

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.

SKELETALLY IMMATURE INDICATIONS	
Skeletally immature patient	<input type="checkbox"/> Yes <input type="checkbox"/> No
Patient is symptomatic	<input type="checkbox"/> Yes <input type="checkbox"/> No
Radiographic findings of a displaced lesion	<input type="checkbox"/> Yes <input type="checkbox"/> No
OR	
Skeletally immature patient	<input type="checkbox"/> Yes <input type="checkbox"/> No
Patient is symptomatic	<input type="checkbox"/> Yes <input type="checkbox"/> No
Failure of at least 12 weeks of non-operative treatment including at least 2 of the following: <ul style="list-style-type: none"> • Rest/activity modification • Ice/heat • Protected weight bearing • Pharmacologic treatment • Brace/orthosis • Physical therapy modalities • Home exercise • Weight optimization • Corticosteroid injection 	<input type="checkbox"/> Yes <input type="checkbox"/> No
Radiographic findings (X-ray and MRI) with stable osteochondral lesion	<input type="checkbox"/> Yes <input type="checkbox"/> No
OR	
Skeletally immature	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asymptomatic	<input type="checkbox"/> Yes <input type="checkbox"/> No
Failure of at least 12 weeks of non-operative treatment including at least 2 of the following: <ul style="list-style-type: none"> • Rest/activity modification • Ice/heat • Protected weight bearing • Pharmacologic treatment • Brace/orthosis • Physical therapy modalities • Home exercise • Weight optimization • Corticosteroid injection 	<input type="checkbox"/> Yes <input type="checkbox"/> No
Radiographic findings (X-ray and MRI) with unstable osteochondral lesion	<input type="checkbox"/> Yes <input type="checkbox"/> No
Confirm absence of: <ul style="list-style-type: none"> • evidence of meniscal deficiency and/or malalignment IF these are not being addressed at the same time as the cartilage restoration procedure 	<input type="checkbox"/> Yes <input type="checkbox"/> No

SKELETALLY MATURE INDICATIONS	
Skeletally mature adult	<input type="checkbox"/> Yes <input type="checkbox"/> No
MRI results confirm a full thickness chondral or osteochondral lesion of the femoral condyles or trochlea > 2.5 cm ²	<input type="checkbox"/> Yes <input type="checkbox"/> No
Patient is less than 50 years of age	<input type="checkbox"/> Yes <input type="checkbox"/> No
BMI < 35	<input type="checkbox"/> Yes <input type="checkbox"/> No
Patient has been symptomatic for at least 6 months	<input type="checkbox"/> Yes <input type="checkbox"/> No
Failure of at least 6 months of non-operative treatment including at least 2 of the following: <ul style="list-style-type: none"> • Rest/activity modification • Ice/heat • Protected weight bearing • Pharmacologic treatment • Brace/orthosis • Physical therapy modalities • Home exercise • Weight optimization • Corticosteroid injection 	<input type="checkbox"/> Yes <input type="checkbox"/> No
MRI and/or physical findings confirm knee has normal alignment as defined as +/- 3 degrees from neutral on long leg X-ray (unless concurrent ligament repair or reconstruction performed)	<input type="checkbox"/> Yes <input type="checkbox"/> No
No evidence of osteoarthritis (Kellgren-Lawrence grade 2 or less)	<input type="checkbox"/> Yes <input type="checkbox"/> No
No prior meniscectomy in the same compartment (unless concurrent or staged meniscal transplant performed)	<input type="checkbox"/> Yes <input type="checkbox"/> No
PATELLOFEMORAL INDICATIONS	
Anterior knee pain and loss of function	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other extra-articular or intra-articular sources of pain/dysfunction have been excluded (referred pain, radicular pain, tendinitis, bursitis, neuroma)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physical exam localizes tenderness to the patellofemoral joint with pain aggravated by activities that load the joint (single leg squat, stairs, extended periods of time seated with the knee flexed)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Radiologic imaging shows grade 3 or 4 patellofemoral chondrosis (ICRS classification) or grade III or IV articular cartilage changes documented by arthroscopic evaluation (Outerbridge classification)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Failure of at least 6 months of non-operative treatment including at least 2 of the following: <ul style="list-style-type: none"> • Rest/activity modification • Ice/heat • Protected weight bearing • Pharmacologic treatment • Brace/orthosis • Physical therapy modalities • Home exercise • Weight optimization • Corticosteroid injection 	<input type="checkbox"/> Yes <input type="checkbox"/> No
No evidence of osteoarthritis in the medial/lateral compartments	<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.