PREMERA HMO

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MEDICAL POLICY – 7.01.550

Knee Arthroplasty in Adults

Effective Date:	Nov. 1, 2024
Last Revised:	Oct. 21, 2024
Replaces:	N/A

RELATED MEDICAL POLICIES:

7.01.15	Meniscal Allograft and Other Meniscal Implants
7.01.78	Autografts and Allografts in the Treatment of Focal Articular Cartilage Lesions
7.01.144	Patient-Specific Cutting Guides for Joint Arthroplasty
7.01.549	Knee Arthroscopy in Adults
7.01.573	Hip Arthroplasty in Adults

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POLICY CRITERIA | DOCUMENTATION REQUIREMENTS | CODING
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Introduction

Knee arthroplasty is the medical term for a total knee replacement. A surgeon removes the damaged part of the joint. The surfaces are shaped to hold a replacement joint that is either metal or plastic. The artificial joint is attached to the thigh bone, shin bone, and knee cap. For the right individual, a knee replacement reduces pain and improves quality of life. People who may qualify for this surgery are those who have severe pain from "wear-and-tear" arthritis (osteoarthritis) of the knee, who are not able to perform their normal daily activities, and who tried and failed nonsurgical treatments. Replacement joints have a limited life. Factors such as a person's age, severity of knee disease, obesity, and the type of replacement affect how long an artificial joint will last. Knee arthroplasty must be pre-approved by the health plan. This policy outlines the information needed for health plan review.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

Policy Coverage Criteria

Note: This policy only applies to adults aged 19 and older. This policy does not apply to patellofemoral knee arthroplasty

Surgery	Medical Necessity

• **Total knee and unicompartmental arthroplasty**	**Total knee and unicompartmental arthroplasty may be considered medically necessary for joint disease when ALL of the following are met:**
	• There is a documented diagnosis of one of the following:
	  ○ Degenerative joint disease (DJD)
	  ○ Osteoarthritis (OA)
	  ○ Rheumatoid arthritis (RA)
	  ○ Traumatic arthritis
	  ○ Osteonecrosis
	AND
	• Treatment is needed because of one or more of the following:
	  ○ Disabling pain for at least 3 months duration
	  ○ Functional disability which interferes with the ability to carry out activities of daily living
	AND
	• Radiographic or imaging evidence of severe osteoarthritis (**Kellgren-Lawrence** grade 3 or 4) in the 12 months prior to surgery evidenced by either:
	  ○ Moderate multiple osteophytes, definite narrowing of joint space, some sclerosis and possible deformity of bone contour
	  OR
	  ○ Large osteophytes, marked narrowing of joint space, severe sclerosis, and definite deformity of bone contour
	  OR
	  ○ Exposed subchondral bone (full thickness cartilage loss) (**Outerbridge** grade 4) (aka chondromalacia grade 4)
	AND

Surgery	Medical Necessity

	• Documentation of three months of failed non-operative, conservative management for **Kellgren-Lawrence** grade 3 findings as demonstrated by a trial of one or more of the following medications:
	  ○ Non-steroidal anti-inflammatory drugs (oral or topical)
	  ○ Acetaminophen
	  ○ Intra-articular injection of corticosteroids as appropriate
	AND
	• A trial of one or more of the following physical measures:
	  ○ Physical therapy ≥ 12 weeks
	  ○ Flexibility and muscle strengthening exercises ≥ 12 weeks
	  ○ Reasonable restriction of activities ≥12 weeks
	OR
	• For **Kellgren-Lawrence** grade 4* findings, a three-month trial of failed non-operative conservative management as demonstrated by a trial of one or more of the following medications: (see **Note**** below)
	  ○ Non-steroidal anti-inflammatory drugs (oral or topical)
	  ○ Acetaminophen
	  ○ Intra-articular injection of corticosteroids as appropriate
	***Note**: Failure of a trial of physical measures is not required if radiographic or imaging findings show evidence of bone-on-bone articulation (Kellgren Lawrence grade 4, Outerbridge grade 4/chondromalacia grade 4).

