Union West Surgery Center PRIVILEGE REQUEST: Orthopedics

| Provider Printed Name: _ | | |
|--------------------------|--|--|
| Provider Signature: | | |
| Date: | | |

| PROCEDURE | REQUESTED | APPROVED |
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| ANISCTUSCIA LOCAL | | |
| ANESTHESIA LOCAL | | |
| ANESTHESIA REGIONAL | | |
| ANESTHESIA TOPICAL | | |
| ACROMIOPLASTY | | |
| AMPUTATION OF PHALANGES | | |
| ANTERIOR CRUCIATE LIGAMENT REPAIR/RECONSTRUCTION | | |
| ARTHROSCOPY, SURGICAL OR DIAGNOSTIC, KNEE, SHOULDER, WRIST, ANKLE, ELBOW | | |
| ARTHROTOMY (MINI) | | |
| BONE BIOPSY | | |
| BONE EXCISION | | |
| BUNION SURGERY | | |
| CARPAL TUNNEL RELEASE | | |
| CAST/DRESSING CHANGE | | |
| CLOSED REDUCTION WITH/WITHOUT PERCUTANEOUS K-WIRE FIXATION | | |
| CYST REMOVAL | | |
| DEBRIDEMENT OF WOUNDS | | |
| DEPUYTREN'S CONTRACTURE RELEASE | | |
| EXCISION OF EXOSTOSIS/JOINT DEBRIDEMENT OPEN/ARTHROSCOPIC | | |
| EXCISION OF GANGLION | | |
| EXCISION OF NEUROMAS | | |
| EXCISION TENDON SHEATH LESION | | |
| FASCIOTOMY EXTREMITY | | |
| FINGER AMPUTATION AND REVISION | | |
| FINGER ARTHROPLASTY | | |
| FINGER ARTHROPLASTY WITH PROSTHESIS | | |
| FINGER NERVE/VASCULAR REPAIR WITH/WITHOUT GRAFT | | |
| FINGER TRIGGER RELEASE | | |
| FLEXOR/EXTENSOR TENDON REPAIR | | |
| Ortho | | |
| HARDWARE REMOVAL | | |
| HISTORY AND PHYSICAL | | |
| INCISION AND DRAINAGE (I&D) PERICHONDRIUM | | |
| INTERPRETATION OF X-RAYS | | |

| JOINT FUSIONS FINGER/HAND | |
|---|----------------|
| JOINT INJECTIONS | |
| JOINT MANIPULATION | |
| LOCAL/DISTANT SKIN FLAPS | |
| MALLET FINGER REPAIR | |
| MORTON'S NEUROMA EXCISION | |
| MUSCLE BIOPSY | |
| NERVE DECOMPRESSION/PERIPHERAL NERVE TRANSFER/DECOMPRESSION | |
| NERVE GRAFT | |
| OLECRANON BURSECTOMY | |
| OPEN REDUCTION INTERNAL FIXATION (ORIF) FRACTURES WITH/WITHOUT K-WIRE INSERTION, PLATES, SCREWS | |
| OSTEOTOMY | |
| PREPATELLAR BURSECTOMY | |
| RELEASE OF DE QUERVAIN'S | |
| RELEASE OF DUPUYTEN'S CONTRACTURE | |
| RELEASE OF TRIGGER FINGERS | |
| REMOVAL OF FINGER OR TOENAIL | |
| REMOVAL OF FOREIGN BODY | |
| REMOVAL OF GANGLION | |
| REMOVAL OF HARDWARE | |
| ROTATION SKIN FLAP | |
| ROTATOR CUFF REPAIR | |
| SKIN GRAFT, FULL THICKNESS, SPLIT THICKNESS | |
| SMALL BONE GRAFT | |
| SUPERVISION OF NON-PHYSICIAN PERSONNEL | |
| SYNOVECTOMY | |
| TENDON EXPLORATION | |
| TENOLYSIS | |
| ULNAR NERVE TRANSFER | |
| Z-PLASTY REPAIR | |
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| | |
| Medical Executive Committee - Approved By: | Approval Date: |
| | |
| Board of Managers — Approved By: | Approval Date: |