

Autologous Chondrocyte Implantation—Pre-authorization Checklist

The following checklist reflects the minimum requirements that the plan will need at the time of pre-authorization. Failure to include all of this information in the pre-authorization request or failure to make sure that all 'no' answers are fully addressed in the pre-authorization request will significantly increase the likelihood that the pre-authorization request will be denied or significantly delayed.

Age between 15 (must be skeletally mature) and 55 years	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cartilage defect greater than or equal to 2 cm ² in total area	<input type="checkbox"/> Yes <input type="checkbox"/> No
Single, full thickness, (Outerbridge Grade III or IV) lesion of a weight bearing surface (medial or lateral femoral condyle, trochlear, or patella region) defect caused by acute or repetitive trauma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Persistent symptoms of disabling localized knee pain present for > 1 year and failure of, intolerance to, or unable to receive conventional medical therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Inadequate response to conservative therapy and established arthroscopic or other surgical treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other therapeutic options not available or medically inappropriate (excluding total knee replacement)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lesion surrounded by normal articular cartilage	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stable knee with intact meniscus	<input type="checkbox"/> Yes <input type="checkbox"/> No
Radiographs demonstrate normal joint alignment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Normal joint space without evidence of osteoarthritis, infection, or inflammation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Willing and capable of complying with post-operative weight bearing restrictions and physical rehabilitation, including continuous passive motion exercise for 3 weeks or more	<input type="checkbox"/> Yes <input type="checkbox"/> No
Confirm absence of: <ul style="list-style-type: none"> • “Kissing lesions” (lesions on opposing articular surfaces) • Presence of mal-aligned knee or non-intact meniscus • Inflammatory arthritis or osteoarthritis of knee • Lesions located on a non-weight bearing area of the knee • Generalized tibial chondromalacia • BMI > 35 • History of malignancy of bone, cartilage, fat, or muscle in ipsilateral leg 	<input type="checkbox"/> Yes <input type="checkbox"/> No

All 'no' answers must be fully addressed at time of pre-authorization.

The reimbursement material contained in this guide represents our current (as of January 2024) understanding of the pre-authorization checklists reflected in various payer policies. Many of the topics covered in this guide are complex and all are subject to change beyond our control. Healthcare professionals are responsible for keeping current and complying with reimbursement-related rules and regulations. Nothing contained herein is intended, nor should it be construed as, to suggest a guarantee of coverage or reimbursement for any product or service. Check with the individual insurance provider regarding coverage. Providers should exercise independent clinical judgment when submitting claims to reflect accurately the services rendered to individual patients.