

# State of Iowa Health and Human Services—Medicaid (EFFECTIVE 10/2023)

## 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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|---|--|
| Presence of disabling symptoms such as locking, swelling, or knee pain that limit activities of daily living and symptoms not responsive to conservative therapy for a minimum of 2 months (e.g., medication, physical therapy)   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Age 15-18 with documented skeletal maturity as documented by closure of growth plates by radiography or adult less than 55 years of age   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| BMI equal to or less than 35  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Focal articular defect down to but not through the subchondral bone (grade III or IV) on a load bearing surface of the femoral condyle (medial, lateral, trochlear) or the patella  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Absence of arthritis or degenerative joint disease of the knee  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Size of the defect is 1 to 10 cm <sup>2</sup>   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Current normal knee mechanics and alignment are present, or provider plans to concurrently repair during ACI procedure  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Confirm absence of: <ul style="list-style-type: none"><li>• Repeat ACI</li><li>• Use for the treatment of osteoarthritis or osteochondritis dissecans lesions</li><li>• Use of non-FDA approved second-generation methods for implanting autologous chondrocytes in a biodegradable matrix and other non-FDA approved products as their effectiveness has not been established</li><li>• Use for the treatment of talar lesions of the ankle or lesions of other joints (e.g., hip and shoulder) as the effectiveness of ACI for these lesions has not been established and is not FDA-approved</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 February 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.