Replacement/revision of previous arthroplasty	**Knee arthroplasty may be considered medically necessary for a replacement/revision of a previous arthroplasty as indicated by one or more of the following:** • Disabling pain • Functional disability • Progressive and substantial bone loss • Fracture or dislocation of patella • Aseptic component instability or loosening • Infection • Periprosthetic fracture
Total knee or unicompartmental arthroplasty	**Knee arthroplasty may be considered medically necessary for the following diagnoses:** • Distal femur fracture repair in an individual with osteoporosis • Failure of a previous proximal tibial or distal femoral osteotomy

Surgery	Medical Necessity
	• Hemophilic arthroplasty • Limb salvage for malignancy

Documentation Requirements

The individual's medical records submitted for review for all conditions should document that medical necessity criteria are met. The record should include the following:

- For degenerative joint disease, osteoarthritis, rheumatoid arthritis, traumatic arthritis, or osteonecrosis with ALL of the following:
  - Needs treatment because of disabling pain and/or limited knee function interfering with activities of daily living (ADLs)

  AND
  - Imaging evidence of severe osteoarthritis by either: moderate multiple osteophytes/large osteophytes (bone spurs), definite narrowing of joint space/severe narrowing of joint space, some sclerosis/severe sclerosis (thickening, hardening, increase in density), and deformity of bone contour/definite deformity of bone contours. Radiologic or imaging must be done in the 12 months prior to planned surgery

  AND
  - History of unsuccessful conservative/medical management with one or more of the following medications: non-steroidal anti-inflammatory medication, acetaminophen, or intra-articular injection of corticosteroids as appropriate and one or more of the following physical measures: physical therapy, flexibility and muscle strengthening exercises, or reasonable restriction of activities for ≥12 weeks (note: failure of a trial of one of the physical measures is not required if imaging findings show bone-on-bone articulation) (Kellgren Lawrence grade 4, Outerbridge grade 4/chondromalacia grade 4).
- For replacement/revision of previous arthroplasty with evidence of one of the following:
  - Disabling pain
  - Limited knee function
  - Progressive and substantial bone loss
  - Patella (kneecap) fracture or dislocation
  - Aseptic component instability (a non-infectious loosening of the bond between the bone and the implant)
  - Infection
  - Periprosthetic fracture (fracture around the knee implant)
- For other significant conditions, detailed clinical documentation supporting the diagnoses of one of the following:

Documentation Requirements

- Repair of distal femur fracture (fracture of the femur just above the knee joint) in an individual with osteoporosis
- Failure of a previous proximal tibial or distal femoral osteotomy (cutting or removal of bone related to a break in the shinbone just below the knee or the femur just above the knee)
- Hemophilic arthroplasty (knee replacement for a person with hemophilia)
- Limb salvage for malignancy

Coding

Code	Description
CPT	
27440	Arthroplasty, knee, tibial plateau;
27441	Arthroplasty, knee, tibial plateau; with debridement and partial synovectomy
27442	Arthroplasty, femoral condyles or tibial plateau(s), knee;
27443	Arthroplasty, femoral condyles or tibial plateau(s), knee; with debridement and partial synovectomy
27445	Arthroplasty, knee, hinge prosthesis (eg, Walldius type)
27446	Arthroplasty, knee condyle and plateau; medial OR lateral compartment (unicompartmental or partial knee replacement)
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

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Related Information

KOOS Knee Survey

It is widely agreed that good outcome measures are needed to be able to tell the difference between treatments that are effective from those that are not. In order to do this, there must be some standardized, individual-centered measures that can be administered at a low cost. A questionnaire (the Knee Injury and Osteoarthritis Outcome Scores, or KOOS) was developed to evaluate short- and long-term individual-relevant outcomes after knee injury. This questionnaire was based on the WOMAC (Western Ontario and McMaster Universities) Osteoarthritis Index, a literature review, an expert panel, and a pilot study. The KOOS is a tool that can be used in the provider's office. It is self-administered and looks at five outcomes: pain, symptoms, activities of daily living, sport and recreation function, and knee-related quality of life.[7] It has been shown to be a useful tool in assessing an individual's pain and functional disability.

