Knee Replacement Surgery (Arthroplasty), Total and Partial (for Louisiana Only)

Policy Number: CS068LA.N
Effective Date: July 1, 2021

Instructions for Use

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Application

This Medical Policy only applies to the state of Louisiana.

Coverage Rationale

Knee replacement surgery (arthroplasty) is proven and medically necessary in certain circumstances. For medical necessity clinical coverage criteria, refer to the InterQual® 2021, Apr. 2021 Release, CP: Procedures:

- Unicondylar or Patellofemoral Knee Replacement
- Removal and Replacement, Total Joint Replacement (TJR), Knee
- Total Joint Replacement (TJR), Knee

Click here to view the InterQual® criteria.

Documentation Requirements

Provide medical notes documenting the following:

- Specific diagnostic image(s) that shows 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 image(s)
  - Note: Diagnostic images must be labeled with the:
    - Date taken
    - Applicable case number obtained at time of notification, or the member's name and ID number on the image(s)
  - Submission of diagnostic image(s) is required via the external portal at www.uhcprovider.com/paan; faxes will not be accepted
- Diagnostic image(s) report(s)
- Condition requiring procedure
- Severity of pain and details of functional disability(ies) interfering with activities of daily living (preparing meals, dressing, driving, walking) using a standard scale, such as the *Western Ontario and McMaster Universities Arthritis Index (WOMAC) or the Knee injury and Osteoarthritis Outcome Score (KOOS)*
- Physician's treatment plan including pre-op discussion

- Pertinent physical examination of the relevant joint
- Co-morbid medical condition(s)
- Therapies tried and failed of the following, including dates:
  - Orthotics
  - Medications/injections
  - Physical therapy
  - Surgical
  - Other pain management procedures
- Date of failed previous surgery to the same joint (proximal tibial or distal femoral osteotomy, if applicable)
- For revision surgery, include documentation of the complication and the complete (staged) surgical plan
- For CPT codes 27446 and 27447, if the location is being requested as an inpatient stay, provide medical notes to support at least one of the following:
  - Surgery is bilateral
  - Member has significant co-morbidities; include the list of comorbidities and current treatment
  - Member does not have appropriate resources to support post-operative care after an outpatient procedure; include the barriers to care as an outpatient

Definitions

Significant Radiographic Findings: Kellgren-Lawrence classification of osteoarthritis grade 4-large osteophytes, marked joint space narrowing, severe sclerosis, definite bone ends deformity (Kohn et al., 2016; Dowsey et al., 2012).

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
27445	Arthroplasty, knee, hinge prosthesis (e.g., Walldius type)
27446	Arthroplasty, knee, condyle and plateau; medial OR lateral compartment
27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)
27486	Revision of total knee arthroplasty, with or without allograft; 1 component
27487	Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial 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.

Knee replacement surgery is a procedure and therefore is not regulated by the FDA. However, devices and instruments used during the surgery require FDA approval. See the following website for additional information (product codes MBH, JWH, KRO): http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm. (Accessed January 20, 2020)

FDA-approved knee replacement surgery devices are generally approved for any or all of the following:
- Non-inflammatory degenerative joint disease such as osteoarthritis
- Rheumatoid arthritis
- Post-traumatic arthritis
- Complex fracture(s) of the distal (lower) femur

- Revision of failed knee replacement surgery
- Correction of functional deformity

References

Bellamy N, Buchanan WW, Goldsmith CH, et al. Validation study of WOMAC: a health status instrument for measuring clinically important patient relevant outcomes to antirheumatic drug therapy in patients with osteoarthritis of the hip or knee. J Rheumatol. 1988 Dec;15(12):1833-40.

Dowsey MM, Nikpour M, Dieppe P, Choong PF. Associations between pre-operative radiographic changes and outcomes after total knee joint replacement for osteoarthritis. Osteoarthritis Cartilage. 2012 Oct;20(10):1095-102.

Kohn MD, Sassoon AA, Fernando ND. Classifications in Brief: Kellgren-Lawrence Classification of Osteoarthritis. Clin Orthop Relat Res. 2016 Aug;474(8):1886-93.

Roos EM, Roos HP, Lohmander LS, et al. Knee Injury and Osteoarthritis Outcome Score (KOOS)–development of a self-administered outcome measure. J Orthop Sports Phys Ther. 1998 Aug;28(2):88-96.

Policy History/Revision Information

Date	Summary of Changes
07/01/2021	**Coverage Rationale** • Replaced reference to "InterQual® 2020" with "InterQual® 2021" **Supporting Information** • Archived previous policy version CS068LA.M

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.