WYOMING WORKERS' SAFETY AND COMPENSATION
PREAUTHORIZATION CHECK SHEET
CHONDROPLASTY
KNEE

Claimant: _____ Case Number: _____ DOI: _____
Surgeon: _____ Phone Number: _____ Contact: _____
Date of Review: _____ Reviewer: _____
Compensability should NOT be in question at the time of preauthorization for this procedure.

NOTE:

1. The claimant MUST have a direct blow to the knee injury. (OR) ☐ Yes
2. The claimant MUST have an osteochrondral defect due to the injury. ☐ Yes

I. Conservative Care:

a. Physical therapy. ☐ Yes ☐ No
b. Medication. ☐ Yes ☐ No

II. Clinical Findings:

Subjective

a. Complaints of joint pain. ☐ Yes ☐ No

Objective

a. Swelling. ☐ Yes ☐ No
b. Effusion. ☐ Yes ☐ No
c. Crepitus. ☐ Yes ☐ No
d. Limited ROM. ☐ Yes ☐ No

*****Not all of these needs to be present.*****

Imaging

a. Optional.

Approved/Nurse name: _____ Date: _____
Sent for Peer review/Doctor: _____ Date: _____
Notes: _____
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