

Medical Mutual of Ohio

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 (must be skeletally mature) and 55 years	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cartilage defect is equal to or greater than 2 cm ²	<input type="checkbox"/> Yes <input type="checkbox"/> No
Single, focal, full thickness (grade III or IV) lesions of the weight-bearing surface of the femoral condyles or trochlea	<input type="checkbox"/> Yes <input type="checkbox"/> No
Persistent symptoms of disabling localized knee pain present for greater than 1 year and failure of, intolerance to or unable to receive conventional medical therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Inadequate response to conservative therapy and established arthroscopic or other surgical treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other therapeutic options not available or medically inappropriate (excluding total knee replacement)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lesion surrounded by normal articular cartilage	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stable knee with intact meniscus	<input type="checkbox"/> Yes <input type="checkbox"/> No
Radiograph demonstrates normal joint alignment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Normal joint space without evidence of osteoarthritis, infection or inflammation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Willing and capable of comply with post-operative weight bearing restrictions and rehabilitation included CPM exercise	<input type="checkbox"/> Yes <input type="checkbox"/> No
Body Mass Index (BMI) below 35	<input type="checkbox"/> Yes <input type="checkbox"/> No
Confirm the absence of the following: <ul style="list-style-type: none"> • "Kissing lesions" (lesions on opposing articular surfaces) • Lesions located on non-weight bearing areas of the knee • Generalized tibial chondromalacia • History of malignancy of bone, cartilage, fat or muscle in ipsilateral leg 	<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 February 28, 2018) 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.