



Required Clinical Information

| Program | Required Medical Information |
|---------------------------|---|
| Radiology Program | 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 Program | Current office notes |
| | Lipid panels |
| | Reports 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) |
| Sleep Program | Reason and type of study Requested |
| | Complaints and symptoms, length of time experiencing symptoms |
| | If there was a prior sleep study, date and what type of study |
| | List of current medications |
| | Co-morbid conditions with recent supporting office notes and length of time with conditions |
| | If repeat test, reason for the need to repeat |
| | Has the patient ever been on PAP therapy before, date |
| | Epworth Sleepiness Scale |
| | STOP-BANG assessment |



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| Radiation (Oncology) Therapy Program | Site of treatment and/or cancer type |
| | Reason for Treatment |
| | Technique to be used, and start date (should be the first day of treatment, not simulation). Will IGRT be needed? |
| | Staging of the cancer, if applicable |
| | Recent imaging if applicable |
| | Number of phases of treatment if more than one, and number of fractions |
| | Radiation Oncologists consultation note |
| | Pertinent clinical information to substantiate medical necessity for requested treatment plan |
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| Musculoskeletal Program Spine Surgery | Date of first office visit related to this condition and/or after symptoms began |
| | Signs/Symptoms |
| | 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 |
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| Musculoskeletal Program Joint Surgery | Date of most recent physical exam along with physical exam findings and patient complaints |
| | Medical history/duration of complaints |
| | Dates/duration/response to conservative treatment such as medication and various therapies (please specify) |
| | Other pertinent medical history/comorbidities |
| | 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 |
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| Musculoskeletal Program for Pain Management | 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) |
| | 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 injectant |
| | Type or method of radiofrequency ablation and/or percutaneous decompression |
| | Dates/duration/response to conservative treatment such as medication and various therapies (please specify) |
| | Type or method of radiofrequency ablation |
| | Specify imaging guidance type |
| | Date of MRI and other imaging with findings |
| | Proposed date of service for current request |
| | Any anesthesia requirements |
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| Musculoskeletal Program Specialty Therapy (PT/OT) | <i>Feel free to utilize the appropriate Clinical Worksheet/Guide as a tool/resource.</i> |
| | Primary and Secondary Diagnosis/ICD10 |
| | Co-morbidities/Complexities that will impact the therapy plan of care |
| | Standardized test scores (a minimum of annually for pediatric neurodevelopmental conditions) |
| | Functional Outcome Measures/Patient Reported Outcome Scores |
| | Surgery – Date and type |
| | 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? |
| | Patients response to care |
| | Reasons for patient not responding to care |
| | Patients status to Provider prescribed pain medication |
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