Articular Cartilage Defect Repairs, Knee (for Indiana Only)

Policy Number: CS006IN.03
Effective Date: August 1, 2021

Instructions for Use

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Related Policies

- Meniscus Implant and Allograft
- Surgery of the Knee

Application

This Medical Policy only applies to the state of Indiana.

Coverage Rationale

Autologous chondrocyte transplantation (ACT) of the knee is proven and medically necessary for treating individuals with a symptomatic full-thickness articular cartilage defect. .

ACT is unproven and not medically necessary for treating individuals with the following indications due to insufficient evidence of efficacy:

- Treatment of joints other than the knee
- Growth plates have not closed
- History of partial-thickness defects
- Osteochondritis dissecans (OCD)
- Malignancy in the bone, cartilage, fat or muscle of the treated limb
- Active infection in the affected knee
- Instability of the knee
- History of total meniscectomy
- Repeat ACT
- Active inflammatory degenerative, rheumatoid or osteoarthritis
- As initial or first line of surgical therapy

Osteochondral Autograft and Allograft transplantation is proven and medically necessary for treating individuals with cartilage defects of the knee.

Microfracture repair to treat full and partial thickness chondral defects of the knee is proven and medically necessary.

Focal articular cartilage repair is unproven and not medically necessary for treating individuals with any of the following due to insufficient evidence of efficacy:

- Osteochondral Autograft and Allograft transplantation for all other indications than those listed above
- Use of minced articular cartilage repair (whether synthetic, allograft or autograft) for treating osteochondral defects of the knee

- Use of cryopreserved viable Osteochondral Allograft products (e.g., Cartiform)
- Microfracture repair of the knee with any of the following indications:
  - Misalignment of the knee
  - Osteoarthritis
  - Systemic immune-mediated disease, disease-induced arthritis, or cartilage disease
  - Unwilling or unable to participate in post-operative physical rehabilitation program

For medical necessity clinical coverage criteria for ACT and microfracture repair, refer to the InterQual® Client Defined 2021, CP: Procedures, Articular Cartilage Defect Repairs (Custom) - UHG.

For medical necessity clinical coverage criteria for Osteochondral Autograft and Allograft transplantation, refer to the InterQual® 2021, Apr. 2021 Release, CP: Procedures:
- Arthrotomy, Knee
- Arthroscopy or Arthroscopically Assisted Surgery, Knee
- Arthroscopy or Arthroscopically Assisted Surgery, Knee (Pediatric)

Click here to view the InterQual® criteria.

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 federal, state, or contractual requirements 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
27412	Autologous chondrocyte implantation, knee
27415	Osteochondral allograft, knee, open
27416	Osteochondral autograft(s), knee, open (e.g., mosaicplasty) (includes harvesting of autograft[s])
28446	Open osteochondral autograft, talus (includes obtaining graft[s])
29866	Arthroscopy, knee, surgical; osteochondral autograft(s) (e.g., mosaicplasty) (includes harvesting of the autograft[s])
29867	Arthroscopy, knee, surgical; osteochondral allograft (e.g., mosaicplasty)
29879	Arthroscopy, knee, surgical; abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture

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HCPCS Code	Description
J7330	Autologous cultured chondrocytes, implant
S2112	Arthroscopy, knee, surgical for harvesting of cartilage (chondrocyte cells)

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.

See the following website for more information regarding products used for Autologous Chondrocyte Transplantation and search by product name in device name section: http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm. (Accessed January 11, 2021)

Transplantation of osteochondral autografts is a surgical procedure and, as such, is not subject to regulation by the FDA. However, the FDA does regulate manufacturing practice requirements applicable to drugs and devices. The FDA does regulate certain aspects of tissue banking, and tissues are subject to FDA requirements for good tissue practices, and infectious disease screening and testing, as well as to the good manufacturing practice requirements applicable to drugs and devices.

Donor tissue products derived from human cartilage, such as the DeNovo NT tissue graft, are regulated under the guidelines for Human Cell, Tissues and Cellular and Tissue-Based Products (HCT/P) issued by the Center for Biologics Evaluation and Research (CBER) of the FDA. The CBER does not regulate the transplantation of these products per se, but it does require tissue establishments to register with the FDA in the Establishment Registration & Device Listing database. As part of the FDA regulations, tissue establishments are required to screen and test donors, to prepare and follow written procedures for the prevention of the spread of communicable disease, and to maintain records.

Policy History/Revision Information

Date	Summary of Changes

08/01/2021	**Coverage Rationale**
	• Revised language to indicate:
	  ○ Autologous chondrocyte transplantation (ACT) of the knee is proven and medically necessary for treating individuals with a symptomatic full-thickness articular cartilage defect
	  ○ ACT is unproven and not medically necessary for treating individuals with the following indications due to insufficient evidence of efficacy:
	  ▪ Treatment of joints other than the knee
	  ▪ Growth plates have not closed
	  ▪ History of partial-thickness defects
	  ▪ Osteochondritis dissecans (OCD)
	  ▪ Malignancy in the bone, cartilage, fat or muscle of the treated limb
	  ▪ Active infection in the affected knee
	  ▪ Instability of the knee
	  ▪ History of total meniscectomy
	  ▪ Repeat ACT
	  ▪ Active inflammatory degenerative, rheumatoid or osteoarthritis
	  ▪ As initial or first line of surgical therapy
	  ○ Osteochondral Autograft and Allograft transplantation is proven and medically necessary for treating individuals with cartilage defects of the knee
	  ○ Microfracture repair to treat full and partial thickness chondral defects of the knee is proven and medically necessary
	  ○ Focal articular cartilage repair is unproven and not medically necessary for treating individuals with any of the following due to insufficient evidence of efficacy:
	  ▪ Osteochondral Autograft and Allograft transplantation for all other indications than those listed above
	  ▪ Use of minced articular cartilage repair (whether synthetic, allograft or autograft) for treating osteochondral defects of the knee
	  ▪ Use of cryopreserved viable Osteochondral Allograft products (e.g., Cartiform)
	  ▪ Microfracture repair of the knee with any of the following indications:
	  ▪ Misalignment of the knee
	  ▪ Osteoarthritis
	  ▪ Systemic immune-mediated disease, disease-induced arthritis, or cartilage disease
	  ▪ Unwilling or unable to participate in post-operative physical rehabilitation program
	  ○ For medical necessity clinical coverage criteria for ACT and microfracture repair, refer to the InterQual® Client Defined 2021, CP: Procedures, Articular Cartilage Defect Repairs (Custom) - UHG
	  ○ For medical necessity clinical coverage criteria for Osteochondral Autograft and Allograft transplantation, refer to the InterQual® 2021, Apr. 2021 Release, CP: Procedures:
	  ▪ Arthrotomy, Knee

Date	Summary of Changes
	▪ Arthroscopy or Arthroscopically Assisted Surgery, Knee ▪ Arthroscopy or Arthroscopically Assisted Surgery, Knee (Pediatric) **Supporting Information** • Archived previous policy version CS006IN.02

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state or contractual requirements for benefit plan coverage. 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.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The 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.