SecurityHealth Plan℠
Promises kept, plain and simple.®

1515 North Saint Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000

1.800.548.1224
TTY: 711

Chronic Knee Pain – Osteoarthritis or Meniscal Degeneration – Specialty Consult

Prior Authorization Request

Date _____

Member information		
Member name (print)	SMID	Date of birth (month/day/year)
Provider information		
Provider name (print)	Telephone number	Fax number
Place of service: ☐ Ambulatory Surgery Center ☐ Hospital outpatient ☐ Hospital inpatient ☐ Provider's office ☐ Other _____		
Facility where services will be provided (include address if the provider provides services at more than one practice location)		
Referring provider name (print)	Telephone number	Fax number
Referring provider's contact person name (print)	Telephone number	
Procedure information		
Scheduled date of service (month/day/year)	Requested service/procedure	Procedure code(s)
Diagnosis	Diagnosis code(s)	

Answer all of the following questions.

1. Is this consult needed due to an acute injury ☐ Yes ☐ No

   If yes, date (month/day/year) of injury _____ /_____ /_____

   If yes, clinical information is not required. Submit form to Security Health Plan for notification.

2. **Meniscal degeneration**

   Symptoms: Chronic knee pain ☐ Yes ☐ No

   Mechanical symptoms (locking, catching, or giving way/buckling) ☐ Yes ☐ No

   Continued symptom findings after treatment: Treatment with NSAIDs greater than 4 weeks or contraindicated/not tolerated, and physical therapy greater than 6 weeks (unless contraindicated or not tolerated) is documented ☐ Yes ☐ No

   OR

   Osteoarthritis

   Does pain in member's knee significantly limit activity (i.e. walking, stairs, getting up from chair) and interfere with activities of daily living ☐ Yes ☐ No

   Is there arthritis at knee by x-ray demonstrating significant signs of degenerative change – such as subchondral cysts, subchondral sclerosis, periarticular osteophytes, joint subluxation, or joint space narrowing ☐ Yes ☐ No

Continued symptoms despite conservative therapy with NSAIDs greater than 4 weeks, contraindicated or not tolerated, and physical therapy greater than 6 weeks (unless contraindicated or not tolerated) is documented. ☐ Yes ☐ No

3. Does the member have a history of unsuccessful conservative therapy (non-surgical medical management) that is clearly addressed in the medical record. If conservative therapy is not appropriate, the medical record must clearly document why such approach is not reasonable ☐ Yes ☐ No

4. Has patient had knee surgery within the last year ☐ Yes ☐ No

   If yes, date (month/day/year) of surgery _____ /_____ /_____

By signing this form, the provider attests that the above information is accurate and documented in the medical record. Security Health Plan may, at its discretion, request medical records to make a final coverage determination.

_____ _____

Provider signature Date

Pre-service decisions: Initial review is received and a coverage determination is made within fourteen (14) calendar days of receipt of request. The member and/or provider are notified in writing of a denial decision within fourteen (14) calendar days of receipt of the request.

Urgent pre-service decisions: Initial review is received and a coverage determination is made within seventy-two (72) hours of receipt of request.

Mail or fax form to:	Security Health Plan Health Services Department PO Box 8000 Marshfield, WI 54449-8000 Fax 715.221.6616	**Marshfield Clinic providers route to:** Health Services Department Routing location, SHP

If you have any questions, please contact Customer Service at 1.800.548.1224

