Surgery of the Elbow

Policy Number: 2021T0551P
Effective Date: July 1, 2021

Instructions for Use

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Coverage Rationale

Surgery of the elbow is proven and medically necessary in certain circumstances.
For medical necessity clinical coverage criteria, refer to the InterQual® 2021, Apr. 2021 Release, CP: Procedures:
- Arthroscopy, Diagnostic, +/- Synovial Biopsy, Elbow
- Arthroplasty, Removal or Revision, Elbow
- Arthroscopy, Surgical, Elbow
- Joint Replacement, Elbow

Click here to view the InterQual® criteria.

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
Surgery of the Elbow	

24360
24361
24362
24363
24370
24371
29830
29834
29837
29838
	Medical notes documenting all of the following:
	• Upon request, we may require the 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
	  ○ Note: Diagnostic images must be labeled with:
	  ▪ 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; faxes will not be accepted
	• Diagnostic image(s) report(s)
	• Reports of all recent imaging studies and applicable diagnostic tests)
	  ○ Microbiological findings

CPT Codes*	Required Clinical Information
Surgery of the Elbow	
	○ Synovial fluid exam ○ Erythrocyte sedimentation rate (ESR) ○ C-reactive protein (CRP) • Condition requiring procedure • Pertinent physical examination of the relevant joint • Pain severity, circadian patterns of pain, location of pain, and details of functional disability(ies) interfering with activities of daily living (preparing meals, dressing, driving) • Prior therapies/treatments tried, failed, or contraindicated; include the dates and reason for discontinuation • Physician's treatment plan, including pre-op discussion • For revision surgery, also include: ○ Details of complication ○ Complete (staged) surgical plan

**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
Arthroscopy, Surgical, Elbow	
29830	Arthroscopy, elbow, diagnostic, with or without synovial biopsy (separate procedure)
29834	Arthroscopy, elbow, surgical, with removal of loose body or foreign body
29837	Arthroscopy, elbow, surgical, debridement, limited
29838	Arthroscopy, elbow, surgical, debridement, extensive
Arthroplasty, Joint Replacement, Elbow	
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)
24365	Arthroplasty, radial head
24366	Arthroplasty, radial head; with implant
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

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.

Surgeries of the elbow are procedures 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: http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm. (Accessed March 2, 2021)

Policy History/Revision Information

Date	Summary of Changes

07/01/2021	**Title Change**
	• Previously titled *Elbow Replacement Surgery (Arthroplasty)*
	Template Update
	• Removed *CMS* section
	Coverage Rationale
	• Replaced language indicating "elbow *replacement surgery* is proven and medically necessary in certain circumstances" with "*surgery of the* elbow is proven and medically necessary in certain circumstances"
	• Revised language pertaining to medical necessity clinical coverage criteria:
	  ○ Added InterQual® 2021, Apr. 2021 Release, CP: Procedures:
	  ▪ Arthroscopy, Diagnostic, +/- Synovial Biopsy, Elbow
	  ▪ Arthroplasty, Removal or Revision, Elbow
	  ▪ Arthroscopy, Surgical, Elbow
	  ▪ Joint Replacement, Elbow
	  ○ Removed InterQual® Client Defined 2020, CP: Procedures:
	  ▪ Joint Replacement, Elbow (Custom) - UHG
	  ▪ Arthroplasty, Removal or Revision, Elbow (Custom) – UHG
	Documentation Requirements
	• Updated list of CPT codes with associated documentation requirements; added 29830 29834, 29837, and 29838
	• Updated list of *Required Clinical Information*
	Applicable Codes
	• Added CPT codes 24365, 24366, 29830, 29834, 29837, and 29838
	Supporting Information
	• Updated *FDA* section to reflect the most current information
	• Archived previous policy version 2021T0551O

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 InterQual® criteria, 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.