Utilization Management
Phone: 1-877-284-0102 Fax: 1-800-510-2162

Orthopedic Surgery/Repair of Osteochondral Defects Precertification Review

Date: ________________ Reference #: ______________________________(provided after initial review)

A Utilization Management representative will fax you a reference number by the next business day after receiving this completed form. This reference number does not indicate an approval or denial of benefits, but only proof that the Plan has been notified. This information will be forwarded to the Plan's Managed Care Department. If you have any questions, please call HealthLink at 1-877-284-0102.

Physician Information

Admitting Physician Name: ______________________________

Group Practice Name: ______________________________

Address: ______________________________

Phone: ______________________________

Fax: ______________________________

TIN: ______________________________

Patient Information

Patient Name: ______________________________

ID Number: ______________________________

Patient DOB: ______________________________

Address: ______________________________

Phone: ______________________________

Hospital/Facility Information

Hospital/Facility Name: ______________________________

Address: ______________________________

Phone: ______________________________

Fax: ______________________________

Treatment Information

Primary Diagnosis: ____________________

Diagnosis (ICD-10) Code: ______________

Primary Procedure: ____________________

Procedure (ICD-10) Code: ______________

Procedure Date: ____________________

Admission Date: ____________________

Anticipated Length of Stay: ______________

Bed Type: ☐ Medical ☐ Surgical ☐ ICU/CCU ☐ Other (specify) ____________________

Pertinent Medical History: (submit history, physical and/or hospital discharge summary with this form)_____________

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Please provide daily clinical review on the Inpatient Acute Hospital Admissions Continued Stay Recertification Form

Benefits depend upon the eligibility of the patient at the time of admission, subject to all other Plan limitations, pre-admission review requirement and prior related claims. Verification of eligibility and description of benefits are based upon the information we have on file and does not guarantee payment.

The below questions MUST be answered for all types of osteochondral repairs

Is the patient a skeletally mature adolescent with documented closure of growth plates or an adult? ☐ YES ☐ NO

Does the patient have persistent symptoms of disabling localized knee pain for at least 6 months, which have failed to respond to conservative treatment? ☐ YES ☐ NO

Is the lesion discrete, single and unipolar, involving only one side of the joint ("kissing lesions" are excluded)?

☐ YES ☐ NO

Is the lesion largely contained with near normal surrounding articular cartilage and articulating cartilage?

☐ YES ☐ NO

What grade is the lesion? ______________________

Is the joint space normal? ☐ YES ☐ NO

Does the joint have any active infection present? ☐ YES ☐ NO

Does the patient have inflammation or osteoarthritis present in the joint? ☐ YES ☐ NO

Is the knee stable with functionally intact menisci, ligaments, and normal alignment? ☐ YES ☐ NO

Have all corrective procedures been performed prior to requesting this surgery? (e.g. ligament or tendon repair, osteotomy for realignment, meniscal allograft transplant or repair may be performed in combination with or prior to transplantation) ☐ YES ☐ NO

Is the patient willing and able to comply with post-operative weight-bearing restrictions and rehabilitation?

☐ YES ☐ NO

Does the patient have a history of cancer in the bones, cartilage, fat or muscle of the affected limb? ☐ YES ☐ NO

What is the patient's current Body Mass Index (BMI)? ____________________________

Please choose the correct procedure below and answer the following questions:

Autologous chondrocyte transplantation (ACT)

Did the patient have an inadequate response to prior surgical therapy to correct the defect? ☐ YES ☐ NO

What size is the cartilage defect (total area)? _________________________

Does the patient have a history of allergy to Gentamicin? ☐ YES ☐ NO

Does the patient have sensitivity to bovine cultures? ☐ YES ☐ NO

Is this a grade III or IV isolated defect involving the weight bearing surface of the medial or lateral femoral condyle or trochlear region(trochlear groove of the femur caused by acute or repetitive trauma? ☐ YES ☐ NO

Does the defect only involve the cartilage and not the subchondral bone? ☐ YES ☐ NO

If ACT is being used to treat osteochondritis dissecans associated with bone defect 10 mm or less which failed previous conservative treatment? ☐ YES ☐ NO

Is the ACT being used for osteochondritis dissecans where the lesion is greater than 10 mm in depth and must also undergo corrective bone grafting? ☐ YES ☐ NO

Osteochondral Allograft Transplantation

Please include copy of arthroscopic or magnetic resonance imaging report.

What is the total area of the cartilage defect? _________________________

Is this defect due to acute or repetitive trauma? ☐ YES ☐ NO

Osteochondral autograft transplantation (either osteochondral autograft transplant OATS or autologous mosaicplasty)

Please include copy of arthroscopic and/or magnetic resonance imaging examination.

What is the total area of the cartilage defect? _________________________

Is this defect due to acute or repetitive trauma? ☐ YES ☐ NO

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Discharge Information

If known, please supply the following:

Discharge Planner Name: ______________________

Phone: ______________________________

Anticipated Discharge Date: _____________________

Anticipated Discharge Needs: ☐ Rehab ☐ SNF ☐ HHC* ☐ Home Infusion*

**Preferred Providers available* ☐ DME* ☐ Outpatient PT ☐ Outpatient OT ☐ HOSPICE

Additional Comments

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Provider Contact Information

Contact Person: ____

Title: ________________________________

Phone: ______________________________

Fax: ________________________________

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