

**WYOMING WORKERS' SAFETY AND COMPENSATION
PREAUTHORIZATION CHECK SHEET
AUTOLOGOUS CHONDROCYTE IMPLANTATION (ACI)
KNEE**

Claimant: _____ **Case Number:** _____ **DOI:** _____
Surgeon: _____ **Phone Number:** _____ **Contact:** _____
Date of Review: _____ **Reviewer:** _____

Compensability should NOT be in question at the time of preauthorization for this procedure.

Note:

1. The claimant MUST have a twisting or direct blow to the knee injury. Yes
2. Any claimant under age 18 years of age with a request to perform this procedure will have an immediate referral for peer review. Yes

I. Conservative Care:

- a. Physical therapy. Yes No
- b. Medication. Yes No

II. Clinical Findings:

Subjective

- a. Complaints of joint pain. Yes No

Objective

- a. Swelling. Yes No

Findings per Arthroscope:

- b. Large full thickness chondral defect on the weight bearing portion of the medial or lateral femoral condyle. Yes No
- c. Failure of microfracture or drilling, osteochondral graft. Yes No

Imaging

- a. Optional. Yes No

Approved/Nurse name: _____ Date: _____

Sent for Peer review/Doctor: _____ Date: _____

Notes: _____