

Kaiser Permanente—Foundation Health Plan of Washington

(ACI CLINICAL REVIEW CRITERIA, EFFECTIVE 5/2022)

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.

Documentation should support why an alternative cartilage restoration procedure such as OATS are contraindicated.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Symptomatic single or multiple full-thickness cartilage defects of the femoral condyle, patella, or trochlea with normal surrounding cartilage (Modified Outerbridge Classification Grade III or IV) and no evidence of degenerative disease such as osteoarthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Severe disabling knee pain limiting ambulation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Absence of systemic disease (gout, rheumatoid arthritis, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Failure of at least 3 months of provider-directed conservative therapy such as physical therapy, braces, and/or non-steroidal anti-inflammatory drugs (NSAIDs)	<input type="checkbox"/> Yes <input type="checkbox"/> No
No more than 30% partial meniscectomy in the target knee	<input type="checkbox"/> Yes <input type="checkbox"/> No
Defect(s) are unipolar—there is no corresponding kissing lesion on facing cartilage	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lesion is greater than 1.0 cm ² (too large for bone stimulation) and less than 10cm ² , or the lesion is less than 1.0 cm ² and the patient has previously failed marrow stimulation for that lesion	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has not had any knee joint surgery within the past 3 months (excluding surgery to procure a biopsy or concomitant procedure to prepare the knee for a MACI implant)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Normal tibial-femoral and or patella-femoral alignment based on weight-bearing alignment X-rays, or osteotomy is planned.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Patient is able and willing to comply with post-operative weight bearing protocol (6 weeks limited weight bearing)	<input type="checkbox"/> Yes <input type="checkbox"/> No
BMI 35 or less	<input type="checkbox"/> Yes <input type="checkbox"/> No
Must be authorized by Kaiser Permanente Medical Director in consultation with Orthopedics	<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.