Kellgren-Lawrence Grading Scale

- Grade 1: Doubtful narrowing of joint space and possible osteophytic lipping
- Grade 2: Definite osteophytes, definite narrowing of joint space
- Grade 3: Moderate multiple osteophytes, definite narrowing of joints space, some sclerosis and possible deformity of bone contour
- Grade 4: Large osteophytes, marked narrowing of joint space, severe sclerosis and definite deformity of bone contour

Modified Outerbridge Classification

The Outerbridge classification is a grading system for joint articular cartilage breakdown (chondromalacia grading). It has been modified to report MRI results, as it was originally used for arthroscopy results. Below is correlation between the two.

Table 1. Modified Outerbridge Classification

	MRI Results	Arthroscopy Results
GRADE I	focal areas of hyperintensity with normal contour	cartilage with softening and swelling
GRADE II	blister-like swelling/fraying of articular cartilage extending to surface	fragmentation and fissuring within soft areas of articular cartilage
GRADE III	partial thickness cartilage loss with focal ulceration	partial thickness cartilage loss with fibrillation (crab-meat appearance)
GRADE IV	full thickness cartilage loss with underlying bone reactive changes	cartilage destruction with exposed subchondral bone*

*Subchondral bone is the bone underneath the white joint cartilage

Background

Modern total knee arthroplasty consists of resection of the diseased articular surfaces of the knee, followed by resurfacing with metal and polyethylene prosthetic components. For the properly selected individual, the procedure results in significant pain relief, as well as improved function and quality of life. Despite the potential benefits of total knee arthroplasty, it is an elective procedure and should only be considered after extensive discussion of the risks, benefits, and alternatives.[1]

The main indication for total knee arthroplasty is for the relief of pain associated with arthritis of the knee in individuals who have failed nonoperative treatments. Correction of deformity and restoration of function should be considered secondary outcomes of the surgery and should not be considered the primary indication. The prosthetic joint has a finite lifetime, and the durability of the prosthesis depends on many factors such as individual age, underlying disease, the presence of obesity, as well as the type of prosthesis and surgical factors.[2]

Individuals with osteoarthritis limited to just one part of the knee may be candidates for unicompartmental knee replacement (also called a "partial" knee replacement). Unicompartmental knee replacements are an option for a small percentage of individuals with osteoarthritis of the knee. In this type of surgery, only the damaged knee compartment is replaced with metal and plastic.[3]

Evidence Review

Knee arthroplasty may be done to treat both posttraumatic arthritis and osteoarthritis.

Although excellent long-term outcomes can be seen with modern methods of ligament reconstruction and open reduction and internal fixation for knee injuries, posttraumatic knee arthritis often develops. Options to treat symptomatic posttraumatic knee arthritis include osteotomy, arthrodesis, and arthroplasty. There may be surgical challenges including the presence of extensive (often broken) hardware, scarring, stiffness, bony defects, compromised soft tissues, and malalignment. When deciding on a treatment plan, the individual's age and level of activity must be taken into account, as well as the anatomic location and extent of damage to the articular surface. For younger individuals, osteotomy, allograft transplantation, or arthrodesis of the knee is often considered, whereas older, low-demand individuals are typically treated with arthroplasty. Attention to specific technical details and careful surgical techniques are required in order to achieve a successful result. Functional improvement is usually seen following arthroplasty and, sometimes, after arthrodesis. However, complications are common.[3]

In people with advanced osteoarthritis of the knee, knee replacement surgery is often done as a way to relieve pain and improve function. Carr et al[4] surveyed the epidemiology and risk factors for knee replacement surgery.

In 2010, Bozic et al[5] looked at the relationship between the number of procedures that a surgeon and hospital do and the clinical outcomes of those procedures. They found that the individuals treated by surgeons who performed more knee replacements had a lower risk of complications, lower readmission and reoperation rates, shorter length of stay, and a higher chance that they would be discharged to home. Hospitals that did more knee replacement surgeries had lower mortality, lower risk of readmission, and a higher likelihood of the individual being discharged to home. Bozic et al also found that when the surgeon and hospital closely follow evidence-based processes of care, there were better clinical outcomes and shorter lengths of stay, regardless of how many procedures the surgeon and hospital had performed.

In 2009, the Osteoarthritis Research Society International (OARSI) updated their global, evidence-based, consensus recommendations previously published in 2006. They found that there were 64 systematic reviews, 266 randomized controlled trials (RCTs) and 21 new economic evaluations (EEs). New data on efficacy was published for more than half (26/39, or 67%) of the 51 new treatment modalities. They found there had been changes in the calculated risk-benefit ratio for some osteoarthritis treatments.[6]

Practice Guidelines and Position Statements

American Academy of Orthopaedic Surgeons

The American Academy of Orthopaedic Surgeons (AAOS) updated new clinical practice guideline on the management of osteoarthritis of the knee (2021)[9] recommends the use of pre-surgical treatments to ease pain and mobility, including corticosteroid injection for short-term relief, physical therapy, and non-narcotic medications. The Academy does not recommend the use of hyaluronic acid or glucosamine sulfate to minimize osteoarthritis symptoms due to a lack of evidence supporting the efficacy of these treatments.

The Osteoarthritis Research Society International (OARSI)

The Osteoarthritis Research Society International (OARSI) (2014)[7] updated its guidelines for non-surgical treatment of osteoarthritis of the knee in one or both knees only with no comorbidities:

Core Treatments Appropriate for all individuals:
Land-based exercise, weight management, strength training, water-based exercise, self-management and education

Recommended treatments Appropriate for Knee-only OA without comorbidities:
Biomechanical interventions, intra-articular corticosteroids, topical NSAIDs, walking cane, oral COX-2 Inhibitors, capsaicin, oral non-selective NSAIDs, duloxetine, acetaminophen

Recommended treatments considered Uncertain for Knee-only OA without comorbidities:
Acupuncture, TENS, ultrasound, avocado soybean unsaponfiables (ASU), chondroitin, diacerein glucosamine, hyaluronic acid (intra-articular injection), opioids (oral or transdermal), rosehip

Recommended treatments considered Not Appropriate for Knee-only OA without comorbidities:
Risedronate

National Institute for Health and Care Excellence (NICE)

In 2014 NICE published Clinical guidelines (CG177) Osteoarthritis: care and management, which was last updated 11 December 2020[17] and recommends intra-articular corticosteroid injections should be considered as an adjunct to core treatments for the relief of moderate to severe pain

in people with OA. The guidelines do not recommend offering intra-articular hyaluronan injections for the management of OA.

In 2022 NICE published an updated guideline on the diagnosis and management of osteoarthritis in those over 16 years of age.[19] The guideline does not recommend offering intra-articular hyaluronan injections to manage osteoarthritis. The guideline directs one to consider intra-articular corticosteroid injections but to explain to the individual receiving them that they only provide short-term relief (2 to 10 weeks).

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History

Date	Comments
11/11/13	New Policy. Added to Surgery section. Considered medically necessary when criteria are met. Approved with 90-day hold for provider notification; this policy is effective February 15, 2014.
03/31/14	Coding update. ICD-9 Diagnosis codes 170.7, 170.8, 716.16, 996.43, and 996.44 added to policy.
09/08/14	Annual Review. Policy rewritten with removal of reference to MCG guidelines; all coverage criteria are now available within this policy; no change in coverage.
12/22/14	Interim update. Removed reference #1.
01/26/15	Update Related Policies. Add 7.01.144.
03/24/15	Update Related Policies. Change title to 7.01.549.
05/27/15	Annual Review. No change to policy statements. No references added.
02/09/16	Annual Review. No change to policy statements. No references added.
07/01/16	Interim Review, approved June 14, 2016. Removed Physical Therapy requirement of 6 visits over 12 weeks.

