

Elbow Replacement Surgery (Arthroplasty)

Policy Number: 2020T0551N
Effective Date: April 1, 2020

[Instructions for Use](#)

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| Community Plan Policy |
| <ul style="list-style-type: none"> Elbow Replacement Surgery (Arthroplasty) |
| Medicare Advantage Coverage Summary |
| <ul style="list-style-type: none"> Joints and Joint Procedures |

Coverage Rationale

Elbow replacement surgery is proven and medically necessary in certain circumstances. For medical necessity clinical coverage criteria, see MCG™ Care Guidelines, 24th edition, 2020, Elbow Arthroplasty, S-420 (ISC).

Click [here](#) to view the MCG™ Care Guidelines.

Documentation Requirements

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The documentation requirements outlined below are used to assess whether the member meets the clinical criteria for coverage but do not guarantee coverage of the service requested.

| CPT Codes* | Required Clinical Information |
|--|---|
| Elbow Replacement Surgery (Arthroplasty) | |
| 24360 24361 24362 24363 24370 24371 | <p>Medical notes documenting all of the following:</p> <ul style="list-style-type: none"> Specific diagnostic image(s) that show the abnormality for which surgery is being requested, which may include MRI, CT scan, X-ray, and/or bone scan; consultation with requesting surgeon may be of benefit to select the optimal images <ul style="list-style-type: none"> Note: Diagnostic images must be labeled with: <ul style="list-style-type: none"> The date taken Applicable case number obtained at time of notification, or member's name and ID number on the image(s) Submission of diagnostic imaging is required via the external portal at www.uhcprovider.com/paan or via email at CCR@uhc.com; faxes will not be accepted Diagnostic image(s) report(s) Condition requiring procedure (i.e., rheumatoid arthritis, osteoarthritis, degenerative joint disease, post-traumatic arthritis, severe fractures) Pertinent physical examination of the relevant joint Pain severity, location of pain, and details of functional disability(ies) interfering with activities of daily living (preparing meals, dressing, driving) |

| CPT Codes* | Required Clinical Information |
|---|---|
| Elbow Replacement Surgery (Arthroplasty) | |
| | <ul style="list-style-type: none"> • Therapies tried and failed of the following, including dates: <ul style="list-style-type: none"> ○ Orthotics ○ Medications/injections ○ Physical therapy ○ Surgery ○ Other pain management procedures • Physician's treatment plan, including pre-op discussion • For revision surgery, also include: <ul style="list-style-type: none"> ○ Details of complication ○ Complete (staged) surgical plan |
| Additional Clinical Information | |
| Note: Device information is not utilized in prior authorization determinations. | |
| Provide the following details on the device you intend to use during the procedure: | |
| <ul style="list-style-type: none"> • Specify which implant brand or manufacturer to be used: <ul style="list-style-type: none"> ○ Arthrex ○ BioMet ○ Conformis ○ Consensus ○ DePuy Synthes ○ Other (include name and reason for this selection) ○ DJO Surgical ○ MicroPort ○ Smith & Nephew ○ Stryker ○ Zimmer • Provide the fixation type from the following: • Cemented <ul style="list-style-type: none"> ○ Cemented with antibiotic impregnated ○ Non-cemented ○ Other (if another fixation type, then explain) ○ Cannot identify fixation prior to procedure | |

*For code descriptions, see the [Applicable Codes](#) section.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

| CPT Code | Description |
|----------|--|
| 24360 | Arthroplasty, elbow; with membrane (e.g., fascial) |
| 24361 | Arthroplasty, elbow; with distal humeral prosthetic replacement |
| 24362 | Arthroplasty, elbow; with implant and fascia lata ligament reconstruction |
| 24363 | Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (e.g., total elbow) |
| 24370 | Revision of total elbow arthroplasty, including allograft when performed; humeral or ulnar component |
| 24371 | Revision of total elbow arthroplasty, including allograft when performed; humeral and ulnar component |

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U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

Elbow replacement surgery is a procedure and, therefore, not regulated by the FDA. However, devices and instruments used during the surgery may require FDA approval. See the following website for additional information (product codes JDC and KWI): <http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmnmn.cfm>. (Accessed January 10, 2020)

FDA-approved total or partial elbow replacement surgery devices are generally approved for the same indications, including any or all of the following:

- Non-inflammatory degenerative joint disease, such as osteoarthritis
- Rheumatoid arthritis
- Post-traumatic arthritis, tumor or bone loss causing elbow instability
- Complex fracture(s) of elbow components
- Ankylosis
- Revision of failed elbow replacement surgery
- Correction of functional deformity

Centers for Medicare and Medicaid Services (CMS)

Medicare does not have a National Coverage Determination (NCD) for elbow replacement surgery (arthroplasty). Local Coverage Determinations (LCDs) do not exist at this time. (Accessed January 13, 2020)

Policy History/Revision Information

| Date | Summary of Changes |
|------------|--|
| 08/01/2020 | Template Update <ul style="list-style-type: none"> • Reformatted policy; transferred content to new template |
| 04/01/2020 | Coverage Rationale <ul style="list-style-type: none"> • Replaced reference to “MCG™ Care Guidelines, 23^d edition, 2019” with “MCG™ Care Guidelines, 24th edition, 2020” Documentation Requirements <ul style="list-style-type: none"> • Updated required clinical information for elbow replacement surgery (arthroplasty) Supporting Information <ul style="list-style-type: none"> • Archived previous policy version 2019T0551M |

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

This Medical Policy may also be applied to Medicare Advantage plans in certain instances. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence ([Medicare IOM Pub. No. 100-16, Ch. 4, §90.5](#)).

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.