

Autologous Cultured Chondrocytes

Prior Authorization Request

Date _____

Member information		
Member name (print)	SMID	Date of birth (month/day/year)
Provider information		
Provider name (print)	Telephone number	Fax number
Place of service: <input type="checkbox"/> Ambulatory Surgery Center <input type="checkbox"/> Hospital outpatient <input type="checkbox"/> Hospital inpatient <input type="checkbox"/> Provider's office <input type="checkbox"/> Other _____		
Facility where services will be provided (include address if the provider provides services at more than one practice location)		
Contact person name (print)	Telephone number	Fax number
Procedure information		
Scheduled date of service (month/day/year)	Requested service/procedure	Procedure code(s)
Diagnosis	Diagnosis code(s)	

Answer all of the following questions.

- Is the member 15 to 55 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 knee with intact meniscus and normal joint space on x-ray. 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. Security Health Plan 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: Security Health Plan
Health Services Department
PO Box 8000
Marshfield, WI 54449-8000
Fax 715-221-6616

Marshfield Clinic providers route to:
Health Services Department
Routing location, SHP

If you have any questions, please contact Customer Service at 1-800-548-1224.