

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