

## 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.

Prior surgical therapy to correct the defect has been unsuccessful	<input type="checkbox"/> Yes <input type="checkbox"/> No
Single grade III or IV focal unipolar lesion measuring 1.5 cm <sup>2</sup> or greater on the patella, trochlea, or weight bearing surface of the femoral condyles confirmed by MRI or arthroscopic report	<input type="checkbox"/> Yes <input type="checkbox"/> No
Defect does not involve subchondral bone, unless the transplantation is being used to treat osteochondritis dissecans associated with a bony defect 10mm or less in depth which has failed previous conservative therapy (lesion greater than 10mm in depth must also undergo corrective bone grafting)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Degenerative changes in the surrounding articular cartilage are minimal or absent (Outerbridge Grade II or less)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Patient is 15 or older with documented closure of growth plates, and less than 55 years of age	<input type="checkbox"/> Yes <input type="checkbox"/> No
Persistent symptoms of disabling localized knee pain for at least 6 months which have failed to respond to non-operative treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Normal joint space is present on weight bearing X-rays	<input type="checkbox"/> Yes <input type="checkbox"/> No
Knee is stable with functionally intact menisci and ligaments and alignment is normal, other procedures to correct (i.e. meniscal allograft, repair of tendons/ligaments, or correction of varus/valgus deformities) may be done at the same time as transplantation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Patient is willing to comply with post-operative weight bearing restrictions and rehabilitation	<input type="checkbox"/> Yes <input type="checkbox"/> No
BMI 35 or less	<input type="checkbox"/> Yes <input type="checkbox"/> No
Confirm absence of: <ul style="list-style-type: none"> <li>• Allergies to Gentamicin</li> <li>• Sensitivity to bovine cultures</li> <li>• Degenerative changes in the surrounding articular cartilage</li> <li>• Malignancy in the affected limb</li> <li>• Active infection (local or systemic)</li> <li>• Presence of inflammation or osteoarthritis in the joint</li> <li>• Localized skin problems at the surgery site</li> </ul>	<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.