KNEE REPLACEMENT SURGERY (ARTHROPLASTY), TOTAL AND PARTIAL

Guideline Number: MMG072.J **Effective Date**: April 1, 2019

Instructions for Use

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Related Medical Management Guideline

- Unicondylar Spacer Devices for Treatment of Pain or Disability

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.

Required Clinical Information

Joint Replacement – 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)
  - Specify which implant brand or manufacturer to be used (e.g., Arthrex, Conformis, Consensus, DePuy Synthes, Zimmer, BioMet, DJO Surgical, MicroPort, Smith & Nephew, Stryker, or Other and include name and reason for this selection)
- Specify which manufacturer model to be used (e.g., Asphere, Biolox Delta, Compress, Duracon, Kinective, Pinnacle)
- Provide the fixation type from the following:
  - Cemented
  - Cemented with antibiotic impregnated
  - Non-cemented
  - Other - If another fixation type then explain
- Current medical notes indicating:
  - 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)
  - Therapies tried and failed of the following including dates:
    - Orthotics
    - Medications
    - Injections
    - Physical therapy
    - Surgical

Required Clinical Information
Joint Replacement – Knee Arthroplasty or Arthroplasty Revision

- 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 **27447 and 27446**, 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

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
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)

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 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

GUIDELINE HISTORY/REVISION INFORMATION

Date	Action/Description
07/01/2019	**Template Update** • Added *Documentation Requirements* section

04/01/2019	• Changed policy title; previously titled *Total Knee Replacement Surgery (Arthroplasty)*
	• 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 MMG072.I

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.