

# FemoroAcetabular Impingement Surgery Fax Form

PRESCRIBER INFORMATION		PATIENT INFORMATION	
PHYSICIAN NAME	PROVIDER ID/TAX ID (if out of state must have tax ID)	PATIENT NAME	
CONTACT PERSON/PRACTICE NAME		PATIENT'S BCBSNC ID	
PRACTICE PHONE	PRACTICE FAX	PATIENT'S DATE OF BIRTH	
PRACTICE ADDRESS	CITY	STATE	ZIP

**PLEASE mark each response for questions 1-7 below, enter CPT codes for requested procedures, sign and fax to BCBSNC.**

1. Age: 15 – 55..... Yes  No
2. Pain: moderate-severe, and worsened by flexion activities (e.g., sitting, squatting, sports) and significantly limits activities..... Yes  No
3. Conservative therapy:  $\geq$  3 mos. avoidance of provocative activities ..... Yes  No
4. Positive impingement sign on clinical exam (flex, adduct, int. rotate) ..... Yes  No
5. Positive imaging findings (x-ray, MRI or CT) indicative of FAI ..... Yes  No
6. There is **No** evidence of advanced OA by x-ray or MRI findings.(i.e., Tonnis grade 2 or worse, or joint space < 2mm ..... True  False
7. There is **No** evidence of severe chondral damage by MRI or arthroscopy (i.e., no Outerbridge grade IV, cartilage loss to subchondral bone ..... True  False
8. Diagnosis Code: \_\_\_\_\_
- 9.. Please list CPT codes for all anticipated procedures:  
 \_\_\_\_\_  
 \_\_\_\_\_

If billing with the unlisted CPT code 29999, a maximum of two units can be reimbursed for services related to femoroacetabular impingement surgery, depending on documentation in the operative note and submission of additional listed CPT codes. For complete billing/coding information, refer to the medical policy: *Arthroscopic Surgery for Femoroacetabular Impingement*.

10. Place of Service: \_\_\_\_\_

Effective: 08/18/10

**PHYSICIAN ATTESTATION:** By signing below, I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available

**Please certify the following by signing and dating below:**

\*Physician signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 (\*Original Physician signature required. Stamped signatures not acceptable)

**For BCBSNC members, fax form to 1-800-672-6587**  
**For NC State Health Plan members, fax form to 1-866-225-5258**

An independent licensee of the Blue Cross and Blue Shield Association. ©, SM Marks of the Blue Cross and Blue Shield Association. SM1 Mark of Blue Cross and Blue Shield of North Carolina.

