



Please complete this form before treating all Bupa patients who need a knee arthroscopy procedure. If the planned procedure is a clinical emergency, please let us know so that we can prioritise it.

Guidance on completing the form

Patients aged over 35:

Please complete **section A** and all questions in **section B** to confirm that the planned treatment follows the ESSKA framework and is covered by your Bupa patient's health insurance scheme. Then fill out the **section E** at the bottom of the form.

If you've answered yes to all the questions in **section B** and, provided the patient has already pre-authorized their knee arthroscopy, you can go ahead without waiting for confirmation of funding from us. It's important that the patient does this so that we can let them know about any policy excess or limits that may apply. You'll also need the pre-authorization number for your invoices.

If you've answered no to any of the questions in **section B**, then please complete **section D** as well to provide the clinical rationale and evidence for the proposed treatment and why the ESSKA framework is not appropriate for the patient.

Patients aged 35 or under:

Please complete **sections A, C, and D** giving your clinical rationale and evidence to support the proposed treatment plan. Then fill out **section E** and send the form back to us. We'll let you know whether the treatment is covered under the patient's health insurance within three working days.

If we're unable to fund the procedure based upon the clinical rationale provided, we'll offer the patient the option of a second opinion with an orthopaedic surgeon.

Once you've completed the form

Please return it to us by:

- **secure email:** kneeandhipteam@bupa.com
- **fax:** 01784 893 255

If you've any questions about completing this form or health insurance cover, please call: **0345 600 0541***. We're here between 8am and 8pm Monday to Friday, and 8am to 4pm Saturday.

Please be aware that information you send to this email address may not be secure unless you send us your email through Egress Switch. For more information and to sign up for a free Egress Switch account, go to <https://switch.egress.com>. You won't be charged for sending secure emails to a Bupa email address using the Switch service.

Section A

Patient's name	
Date of birth	<input type="text"/>
Bupa membership number	
Treatment date (if known)	<input type="text"/>
Consultant's name	
Name of hospital	Phone
Anaesthetist's name (if known)	
<input type="checkbox"/> Is this an emergency? If so please complete the relevant sections below and provide details in section D	
Is the patient aged over 35? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please go straight to section C	
Please tick if you're planning one of the following codes <input type="checkbox"/> W8500 <input type="checkbox"/> W8580 <input type="checkbox"/> W8200 <input type="checkbox"/> W8230 If you've ticked one please go to section B . If not, please go straight to section C	
Please tick all imaging that has been carried out <input type="checkbox"/> None <input type="checkbox"/> X-ray <input type="checkbox"/> MRI <input type="checkbox"/> USS <input type="checkbox"/> Other	

Section B: ESSKA framework

Is the history and examination compatible with a degenerative meniscus lesion?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the patient had an MRI scan?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the patient had standard weight bearing X rays?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do they confirm a degenerative meniscal tear?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Please confirm that the knee is either normal or has only minimal osteoarthritis on imaging Please see: Kellgren Lawrence 0-I on X-Ray or equivalent MRI for more information	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the patient had non-operative treatment (+/-injection) for at least three months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has this treatment failed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If you've ticked yes to all the above, go to section E		

Section C: standard knee arthroscopy

Proposed surgery and codes	
What are the indications for surgery	
<input type="checkbox"/> Anterior Cruciate Ligament	<input type="checkbox"/> Posterior Cruciate Ligament
<input type="checkbox"/> Instability	<input type="checkbox"/> Laxity
<input type="checkbox"/> Isolated meniscal lesion	<input type="checkbox"/> Loose body
<input type="checkbox"/> Concurrent meniscal injury	<input type="checkbox"/> Knee locking or giving way
<input type="checkbox"/> Other symptoms, please detail in section D	
Past arthroscopies on same knee? If yes, please give dates	<input type="checkbox"/> Yes <input type="checkbox"/> No
Duration of symptoms	
Non-operative management	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physiotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Duration of therapy	
Please detail other therapies in section D	

Section D: comments and supporting details

Please continue on a separate sheet

Section E: declaration

Please complete the section below to confirm that the information above is accurate to the best of your knowledge. We may review this case and ask for further information in the future.

Have you explained the evidence, benefits, risks and likely success of surgery to the patient? Yes No

I understand that the clinical information I've supplied may be considered to be a medical report for insurance purposes. I confirm that my patient (or their legal representative) has given their permission for me to share this information and, where they've asked to review this information, they've been given an opportunity before I submitted this form.

Consultant's name

Date

General Medical Council number