Date	Comments
11/01/16	Interim Review, approved October 11, 2016. In osteoarthritis/degenerative joint disease policy statement, clarified physical therapy statement from "if indicated" to "unless not tolerated". Retained link to KOOS site and removed KOOS information from Appendix. Added Prior Authorization Requirements. Converted to new format. Removed reference 3. Added reference 9.
01/24/17	Minor formatting update; added second level bullets in Prior-Authorization Requirements section.
03/01/17	Annual Review, approved February 14, 2017. Policy section and Prior Authorization requirements updated to clarify that a copy of the radiologist's report must be submitted for diagnostic imaging performed within the past 12 months and read by an independent radiologist when submitted requests for treatment related to osteoarthritis or degenerative joint disease. This replaces verbiage previously indicating an x-ray report.
03/01/18	Annual Review, approved February 27, 2018. Clarified that the medical necessity criteria are for total knee and unicompartmental arthroplasty. Revised policy statement using descriptors of Kellgren Lawrence Grading Scale and Modified Outerbridge Classification. Intent of policy unchanged. Clarification added that this policy does not address patellofemoral knee arthroplasty. Reference added.
03/09/18	Minor update, added Documentation Requirements section.
04/01/19	Annual Review, approved March 12, 2019. References 11-16 added. Requirement that a copy of the radiologist's report must be submitted for diagnostic imaging performed and read by an independent radiologist reinstated. Minor edits for clarity; otherwise policy statements unchanged.
05/10/19	Minor update, removed requirement that imaging must be performed and read by an independent radiologist, as this was inadvertently added back to policy.
12/01/19	Interim Review, approved November 21, 2019, effective March 5, 2020. Added description of Kellgren-Lawrence grade 3 back to medical necessity statement of radiographic evidence. Modified conservative management to include one or more medical measures **and** physical measures unless symptoms are severe and there is radiographic evidence of advanced osteoarthritis then only one or more medical measure is required.
04/01/20	Delete policy, approved March 10, 2020. This policy will be deleted effective July 2, 2020, and replaced with InterQual criteria for dates of service on or after July 2, 2020.
06/01/20	Coding update. Removed CPT code 27445.
11/01/20	Policy reinstated effective February 5, 2021, approved October 13, 2020. Policy updated with literature review. References updated. Minor reformatting to policy statements for clarity; otherwise policy statements unchanged.
10/01/21	Annual Review, approved September 2, 2021.Policy reviewed. References added. Policy statements unchanged.

Date	Comments
09/01/22	Annual Review, approved August 22, 2022. Policy reviewed. References added. Policy statement unchanged except for minor clarifying edits.
10/01/22	Interim Review, approved September 26, 2022. Clarifying note added that if radiographic findings show evidence of bone-on-bone articulation, failure of non-surgical management is not required. Changed the wording from "patient" to "individual" throughout the policy for standardization.
04/01/23	Interim Review, approved March 20, 2023.Added clarification to the policy criterion of exposed subchondral bone (full thickness cartilage loss) is aka chondromalacia grade 4 and added link to Outerbridge Classification within the Related Information section of the policy for greater clarity.
11/01/23	Annual Review, approved October 23, 2023. Policy reviewed. Reference added. Policy statement unchanged.
01/01/24	Interim Review, approved December 11, 2023. Minor corrections made to policy for greater clarity. Policy intent unchanged.
11/01/24	Annual Review, approved October 21, 2024. Policy reviewed; no references added. Policy statements unchanged. Minor reformatting performed for greater clarity. Added CPT codes 27440-27443 and 27445 to match policy criteria.

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. The Company adopts policies after careful review of published peer-reviewed scientific literature, national guidelines and local standards of practice. Since medical technology is constantly changing, the Company reserves the right to review and update policies as appropriate. Member contracts differ in their benefits. Always consult the member benefit booklet or contact a member service representative to determine coverage for a specific medical service or supply. CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). ©2024 Premera All Rights Reserved.

Scope: Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.