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: • *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:** *Results must be separate report or H&P heading*
☐ **1. Advanced joint disease as demonstrated by radiological supported evidence:**	**Documentation Location:**
☐ Subchondral cysts ☐ Joint subluxation ☐ Distortion of the joint surfaces ☐ Subchondral sclerosis ☐ Joint space narrowing ☐ Fracture or deterioration ☐ Periarticular osteophytes ☐ Avascular necrosis	☐ MRI ☐ X-ray report ☐ H&P heading
☐ **2. Unsuccessful conservative treatment for 3+ months**	**Documentation Location:**
Treatment type: / **Start Date:** ☐ NSAIDS _ _ /_ _ /_ _ _ _ ☐ Analgesics _ _ /_ _ /_ _ _ _ ☐ Physical Therapy for flexibility and muscle strengthening _ _ /_ _ /_ _ _ _	☐ H & P ☐ Consult ☐ PT notes ☐ Office notes ☐ Other:_____
☐ **3. Pain and functional disability from injury due to trauma or arthritis of the knee joint:**	**Documentation Location:**
☐ Assistive device use ☐ Appropriate weight reduction ☐ Appropriate therapeutic injections into knee ☐ Activities of daily living diminished despite compliance with plan of care including activity restrictions **Additional Documentation:** ☐ Distance patient can walk/stairs ☐ Type of assistive device or brace ☐ Activity modification	☐ H & P ☐ Consult ☐ Office notes ☐ Pain and disability summary: _____
☐ **4. Distinct structural abnormalities:**	**Documentation Location:**
☐ Distal femur fracture ☐ Proximal tibia fracture ☐ Rheumatologic changes precluding or inconsistent with rehab ☐ Malignancy of the distal femur, proximal tibia, knee joint or adjacent soft tissues ☐ Avascular or other form of osteonecrosis of the knee	☐ MRI ☐ X-ray report ☐ Path report ☐ Oncologist consult
☐ **5. Failed previous joint replacement necessitating revision indicated by any of the following:**	**Documentation Location:**
☐ Infection/inflammatory response ☐ Tibiofemoral or extensor mechanism instability ☐ Previous osteotomy/partial arthroplasty ☐ Bearing surface wear leading to symptomatic synovitis ☐ Periprosthetic fracture or bone loss of distal femur, proximal tibia or patella; Implant or knee malalignment ☐ Loosening, fracture or mechanical failure of one or more components ☐ Technical or functional failure of previous knee surgery, e.g. unicompartmental knee replacement ☐ Knee stiffness, arthrofibrosis or other destructive conditions that render the knee impaired to the extent to preclude employment or functional activities.	☐ MRI ☐ X-ray report ☐ Lab report ☐ Revision supporting documentation: _____

MRPPS
H10137 (11/2015)

Total Knee Replacement
Medical Necessity Check List

Patient Information/Label

Patient name: _____

DOB: _____

Anticipated admit date: _____

Revised 11/24/15

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.*	
☐ **1.**	**Pre-authorization Check List with included supporting documentation** (if required)
☐ **2.**	**Pre-Surgical documentation** (if not submitted with Pre-authorization Check List) ☐ PAT Order ☐ EKG ☐ Lab ☐ Clinic Note ☐ Preoperative Order ☐ H & P ☐ Surgical Consent