



# TOTAL KNEE JOINT REPLACEMENT REVIEW TOOL

## Prior Justification for Inpatient Total Knee Replacement

### CPT code 27447 (Total Knee Replacement)

Fax this form to (585) 327-2275 or call (585) 327-5775 or 1 (800)324-3899 and select option #2  
(Monday through Friday 8am – 4pm)

The completed faxed form will contain all the information for an inpatient authorization.  
The office will be called with the authorization number.

Patient/Member Information			
Last Name:		First Name:	DOB:
Member ID no:		Secondary insurance:	BMI: or Weight:
Surgeon Information			
Surgeon:	Office phone number:	Fax:	Provider ID#
Date of Request:	Date of Surgery:	Hospital:	ICD 9 Code:
Circle knee requiring joint replacement:                      right                      left                      both			
Assistant Surgeon (if known):			
Check off all that apply to member <b>(additional office notes may be requested)</b>			
Indication:			
Osteoarthritis - <input type="checkbox"/>	Avascular necrosis (osteonecrosis), tibial plateau/femoral condyle- <input type="checkbox"/>		
Bone Tumor - <input type="checkbox"/>	Rheumatoid arthritis - <input type="checkbox"/>	Nonunion/malunion, articular fracture- <input type="checkbox"/>	
Pain :		Findings :	
<ul style="list-style-type: none"> <li>• Increased with initiation of activity - <input type="checkbox"/></li> <li>• Increased with weight bearing - <input type="checkbox"/></li> <li>• Interferes with ADLs - <input type="checkbox"/></li> </ul>		<ul style="list-style-type: none"> <li>• Pain with passive ROM - <input type="checkbox"/></li> <li>• Limited ROM - <input type="checkbox"/></li> <li>• Crepitus - <input type="checkbox"/></li> <li>• Joint effusion/swelling - <input type="checkbox"/></li> </ul>	
X-ray findings <b>(if available, please submit report):</b>			
<ul style="list-style-type: none"> <li>• Subchondral cysts - <input type="checkbox"/></li> <li>• Subchondral sclerosis - <input type="checkbox"/></li> <li>• Joint space narrowing - <input type="checkbox"/></li> <li>• Periarticular osteophytes - <input type="checkbox"/></li> <li>• Joint subluxation - <input type="checkbox"/></li> <li>• Tumor involvement of Knee- <input type="checkbox"/></li> </ul>		<b>Nonunion/malunion of fracture by x-ray:</b> <ul style="list-style-type: none"> <li>• Tibial plateau - <input type="checkbox"/></li> <li>• Femoral condyle - <input type="checkbox"/></li> </ul> <b>Avascular necrosis with collapse of tibial plateau/condyle by x-ray - <input type="checkbox"/></b>	
Continued Sx/findings after Rx:			
<ul style="list-style-type: none"> <li>• NSAID <ul style="list-style-type: none"> <li>▪ Rx ≥ 4 wks - <input type="checkbox"/></li> <li>▪ Contraindicated/not tolerated - <input type="checkbox"/></li> </ul> </li> </ul>		<ul style="list-style-type: none"> <li>• PT or structured exercise program ≥ 12 wks in member's history <i>(if not, please add additional comments below)</i> - <input type="checkbox"/></li> <li>• Trial of external joint support offered (cane, brace or walker)-<input type="checkbox"/></li> </ul>	
Narrative: (include presence of infection/history of infection in joint, Charcot joint and noncompliance issues, what type of external joint support, reason member did not receive physical therapy/exercise, NSAIDs and/or external joint support)			
Physician Signature:		Date:	

**PLEASE NOTE:** By signing above, you are attesting to the accuracy of the information provided, and that medical record documentation is available if requested.