ELBOW REPLACEMENT SURGERY (ARTHROPLASTY)

Guideline Number: MMG035.I **Effective Date**: April 1, 2019

Instructions for Use

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Related Policies

None

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
- Co-morbid medical conditions (Rheumatoid Arthritis, Osteoarthritis, Degenerative Joint Disease, Post-traumatic Arthritis, Severe Fractures)
- Pertinent physical examination of the relevant joint
- Physician's treatment plan including pre-op discussion
- Severity of pain and details of functional disability(ies) interfering with activities of daily living (preparing meals, dressing, driving, walking)
- Therapies tried and failed of the following including dates:
  - Orthotics
  - Medications/injections
  - Physical therapy
  - Surgery
  - Other pain management procedures
- For arthroplasty due to rheumatoid arthritis, include:
  - Member's symptoms, pain, location, and severity including functional impairment that is interfering with activities of daily living (preparing meals, walking, getting dressed, driving)
- For revision surgery, include complication and complete (staged) surgical plan

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 guideline 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 and Guidelines may apply.

CPT Code	Description
24360	Arthroplasty, elbow; with membrane (e.g., fascial)
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)
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

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/pmn.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

GUIDELINE HISTORY/REVISION INFORMATION

Date	Action/Description
08/01/2019	**Template Update** • Added *Documentation Requirements* section

04/01/2019	• Reorganized policy template:
	  ○ Simplified and relocated *Instructions for Use*
	  ○ Removed *Benefit Considerations* section
	• Revised coverage rationale:
	  ○ 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 MMG035.H

INSTRUCTIONS FOR USE

This Medical Management Guideline provides assistance in interpreting UnitedHealthcare 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 benefit plan. In the event of a conflict, the member specific benefit plan document governs. Before using this guideline, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Management Guideline is provided for informational purposes. It does not constitute medical advice.

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

Member benefit coverage and limitations may vary based on the member's benefit plan Health Plan coverage provided by or through UnitedHealthcare of California, UnitedHealthcare Benefits Plan of California, UnitedHealthcare of

Oklahoma, Inc., UnitedHealthcare of Oregon, Inc., UnitedHealthcare Benefits of Texas, Inc., or UnitedHealthcare of Washington, Inc.