

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.

THE MEMBER:	
Has reached skeletal maturity	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is less than 55 years of age	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has a BMI less than or equal to 35	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has persistent symptoms of pain, swelling, and/or knee catching/locking	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has not had any knee surgery to the affected knee within six (6) months directly before evaluation for ACT, excluding surgery to procure a biopsy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Failed non-surgical management (e.g., physical therapy, NSAIDs, bracing, corticosteroid therapy, or viscosupplementation) for at least six (6) weeks	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has normal knee biomechanics with intact meniscus, or corrective procedures can be achieved prior to or concurrently with ACT	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does not have diffuse osteoarthritis of the knee	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is able to comply with post-operative weight bearing and activity restrictions and rehabilitation	<input type="checkbox"/> Yes <input type="checkbox"/> No

THE LESION IS:	
A single or multiple full thickness (Outerbridge Classification Grade III or IV) articular cartilage defect of the femoral condyle (medial, lateral, or trochlea) and/or patella	<input type="checkbox"/> Yes <input type="checkbox"/> No
There is no corresponding lesion on the opposing surface	<input type="checkbox"/> Yes <input type="checkbox"/> No
Caused by acute or repetitive trauma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Greater or equal to 2cm ²	<input type="checkbox"/> Yes <input type="checkbox"/> No
There is no or minimal bone loss or degenerative changes in the surrounding articular cartilage (e.g., corresponding tibia)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Healthy, normal appearing hyaline cartilage surrounds the border of the defect	<input type="checkbox"/> Yes <input type="checkbox"/> No

Documentation indicates an FDA approved product is being used.

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.