Funding request form: Knee arthroscopy

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-authorised 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-authorisation 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/ui/learn. You won't be charged for sending secure emails to a Bupa email address using the Switch service.

*We may record or monitor our calls.

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Section A:

Patient's name:	Consultant's name:
Date of birth:	Hospital name:
Bupa membership number:	Phone:
Treatment date(if known):	Anaesthetist's name(if known):

☐ Is this an emergency? If so please complete the relevant sections below and provide details in **section D**

Is the patient aged over 35? ☐ Yes ☐ No — If no, please go straight to **section C**

Please tick if you're planning one of the following codes: ☐ W8500 ☐ W8580 ☐ W8200 ☐ 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: ☐ None ☐ X-ray ☐ MRI ☐ USS ☐ Other

Section B: ESSKA framework

Question		
Is the history and examination compatible with a degenerative meniscus lesion?	☐ Yes	☐ No
Has the patient had an MRI scan?	☐ Yes	☐ No
Has the patient had standard weight bearing X rays?	☐ Yes	☐ No
Do they confirm a degenerative meniscal tear?	☐ Yes	☐ 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	☐ Yes	☐ No
Has the patient had non-operative treatment (+/-injection) for at least three months?	☐ Yes	☐ No
Has this treatment failed?	☐ Yes	☐ 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:

- ☐ Anterior Cruciate Ligament
- ☐ Posterior Cruciate Ligament
- ☐ Isolated meniscal lesion
- ☐ Loose body
- ☐ Other, please detail in **section D**
- ☐ Instability
- ☐ Laxity
- ☐ Concurrent meniscal injury
- ☐ Knee locking or giving way
- ☐ Other symptoms, please detail in **section D**

Past arthroscopies on same knee? ☐ Yes ☐ No

If yes, please give dates:

Duration of symptoms:

Non-operative management: ☐ Yes ☐ No

Physiotherapy? ☐ Yes ☐ 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

Consultant's signature:	Consultant's name:
General Medical Council number:	Date: