ELBOW REPLACEMENT SURGERY (ARTHROPLASTY)

Policy Number: SURGERY 100.15 T2

Effective Date: April 1, 2019

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Related Policies

None

Conditions of Coverage

Applicable Lines of Business/Products: This policy applies to Oxford Commercial plan membership.

Benefit Type: General benefits package

Referral Required: No

Authorization Required: Yes

Pre-certification with Medical Director Review Required: No

Applicable Site(s) of Service: Inpatient, Outpatient

Coverage Rationale

Elbow replacement surgery is proven and medically necessary in certain circumstances. For medical necessity clinical coverage criteria, see MCG™ Care Guidelines, 23rd edition, 2019, Elbow Arthroplasty, S-420 (ISC).

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.

Required Clinical Information

Elbow Replacement Surgery (Arthroplasty)

Medical notes documenting all of the following:

- Complete report(s) of diagnostic imaging (MRI, CT scan, x-rays and bone scan)
- 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)
- Therapies tried and failed of the following, including dates:
  - Orthotics
  - Medications/injections
  - Physical therapy
**Required Clinical Information**

**Elbow Replacement Surgery (Arthroplasty)**
- Surgery
- Other pain management procedures
- Physician’s treatment plan, including pre-op discussion
- For revision surgery, also include:
  - 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:

- Specify which implant brand or manufacturer to be used:
  - Arthrex
  - BioMet
  - Conformis
  - Consensus
  - DePuy Synthes
  - Other (include name and reason for this selection)
- Provide the fixation type from the following:
  - Cemented
  - Cemented with antibiotic impregnated
  - Non-cemented
  - Other (if another fixation type, then explain)
  - Cannot identify fixation prior to procedure

**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 may apply.

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

*CPT® is a registered trademark of the American Medical Association*

**U.S. FOOD AND DRUG ADMINISTRATION (FDA)**

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/pmncf.cfm](http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmncf.cfm).

(Accessed December 14, 2018)

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

REFERENCES

The foregoing Oxford policy has been adapted from an existing UnitedHealthcare national policy that was researched, developed and approved by UnitedHealthcare Medical Technology Assessment Committee. [2019T0551M]

POLICY HISTORY/REVISION INFORMATION

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<tr>
<th>Date</th>
<th>Action/Description</th>
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| 10/01/2019 | Documentation Requirements  
• Updated and reformatted documentation requirements |
| 08/01/2019 | Template Update  
• Added Documentation Requirements section |
| 04/01/2019 | • Reorganized policy template:  
  o Simplified and relocated Instructions for Use  
  o Removed Benefit Considerations section  
  • Revised coverage rationale:  
    o Replaced reference to "MCG™ Care Guidelines, 22nd edition, 2018" with "MCG™ Care Guidelines, 23rd edition, 2019"; refer to 23rd edition for complete details on applicable updates to the MCG™ Care Guidelines  
    • Archived previous policy version SURGERY 100.14 T2 |

INSTRUCTIONS FOR USE

This Clinical Policy provides assistance in interpreting UnitedHealthcare Oxford 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 Oxford reserves the right to modify its Policies as necessary. This Clinical Policy is provided for informational purposes. It does not constitute medical advice.

The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. UnitedHealthcare Oxford Clinical 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.