



HEALTHCARE COOPERATIVE

Common Ground Healthcare Cooperative
PO Box 1630
Brookfield, WI 53008-1630
T: 877.825.9293 | F: 715.221.9749

Autologous Cultured Chondrocytes

Prior Authorization Request

Date _____

Form with sections: Member information, Provider information, Procedure information. Includes fields for member name, SMID, date of birth, provider name, telephone/fax numbers, place of service, facility address, contact person, scheduled date, requested service, procedure code, diagnosis, and diagnosis code.

Answer all of the following questions.

- Is the member 15 to 60 years of age ... Yes No
Does the member have a body mass index (BMI) of less than or equal to 35... Yes No
Is the member a cooperative person for postoperative weight-bearing restrictions and activity restrictions together with a potential for completion of postoperative rehabilitation... Yes No
Has there been a failure of conservative therapy (minimum of 6 weeks of physical therapy) as well as established surgical interventions (i.e. microfraction, drilling, abrasion, or osteochondral autograft) (diagnostic arthroscopy, lavage, or debridement) ... Yes No
Does the member have full-thickness (grade III or IV) isolated cartilaginous defect of the knee involving the femoral condyle (medial, lateral or trochlear) caused by acute or repetitive trauma – the defect only involves the cartilage and not the subchondral bone ... Yes No
Has the member signed an informed consent with realistic expectations ... Yes No
Is there no active inflammatory or other arthritis, clinically and by x-ray... Yes No
Does the member have a presence of disabling pain and/or knee locking... Yes No
The procedure is not being done for treatment of degenerative arthritis (osteoarthritis) ... Yes No
Does the size of defect measure less than 7 millimeters (mm) in depth, less than 6.0 centimeters (cm) in length, and area ranging from 1.6 to 10 square cm (cm2)... Yes No

Does the member have a stable and aligned knee with intact meniscus and normal joint space on x-ray (a corrective procedure in combination with, or prior to, chondrocyte implantation may be necessary to ensure stability, alignment, and normal weight distribution within the joint). Yes No

By signing this form, the provider attests that the above information is accurate and documented in the medical record. CGHC may, at its discretion, request medical records to make a final coverage determination.

Provider signature Date

Pre-service decisions: Initial review is received and a coverage determination is made within fourteen (14) calendar days of receipt of request. The member and/or provider are notified in writing of a denial decision within fourteen (14) calendar days of receipt of the request.

Urgent pre-service decisions: Initial review is received and a coverage determination is made within seventy-two (72) hours of receipt of request.

Mail or fax form to: Common Ground Healthcare Cooperative
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If you have any questions, please contact Customer Service at 1.877.514.2442.