



TOTAL KNEE JOINT REPLACEMENT REVIEW TOOL

Prior Justification for Inpatient Total Knee Replacement CPT code 27447 (Total Knee Replacement)

Fax this form to (800) 280-7346 or call (585) 325-3114 or 1 (800) 999-3920
(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 (additional office notes may be requested)			
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"> • Increased with initiation of activity - <input type="checkbox"/> • Increased with weight bearing - <input type="checkbox"/> • Interferes with ADLs - <input type="checkbox"/> 		<ul style="list-style-type: none"> • Pain with passive ROM - <input type="checkbox"/> • Limited ROM - <input type="checkbox"/> • Crepitus - <input type="checkbox"/> • Joint effusion/swelling - <input type="checkbox"/> 	
X-ray findings (if available, please submit report):			
<ul style="list-style-type: none"> • Subchondral cysts - <input type="checkbox"/> • Subchondral sclerosis - <input type="checkbox"/> • Joint space narrowing - <input type="checkbox"/> • Periarticular osteophytes - <input type="checkbox"/> • Joint subluxation - <input type="checkbox"/> • Tumor involvement of Knee- <input type="checkbox"/> 		Nonunion/malunion of fracture by x-ray: <ul style="list-style-type: none"> • Tibial plateau - <input type="checkbox"/> • Femoral condyle - <input type="checkbox"/> Avascular necrosis with collapse of tibial plateau/condyle by x-ray - <input type="checkbox"/>	
Continued Sx/findings after Rx:			
<ul style="list-style-type: none"> • NSAID <ul style="list-style-type: none"> ▪ Rx ≥ 4 wks - <input type="checkbox"/> ▪ Contraindicated/not tolerated - <input type="checkbox"/> 		<ul style="list-style-type: none"> • PT or structured exercise program ≥ 12 wks in member's history <i>(if not, please add additional comments below)</i> - <input type="checkbox"/> • Trial of external joint support offered (cane, brace or walker)-<input type="checkbox"/> 	
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.