

**Review Request  
for Continuous Passive Motion Devices**

Please fax the completed form to **1-800-823-5520**.

If you have questions, call **1-866-902-1689** during regular business hours.

Policy Last Review Date: 5/21/09	Policy Effective Date: 5/21/09	Provider Tool Effective Date: 8/10/09
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Member Name:	Date of Birth:
Insurance Identification Number:	Member Phone Number:

Ordering Provider Name and Specialty:	Provider ID Number:
Office Address:	
Office Phone Number:	Office Fax Number:

Rendering Provider Name and Specialty:	Provider ID Number:
Office Address:	
Office Phone Number:	Office Fax Number:

Facility Name:	Facility ID Number:
Facility Address:	

Date/Date Range of Service:	Place of Service: <input type="checkbox"/> Home <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Other: _____
Service Requested (CPT if known):	
Diagnosis (ICD-9) if known:	

**Please check all that apply to the member:**

- Member is status post total knee arthroplasty (TKA) or TKA revision (device applied within 72 hours following surgery)
- Member is status post tibial plateau fracture (device applied within 72 hours following surgery)
- Member is status post anterior cruciate ligament (ACL) repair (device applied within 72 hours following surgery)
- Member is status post posterior cruciate ligament (PCL) repair (device applied within 72 hours following surgery)
- Member is in non-weight bearing period following articular cartilage grafting procedures; (e.g. autologous chondrocyte implantation [ACI], osteochondral implant) (device applied within 72 hours following surgery)
- Request is subsequent to arthroplasty or the release of an arthrofibrosis of the elbow or knee, shoulder, wrist or hand. (e.g. elbow arthroplasty, rotator cuff repair or arthroplasty or metacarpal joint phalangeal arthroplasty) (device applied within 72 hours following surgery)
- Request is for any primary therapeutic application for any of the following (check all that apply):
  - Ankle
  - TMJ (temporomandibular joint)
  - Toes
  - Treatment of degenerative joint diseases
  - Treatment of chronic contractures
  - Other (please explain): \_\_\_\_\_
- Device was initially applied in an inpatient setting prior to discharge
  - Date of surgery: \_\_\_\_\_
  - Date of device application: \_\_\_\_\_
  - Discharge date: \_\_\_\_\_
- Request is for use longer than 21 days from date of first application
  - Other (please list): \_\_\_\_\_

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This request is being submitted:

- Pre-Claim
- Post-Claim. If checked, please attach the claim or indicate the claim number: \_\_\_\_\_

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By checking this box, I attest the information provided is true and accurate to the best of my knowledge. I understand that BlueChoice HealthPlan Medicaid may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

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Name and Title of Provider or Provider Representative \_\_\_\_\_ Date \_\_\_\_\_  
Completing Form (Please Print)\*

**\*The attestation fields must be completed by a provider or provider representative in order for the tool to be accepted.**