

Prior Authorization for Knee Arthroplasty review

Fax completed forms to (952)853-8713. Call Utilization Management (UM) at (952)883-6333 with questions. Incomplete forms will be returned. Submit clinical documentation to support your request. Sign in at healthpartners.com/provider and use the Authorizations and referrals link to check the status of your prior authorization request.

| Member information | | | |
|--|--------------------|-----------|-------------------|
| First Name | MI | Last Name | |
| HealthPartners ID # | DOB | | |
| Requester information | | | |
| Form completed by: First Name | | Last Name | |
| Your business name | | | |
| Your business street address | | | |
| Your business city | Your business | s state | Your business zip |
| Phone* | | Fax** | |
| Ordering provider information | | | |
| Provider first name | Provider last name | | |
| Specialty | | NPI | |
| Clinic name | | | |
| Clinic street address | | | |
| Clinic city | Clinic state | | Clinic zip |
| Clinic tax ID (claim may be rejected if incorrect) | | | |
| Email | | Phone* | Fax** |
| Procedural provider information | | | |
| Provider first name | Provider last name | | |
| Specialty | | NPI | |
| Clinic name | | | |
| Clinic street address | | | |
| Clinic city | Clinic state | | Clinic zip |
| Clinic tax ID (claim may be rejected if incorrect) | | | |
| Email | | Phone* | Fax** |
| Facility site for procedure or surgery | | | |
| Facility name | | | |
| Facility street address | | | |
| Facility City | Facility state | | Facility zip |
| Billing tax ID (claim may be rejected if incorrect) | | | |
| Phone* | | Fax** | |
| *Confidential voicemail required **For outcome notification | | | 20-913603-913616 |



Procedure or surgery

Only include codes requiring prior authorization; other codes will not be addressed

Primary diagnosis code Description

Secondary diagnosis code

. Description

Procedure code(s)

Procedure(s) or surgery description

Proposed date of procedure

or TBD

Will waiting the standard review time seriously jeopardize member's health, life or ability to regain maximum functioning? yes no

Clinical reason for urgency (not scheduling issues)

Please submit all the following:

- Clinical document that supports the medical need for the knee arthroplasty
 - o Documentation that treatment is needed for disabling pain or functional disability AND
 - o Documentation that treatment is needed for degenerative joint disease indicated by:
 - Radiographic report(s) (plain radiographs, MRI/CT) documenting the indication for knee surgery: e.g., knee joint destruction, angular deformity, or severe narrowing

AND

- Documentation of conservative measures
 - Physical therapy notes (must correspond to the current episode of pain)
 - o Attempts of weight loss
 - Use of NSAIDs or other pain management trial
 - o Activity modification trial

OR

• Documentation that patient is not a candidate for conservative measures and why (e.g., osteotomy)

Replacement/Revision

- Clinical document that supports the medical need for the knee replacement/revision
 - o Radiographic report(s) (plan radiographic, MRI/CT) documenting the indication for knee revision

Patellofemoral arthroplasty and Replacement/Revision

- Clinical document that supports the medical need for the patellofemoral arthroplasty
 - o Documentation that treatment is needed for disabling pain or functional disability AND
 - Radiographic report(s) (plain radiographs, MRI/CT) documenting the indication for the patellofemoral arthroplasty surgery AND
 - o Documentation of Conservative measures
 - > Physical therapy notes (must correspond to the current episode of pain)
 - Attempts of weight loss
 - > Use of NSAIDs or other pain management trial
 - Activity modification trial

OR

o Documentation that patient is not a candidate for conservative measures and why