if applicable)
☐	Skilled nursing/medical needs to be continued in post-acute setting and anticipated length of treatment(s)

Required Medical Information Check List

Durable Medical Equipment	
	☐ Written prescription
	☐ Certificate of medical necessity (CMN)
	☐ Preauthorization request form
	☐ Most recent office visit notes (for most requests, must be within last 3 months)
	☐ Current detailed invoice listing all requested equipment
	☐ Diagnosis (if part of discharge plan, include the admitting diagnosis)
	☐ Patient history and physical exam findings, progress notes, wound or incision/location
	☐ Rental vs Purchase and Quantity requested (if applicable)
	☐ Has the patient previously used this/these item(s)
	☐ DME vendor/site

Sleep	
	☐ Study Requested
	☐ Complaints and symptoms, length of time experiencing symptoms
	☐ Co-morbid conditions with recent supporting office notes and length of time with conditions
	☐ List of current medications
	☐ If there was a prior sleep study, date and what type of study?
	☐ What is the reason for a repeat study
	☐ Has the patient ever been on PAP therapy before, date
	☐ Epworth Sleepiness Scale
	☐ BMI
	☐ STOP-BANG assessment

Gastroenterology	
	☐ A relevant history and physical exam
	☐ Summary of patient's condition
	☐ Imaging and/or pathology and/or lab reports indicated relevant to the requested procedure
	☐ Co-morbidities if relevant
	☐ The indication for the specified procedure
	☐ Prior treatment regimens (for example, appropriate clinical trial of conservative management, if indicated)
	☐ Results of prior endoscopic procedures if relevant
	☐ Genetic testing results if applicable