SecurityHealth Plan℠
Promises kept, plain and simple.®

1515 North Saint Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000

1.800.472.2363 | 715.221.9555
TTY: 711

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: ☐ Ambulatory Surgery Center ☐ Hospital outpatient ☐ Hospital inpatient ☐ Provider's office ☐ 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 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. 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.