806 KAR 17:090
MATERIAL INCORPORATED BY REFERENCE
TEMPOROMANDIBULAR JOINT DISORDER (TMJ)
SURGICAL TREATMENT PREAUTHORIZATION REQUEST FORM
(Please type or print legibly)

Date of Request___________________________

PATIENT INFORMATION:
Name_________________________________
Policy or Claim # _______________________
Street_________________________________
City/State _____________________________
Zip Code_____ Phone (___)_______________

PROVIDER INFORMATION:
Name_________________________________
Provider Number_______________________
Street_________________________________
City/State _____________________________
Zip Code_____ Phone (___)_______________

********************************DEAR PROVIDER******************************
PLEASE COMPLETE AND SIGN THE FOLLOWING, FOR PREAUTOIZATION REVIEW OF ANTICIPATED CRANIOMADIBULAR/TEMPOROMANDIBULAR JOINT TREATMENT.

1. Does the patient have a history of pain or dysfunction of one month or greater?
_____ Yes _____ No How long? ____
Continuous _____ Intermittent_____ Comments__________________________________
____

2. Does the patient exhibit signs or symptoms of TMJ Disc Disorder?
_____ Yes _____ No (If yes, describe the signs or symptoms with proper ICD-9-CM diagnostic number)
____Code___________________
____Code___________________

3. Does the patient exhibit signs or symptoms of Muscle Disorder?
_____ Yes _____ No (If yes, describe the signs or symptoms with proper ICD-9-CM diagnostic number)
____Code___________________
____Code___________________

4. In the absence of pain, are the signs and symptoms indicated above accompanied by functional limitations? _____ Yes _____ No (If yes, please document below)

Maximal Incisal Opening: _____mm

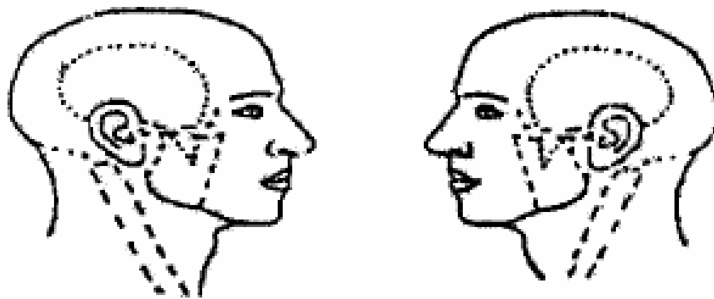
Incisal Opening Without Pain: _____mm

Maximal Lateral Movements: Right _____mm Left _____mm

Lateral Movement Without Pain: Right _____mm Left _____mm

Deviation Normal Opening: Right _____mm Left _____mm

5. Indicate with an "X" on the diagrams below where the patient exhibited pain on initial examination.



6. Additional diagnostic tests that are requested (i.e. arthrograms, tomograms, and other imaging studies). List and include ADA or CPT code numbers.

____Code____________________

____Code____________________

7. Has splint therapy been instituted prior to surgical consideration? _____ Yes _____ No

A. If yes, describe length of time and type of therapy ___________________________

____

B. If no, explain why you feel it is not indicated _______________________________

____

8. Other than splint therapy, what nonsurgical therapy has been instituted? (i.e., physical therapy, archrocentesis, medication) ____

____

9. What were the results of nonsurgical TMJ Therapy? (i.e., splint therapy, medication, physical therapy, arthrocentesis) ____

____

10. Is there diagnostic medical evidence of a TMJ Disc Disorder? _____ Yes _____ No

____

____

11. List the treatment plan or mode of treatment you propose (List ADA or CPT codes).

____Code___________________

____Code___________________

____Code___________________

12. Do you contemplate irreversible alteration of the occlusion as a result of your treatment?

_____ Yes _____ No (If yes, please describe below)

____

____

____

13. Indicate you anticipated fee per procedure including follow-up (post surgical) care.

Procedure:______________________________________ Fee______________________

Procedure:______________________________________ Fee______________________

Procedure:______________________________________ Fee______________________

14. Date treatment was initiated or anticipated initiation.

____

Additional Comments: ____

____

____

I acknowledge that the above is true and accurate.

____

Provider's Signature