

# Surgery of the Elbow (for Tennessee Only)

Policy Number: CS033TN.M  
Effective Date: September 1, 2021

[Instructions for Use](#)

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Related Policies
None

## Application

This Medical Policy applies to Medicaid only plans in the state of Tennessee.

## 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.

## 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
<b>Arthroscopy, Surgical, Elbow</b>	
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
<b>Arthroplasty, Joint Replacement, Elbow</b>	
24360	Arthroplasty, elbow; with membrane (e.g., fascial)

CPT Code	Description
Arthroplasty, Joint Replacement, Elbow	
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

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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.

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 9, 2021)

## Policy History/Revision Information

Date	Summary of Changes
09/01/2021	<p><b>Policy Title</b></p> <ul style="list-style-type: none"> <li>Previously titled <i>Elbow Replacement Surgery (Arthroplasty) (for Tennessee Only)</i></li> </ul> <p><b>Coverage Rationale</b></p> <ul style="list-style-type: none"> <li>Replaced language indicating “elbow <i>replacement surgery</i> is proven and medically necessary in certain circumstances” with “<i>surgery of the elbow</i> is proven and medically necessary in certain circumstances”</li> <li>Revised language pertaining to medical necessity clinical coverage criteria; added InterQual® 2021, Apr. 2021 Release, CP: Procedures: <ul style="list-style-type: none"> <li>Arthroscopy, Diagnostic, +/- Synovial Biopsy, Elbow</li> <li>Arthroplasty, Removal or Revision, Elbow</li> <li>Arthroscopy, Surgical, Elbow</li> </ul> </li> </ul> <p><b>Applicable Codes</b></p> <ul style="list-style-type: none"> <li>Added CPT codes 24365, 24366, 29830, 29834, 29837, and 29838</li> </ul> <p><b>Supporting Information</b></p> <ul style="list-style-type: none"> <li>Updated <i>FDA</i> section to reflect the most current information</li> <li>Archived previous policy version CS033TN.L</li> </ul>

## 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.