KNEE REPLACEMENT SURGERY (ARTHROPLASTY),
TOTAL AND PARTIAL

Policy Number: SURGERY 098.14 T2

Related Policy
- Unicondylar Spacer Devices for Treatment of Pain or Disability

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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

Precertification with Medical Director Review Required
No

Applicable Site(s) of Service
Inpatient, Outpatient

COVERAGE RATIONALE

Knee replacement surgery (arthroplasty) is proven and medically necessary in certain circumstances. For medical necessity clinical coverage criteria, see the following MCG™ Care Guidelines, 23rd edition, 2019:
- For total knee arthroplasty: Knee Arthroplasty, Total. S-700 (ISC)
- For unicompartmental knee arthroplasty: Musculoskeletal Surgery or Procedure GRG: SG-MS (ISC GRG)

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.

Knee Arthroplasty or Arthroplasty Revision

Medical notes documenting all of the following:
- Complete report(s) of diagnostic imaging (MRI, CT scan, x-rays and bone scan)
- Condition requiring procedure
- Severity of pain and details of functional disability(ies) interfering with activities of daily living (preparing meals, dressing, driving, walking)
- Physician’s treatment plan including pre-op discussion
- Pertinent physical examination of the relevant joint
- Co-morbid medical condition(s)
Required Clinical Information

Knee Arthroplasty or Arthroplasty Revision

- 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

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>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
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<tr>
<td>27445</td>
<td>Arthroplasty, knee, hinge prosthesis (e.g., Walldius type)</td>
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<tr>
<td>27446</td>
<td>Arthroplasty, knee, condyle and plateau; medial OR lateral compartment</td>
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<tr>
<td>27447</td>
<td>Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)</td>
</tr>
<tr>
<td>27486</td>
<td>Revision of total knee arthroplasty, with or without allograft; 1 component</td>
</tr>
<tr>
<td>27487</td>
<td>Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component</td>
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U.S. FOOD AND DRUG ADMINISTRATION (FDA)

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/pmncfm](http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmncfm). (Accessed November 25, 2018)

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

### POLICY HISTORY/REVISION INFORMATION

<table>
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<th>Date</th>
<th>Action/Description</th>
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<tr>
<td>09/23/2019</td>
<td>Updated and reformatted documentation requirements</td>
</tr>
<tr>
<td>07/01/2019</td>
<td><strong>Template Update</strong>&lt;br&gt;Added Documentation Requirements section</td>
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<tr>
<td>04/01/2019</td>
<td><strong>Documentation Requirements</strong>&lt;br&gt;- Changed policy title; previously titled <em>Total Knee Replacement Surgery (Arthroplasty)</em>&lt;br&gt;- Reorganized policy template:&lt;br&gt;  o Simplified and relocated Instructions for Use&lt;br&gt;  o Removed Benefit Considerations section&lt;br&gt;- Revised coverage rationale:&lt;br&gt;  o Replaced reference to &quot;MCG™ Care Guidelines, 22nd edition, 2018&quot; with &quot;MCG™ Care Guidelines, 23rd edition, 2019&quot;; refer to 23rd edition for complete details on applicable updates to the MCG™ Care Guidelines&lt;br&gt;  o Archived previous policy version SURGERY 098.13 T2</td>
</tr>
</tbody>
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### 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.