JOINT SURGERY REQUEST CLINICAL WORKSHEET

Page 1 of 3: DEMOGRAPHIC INFORMATION

For NON-URGENT requests, please fax this completed document along with medical records, imaging, tests, etc. If there are any inconsistencies with the medical office records, please elaborate in the comment section. Failure to provide all relevant information may delay the determination. Phone and fax numbers can be found on eviCore.com under the Guidelines and Fax Forms section. You may also log into the provider portal located on the site to submit an authorization. URGENT (same day) REQUESTS MUST BE SUBMITTED BY PHONE.

Date: _____

Patient/ Member

First Name: _____ MI: ____ Last Name: _____

Date of Birth *(mm/dd/yyyy)*: _____ Gender: ☐ Male ☐ Female

Street Address: _____ Apt/Suite: _____

City: _____ State: _____ Zip: _____

Home Phone Number : ___/___-_____ Cell: ___/___-_____ Preferred Contact: ☐ Home ☐ Cell

Health Plan Name: _____ Member ID: _____ Group ID: _____

Rendering Physician

First Name: _____ Last Name: _____

Primary Specialty: _____ NPI: _____ TIN: _____

Phone Number: ___/___-_____ Fax Number: ___/___-_____

Street Address: _____ Apt/Suite: _____

City: _____ State: _____ Zip: _____

Office Contact: _____ Ext: _____ Email: _____

Facility/Site of Service

Group/Site Name: _____

Primary Specialty: _____ NPI: _____ TIN: _____

Phone Number: ___/___-_____ Fax Number: ___/___-_____

Street Address: _____ Apt/Suite: _____

City: _____ State: _____ Zip: _____

Office Contact: _____ Ext: _____ Email: _____

To avoid unnecessary delays with the processing of your request, please ensure all fields are completed and accurate before submission.

Clinical Information

Anticipated Date of Service *(mm/dd/yyyy)*: _____

Site of Service: ☐ Office ☐ Outpatient ☐ Inpatient ☐ Ambulatory

CPT Codes

Note - Units may be requested as follows:

- *Facet (MBB), Transforaminal and Interlaminer (ESI) injections are limited to one (1) per spinal level;*
- *Spinal Radiofrequency Ablation/Denervation (RFA) Cervical: 64633 (1) 64634 (2); Lumbar: 64635 (1) 64636 (2)*
- *Implants are limited to (16) electrodes and (2) leads; each lead limited to (8) electrodes*
- *Joint Surgery limited to (1)*

Code	**Units** (if > 1)	**Level** (i.e. C4-C5)	**Left, Right or Bilateral**	**Code**	**Units** (if > 1)	**Level** (i.e. C4-C5)	**Left, Right or Bilateral**

Diagnoses:

ICD-10 Code:		**ICD-10 Code:**	
ICD-10 Code:		**ICD-10 Code:**	
ICD-10 Code:		**ICD-10 Code:**	

If Site of Service selected is Inpatient: Does your patient have any one or more of the following due to severe systemic disease? (Check all that apply)

- ☐ Poorly Controlled diabetes (DM) or hypertension (HTN)
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Morbid Obesity (Body Mass Index (BMI) ≥ 40)
- ☐ Active Hepatitis
- ☐ End Stage renal disease (ESRD) undergoing regularly scheduled dialysis
- ☐ Alcohol dependence or abuse
- ☐ Implanted pacemaker
- ☐ Moderate reduction of ejection fraction
- ☐ History (> 3 months) of myocardial infarction (MI), cerebrovascular accident (CVA), transient ischemic attack, or coronary artery disease (CAD)/stents
- ☐ None of the Above

Joint Surgery CLINICAL WORKSHEET

Patient Name _____ DOB: __/__/____ Patient ID: _____

JOINT SURGERY CLINICAL INFORMATION

Is surgery for a fracture, tumor, infection, or foreign body that will cause progressive destruction? ☐ Yes ☐ No

Which of the following best describes current condition? ☐ Acute ☐ Chronic | **Date of onset** of current condition: __/__/____

Does member have loss of function that interferes with the ability to perform activities of daily living/work? ☐ Yes ☐ No

Please indicate the member's most recent reported level of pain:

☐ 0 (No Pain) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Severe disabling pain) ☐ Unknown

For how long has the pain been present: _____ ☐ Weeks ☐ Months

Please indicate the member's present symptoms:

☐ Popping or clicking
☐ Locking/catching
☐ Looseness
☐ Give way/buckling
☐ Weakness
☐ Limited range of motion
☐ Swelling
☐ Pinching
☐ Other: _____
_____
_____

Has the member failed a course of non-surgical management: ☐ Yes ☐ No

Indicate length of conservative care performed: ☐ None ☐ < 1 Month ☐ 1-2 months ☐ 3-5 months ☐ 6 or more months

Please indicate all conservative therapy activities that apply:

☐ Over the Counter Medication (ex: Tylenol, Aspirin)
☐ NSAIDs (Non-steroid Anti-inflammatory Drugs) (ex: Advil, Aleve)
☐ Narcotics / Opioids (ex: Percocet, Vicodin, Oxycontin,Norco)
☐ Physical medicine program: (such as Physical Therapy, Chiropractic Care, Acupuncture, Massage Therapy, Rest/Ice/Heat, Active Exercise)
☐ Bracing or immobilization / use of assisted devices
☐ No conservative therapy
☐ Other: _____

Does the member's imaging finding confirm the need for surgery? ☐ Yes ☐ No ☐ Not Performed

If yes, please indicate findings:

☐ Joint Effusion
☐ Fraying
☐ Partial Tear
☐ Full Tear
☐ Grade 1 DJD
☐ Grade 2 DJD
☐ Grade 3 DJD
☐ Grade 4 DJD
☐ Partial Dislocation
☐ Full Dislocation
☐ Component failure
☐ Fracture
☐ Avascular Necrosis
☐ No abnormal findings
☐ Imaging has not been performed

☐ Other: _____

Does the member's physical exam confirm the need for surgery? ☐ Yes ☐ No

If yes, please indicate findings:

☐ Joint line tenderness
☐ Joint Inflammation/Effusion
☐ Measurable loss of joint range of motion
☐ Measurable loss of joint strength
☐ Ligament instability
☐ Capsular instability
☐ Positive orthopedic test
Please specify: _____
_____

Please indicate member's BMI: _____