

Blue Cross Blue Shield of Georgia (CARELON BENEFITS MANAGEMENT, EFFECTIVE 5/2020)

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.

Skeletal maturity as documented by closure of growth plates	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Disabling localized pain of at least 3/10 intensity, for at least 3 months which has failed to respond to conservative treatment and is associated with the inability to perform at least 2 ADL's</p> <ul style="list-style-type: none"> Conservative treatment must include at least one of the following for the physical therapy requirement: <ul style="list-style-type: none"> Physical therapy Physician or physical therapist supervised home exercise program Exception to the PT requirement in unusual circumstances (example: if intractable pain so severe that PT is not possible) when clearly documented in the medical records Conservative treatment must also include at least one of the following for the complementary management requirement: <ul style="list-style-type: none"> Anti-inflammatory medications and analgesics Complementary alternative medicine including but not limited to: chiropractic care, acupuncture, cognitive behavioral therapy or massage therapy Intraarticular corticosteroid injection(s) 	<input type="checkbox"/> Yes <input type="checkbox"/> No
Operative report of a prior arthroscopic procedure and/or MRI performed of the knee within 12 months that correlates with clinical findings for the requested procedure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Inadequate response to prior surgery to correct the defect	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cartilage defect is 1.5 cm ² or greater as documented by MRI or arthroscopy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Condition involves a focal, full thickness, (grade III or IV) isolated defect of the knee involving the weight bearing surface of the medial or lateral femoral condyles or patellofemoral region (includes trochlear region, trochlear groove, and patella)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>The defect involves on the cartilage and not the subchondral bone*</p> <p>*Exception to this requirement: the treatment of osteochondritis dissecans (OCD) associated with a bony defect of 10 mm or less in depth, which has failed prior conservative treatment. OCD lesions associated with a bony lesion greater than 10mm in depth must also undergo corrective bone grafting.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
BMI less than or equal to 35	<input type="checkbox"/> Yes <input type="checkbox"/> No
Absence of localized or systemic infection	<input type="checkbox"/> Yes <input type="checkbox"/> No
No history of cancer in the bones, cartilage, fat or muscle of the affected limb	<input type="checkbox"/> Yes <input type="checkbox"/> No
Willingness and ability to comply with post-operative weight bearing restrictions and rehabilitation	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Lesion and joint characteristics must include ALL of the following:</p> <ul style="list-style-type: none"> Discrete, single, and involve only one side of the joint Lesion is largely contained with near normal surrounding cartilage and articulating cartilage Joint space is normal without inflammation or degenerative changes Knee is stable with functionally intact menisci and ligaments with normal alignment* <p>*Corrective procedures (ligament or tendon repair, realignment, meniscal allograft or repair) may be performed in combination with or prior to transplantation</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Confirm absence of:</p> <ul style="list-style-type: none"> Known allergy to gentamicin Known sensitivity to bovine cultures 	<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.