

## 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.

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| Symptoms of disabling knee pain related to a full thickness focal chondral defect  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Age 15 or older with documented growth plate closure or adult less than 55 years of age  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| BMI less than or equal to 35   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cooperative person for post-operative weight bearing/activity restrictions and potential of completion for post-operative rehabilitation   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Failure of conservative therapy to include at least 2 months of formal physical therapy  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Focal articular defect down to but not through the subchondral bone on a load bearing surface of the femoral condyle (medial, lateral, trochlea) or the patella  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Informed consent with realistic expectations   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| No active inflammatory or other arthritis clinically and by X-ray  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Presence of disabling pain and/or knee locking which limits activities of daily living   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Procedure is not being done for treatment of degenerative osteoarthritis   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Size of the defect measures less than 7 mm in depth, less than 6.0 cm in length, and area ranging from 1.6 to 10 cm <sup>2</sup>   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stable and aligned knee with intact meniscus and normal joint space on X-ray. Corrective procedures can be performed prior to or concurrently with chondrocyte implantation to ensure stability, alignment, and normal weight distribution in the joint  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Confirm absence of: <ul style="list-style-type: none"> <li>• Previous total meniscectomy</li> <li>• Cartilagenous defect associated with OA, RA, or inflammatory diseases OR where an osteoarthritic or inflammatory process significantly and adversely affects the quality of the peri-lesional cartilage</li> <li>• Anaphylaxis to gentamicin or sensitivities to materials of bovine origin</li> <li>• Initial or first line surgical therapy</li> </ul> | <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 May, 2021) 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.