

Medical Policy: Prior Authorization Criteria Arthroplasty/Arthroscopy (Commercial)



POLICY NUMBER	EFFECTIVE DATE	APPROVED BY
M202000039	01/01/2020	MPC (Medical Policy Committee)

IMPORTANT NOTE ABOUT THIS MEDICAL POLICY:

Property of ConnectiCare, Inc. All rights reserved. The treating physician or primary care provider must submit to ConnectiCare, Inc. the clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, ConnectiCare will not be able to properly review the request for prior authorization. This clinical policy is not intended to pre-empt the judgment of the reviewing medical director or dictate to health care providers how to practice medicine. Health care providers are expected to exercise their medical judgment in rendering appropriate care. The clinical review criteria expressed below reflects how ConnectiCare determines whether certain services or supplies are medically necessary. ConnectiCare established the clinical review criteria based upon a review of currently available clinical information (including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). ConnectiCare, Inc. expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test or procedure over another. Each benefit plan defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by ConnectiCare, as some plans exclude coverage for services or supplies that ConnectiCare considers medically necessary. If there is a discrepancy between this guideline and a member's benefits plan, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of the State of CT and/or the Federal Government. Coverage may also differ for our Medicare members based on any applicable Centers for Medicare & Medicaid Services (CMS) coverage statements including including National Coverage Determinations (NCD), Local Coverage Determinations (LCD) and/or Local Medical Review Policies(LMRP). All coding and web site links are accurate at time of publication.

Criteria: Effective 1/1/2020

Requests will be considered using Milliman Clinical Care Guidelines (MCGs). Guidelines are developed using publications that have been assessed in terms of quality, utility, and relevance. Preference is given to publications that:

- Are designed with rigorous scientific methodology.
- Are published in higher-quality journals (e.g., journals that are read and cited most often within their field).
- Address an aspect of specific importance to the guideline in question (admission criteria, length of stay).
- Represent an update or contain new data or information not reflected in the current guideline.

On an annual basis, each guideline undergoes external review by clinically active experts (e.g., board-certified specialist physicians without stated financial conflicts of interest) to confirm the clinical appropriateness, accuracy, validity, and applicability of each guideline.

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[Click Here: ConnectiCare-MCG Clinical Criteria](#)

Arthroplasty

CPT code 23470-S-633 ISC ORG Shoulder Hemiarthroplasty
CPT code 23472, 23473, 23474-S-634 ISC ORG Shoulder Arthroplasty
CPT code 24360, 24361, 24362, 24363, 24370, 24371- S-420 ISC ORG Elbow Arthroplasty
CPT code 27120, 27122, 27437, 27438, 27440, 27441, 27442, 27443-SG-MS GRG Musculoskeletal Surgery or Procedure GRG
CPT code 27125-S-560 ISC ORG Hip Arthroplasty
S-600 ISC ORG Hip: Displaced Fracture of Femoral Neck, Hemiarthroplasty
CPT code 27130- S-560 ISC ORG Hip Arthroplasty
S-565 ISC ORG Hip Resurfacing
CPT code 27132, 2713, 27137, 27138- S-560 ISC ORG Hip Arthroplasty
CPT code 27445, 27486, 27487- S-700 ISC ORG Knee Arthroplasty, Total

Arthroscopy

CPT code 29805, 29806, 29819, 29820, 29821, 29822, 29823, 29824, 29828. 29893- SG-MS GRG Musculoskeletal Surgery or Procedure GRG
CPT code 28907- A-0524 AC ACG Superior Labrum Anterior to Posterior (SLAP) Tear Repair, Arthroscopic
CPT code 29825- A-0526 AC ACG Release of Adhesive Capsulitis, Shoulder, Closed or Arthroscopic
CPT code 29826, 29827- S-1045 ISC ORG-AP Acromioplasty and Rotator Cuff Repair
CPT code 29830, 29834, 29835, 29836, 29837, 29838 - S-421 ISC ORG-AP Elbow Arthroscopy
CPT code 29840, 29843, 29844, 29845, 29846, 29847 - S-1220 ISC ORG Wrist Arthroscopy
CPT code 29848- A-0211 AC ACG Carpal Tunnel Decompression Procedures: Open and Endoscopic
CPT code 29860, 29861, 29862, 29863 - S-572 ISC ORG-AP Hip Arthroscopy
CPT code 29870, 29871, 29873, 29874, 29875, 29876, 29877, 29880, 29881, 29882, 29883, 29884, 29885, 29886, 29887, 29888, 29889- S-705 ISC ORG-AP Knee Arthroscopy
CPT code 29879- S-705 ISC ORG-AP Knee Arthroscopy
A-0518 AC ACG Microfracture
CPT code 29891, 29892, 29894, 29895, 29897, 29898, 29899- S-72 ISC ORG-AP Ankle Arthroscopy
CPT code 29914, 29915, 29916- S-572 ISC ORG-AP Hip Arthroscopy

Revision history

DATE	REVISION
07/27/2021	<ul style="list-style-type: none">Updated policy with CPT codes and MCG criteria
12/2019	<ul style="list-style-type: none">Reformatted and reorganized policy, transferred content to new template