

Blue Cross Blue Shield of Nebraska

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.

Patient is between 15 and 60 years old	<input type="checkbox"/> Yes <input type="checkbox"/> No
Significant knee pain or knee locking that interferes with activities of daily living (ADLs)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Body Mass Index (BMI) is less than or equal to 35	<input type="checkbox"/> Yes <input type="checkbox"/> No
Focal articular cartilage defect is caused by acute or repetitive trauma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Full thickness (grade III or IV) defect on the load bearing surface of the femoral condyle (medial, lateral, trochlear) or the patella	<input type="checkbox"/> Yes <input type="checkbox"/> No
Defect is at least 1.5 cm ²	<input type="checkbox"/> Yes <input type="checkbox"/> No
Documented minimal to absent degenerative changes in the surrounding articular cartilage (Outerbridge grade II or less) and normal-appearing hyaline cartilage surrounding the border of the defect	<input type="checkbox"/> Yes <input type="checkbox"/> No
Failure to respond to conservative treatment for at least two months such as physical therapy, braces, and NSAIDs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Inadequate response to a prior arthroscopic or other surgical repair procedure such as debridement, microfracture, drilling, abrasion or osteochondral allograft/autograft	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stable and aligned knee with normal joint space on X-ray	<input type="checkbox"/> Yes <input type="checkbox"/> No
Capable of cooperating with post-operative weight bearing restrictions and completion of post-operative rehabilitation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Confirm the absence of the following: <ul style="list-style-type: none">• Total meniscectomy• Use in all other joints including talar lesions• Osteoarthritis or inflammatory arthritis• ACI in combination with meniscal allograft or osteochondral autograft (OATS)	<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 November, 2020) 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. This information is not intended to be directive, nor does the use of the recommended criteria guarantee reimbursement. Providers are responsible for the accuracy of any claims, invoices and related documentation submitted to payers.