

Tissue Transplantation of the Knee, Ankle and Talus, Surgical 39

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<u>Coverage Policy</u>	Surgical 39
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Member-specific benefits take precedence over medical policy and benefits may vary across plans. Refer to the individual’s benefit plan for details [*](#).

Purpose:

This policy addresses the medical necessity of the surgical procedure for Tissue Transplantation of the Knee, Ankle and Talus.

- Patellar tendon allograft is covered without criteria.

Description & Definitions:

Tissue transplantation by various methods (autologous chondrocyte/allograft/autograft) is used to replace or repair damaged cartilage in the knee, ankle or talus.

Criteria:

Tissue transplantation of the knee is considered medically necessary with **1 or more of the following**:

- Autologous chondrocyte transplant is considered medically necessary for individuals with **All of the following**:
 - Disabling pain related to a full thickness focal chondral defect
 - Physician letter listing any prior surgery for treatment of femoral condyle defect
 - Arthroscopic evidence of significant cartilaginous defect of the femoral condyle by photography or operative report or MRI
 - Age 15 – 60 years
 - Body mass index 35 or less
 - Presence debilitating pain and/or knee locking for at least one year
 - Single focal articular cartilage defect down to but not through the subchondral bone on a load bearing surface
 - Total size of defect measures 2 – 10 centimeters
 - Knee is stable with intact meniscus and normal joint space on x-ray
 - No active inflammation or other arthritis clinically or by x-ray
 - Failure of conservative therapy including minimum of 2 months physical therapy and traditional surgical interventions

- Individual will cooperate with post operative weight bearing and activity restrictions
- Individual has the potential to complete post operative rehabilitation
- No active infection present
- No history of cancer in affected limb
- No known history of allergy to the antibiotic Gentamicin
- No known sensitivities to bovine cultures
- Matrix-induced autologous chondrocyte implantation (MACI) is considered medically necessary for individuals with **ALL of the** following:
 - FDA-approved matrix-induced chondrocyte implantation (e.g., MACI (Vericel) autologous cultured chondrocytes on porcine collagen membrane)
 - Symptomatic
 - Pain that interferes with ADLs or employment
 - Failed to respond to conservative treatment after 6 months
 - As an alternative to autologous cultured chondrocytes (e.g., Carticel) for knee joint only
 - Full-thickness cartilage defects of the knee (articular cartilage defect)
 - Adult patients
 - (grade III or IV) isolated defect of the knee
 - Does not involve defects of the subchondral bone
 - There has been an inadequate response to prior surgical therapy to correct the defect
 - No allergies to bovine material/cultures or gentamicin
- Osteochondral Autograft Transplantation or Autologous Mosaicplasty is considered medically necessary for individuals with **All of the following**:
 - MRI or arthroscopic examination results provided which detail the size, location, and type of the defect
 - Size of the cartilage defect is between 1.0 to 2.5 centimeters squared in total area
 - Condition of the knee includes a focal, full thickness (Grade III or IV) isolated defect of the knee involving the weight bearing surface of the medial or lateral femoral condyles or trochlear region caused by acute or repetitive trauma
 - Age 15-50 years
 - Persistent symptoms of disabling localized knee pain for at least 6 months, which have failed to respond to conservative treatment
 - An intact meniscus is present
 - The lesion is largely contained with near normal surrounding articular cartilage and articulating cartilage, (grades 0, 1, 2)
 - Normal joint space is present
 - No active infection is present
 - No inflammation or osteoarthritis is present in the joint
 - Knee is stable with normal alignment (corrective procedure may be performed in combination/prior to transplantation)
 - Individual is willing and able to comply with post operative weight-bearing restrictions and rehabilitation
 - No history of cancer in the bones, cartilage, fat, or muscle of the affected limb
 - Body mass index 35 or less
- Allograft transplantations of the Anterior/Posterior Cruciate Ligament or the Medial/Lateral Collateral Ligament are considered medically necessary for individuals with **1 or more of the following**:
 - Ligament deficiency who are not candidates for autogenous transplantation
 - Pathology such as chronic patellar tendonitis and hamstring injury
 - Any other contraindications to using their own tissue such as collagen disease or generalized ligamentous laxity
- Osteochondral allograft transplantation including DeNovo products is considered medically necessary for individuals with **1 or more of the following**:
 - Avascular necrosis lesions of the femoral condyle
 - Non repairable stage 3 or 4 osteochondritis dissecans
 - Otherwise healthy, active, non-elderly individuals with **1 of the following**:

- Failed arthroscopic procedures
- Not a candidate due to **1 or more of the following:**
 - Size of lesion
 - Shape of lesion
 - Location of lesion
- Treatment is for **All of the following:**
 - Isolated traumatic injury
 - Full thickness depth lesion (grade 4 down to or including the bone)
 - Lesion is surrounded by healthy cartilage
 - Opposing articular surface is generally free of disease or injury
- Osteochondral autograft or allograft for the **talus** may be considered medically necessary for **one or more of the following:**
 - large diameter lesions >4cm
 - cystic lesions
 - Osteochondral lesions that have failed previous surgical treatment.
- Meniscal allograft transplantation is considered medically necessary for individuals with **All of the following:**
 - More than 50% or complete loss of meniscus
 - Degenerative changes are absent or minimal
 - Knee is stable (intact or reconstructed ACL)
 - Individual is under age 55
 - Pre-operative studies (MRI or previous arthroscopy) show absence of near absence of the meniscus

Autologous chondrocyte transplantation is NOT COVERED for ANY of the following:

- Autologous cellular implant derived from adipose tissue (MFAT)
- Bioactive scaffolds (e.g., collagen meniscal implants)
- Bio-Gide (resorbable bilayer membrane made of porcine collagen)
- Bioresorbable porous polyurethane
- Collagen meniscus implants
- Combined meniscal allograft and autologous chondrocyte implantation of the knee
- Decellularized osteochondral allograft plugs (e.g., Chondrofix®) or reduced osteochondral allograft discs (e.g., ProChondrix®, Cartiform®) to repair osteochondral defects of the knee or ankle
- Extracellular Matrix with BioCartilage (Arthrex) for Orthopedic Indications
- Healing Response Technique
- Hybrid autologous chondrocyte implantation performed with osteochondral autograft transfer system (OATS) technique
- Kissing lesions with Osteochondral autograft transplantation
- Lesions in other joints, including the ankle and talus
- Lesions of the tibia or patella
- Matrix-induced autologous chondrocyte implantation in joints other than the knee
- Meniscal prosthesis
- Non-autologous mosaicplasty using resorbable synthetic bone filler materials (including but not limited to plugs and granules) to repair osteochondral defects of the knee or ankle
- Osteochondritis dissecans
- Previous history of cancer in the bones, cartilage, fat or muscle of the treated limb
- Synthetic resorbable polymers (e.g., PolyGraft BGS, TruFit [cylindrical plug], TruGraft [granules]) for osteochondral articular cartilage defects
- Tissue-engineered menisci
- Transplantation indications for repair chondral defects of the elbow, shoulder, ankle or other joints except the knee
- Treatment of cartilage damage associated with generalized osteoarthritis

- Treatment of cartilage damage associated with osteoarthritis or degenerative joint disease
- Use of minced articular cartilage (whether synthetic, allograft or autograft) to repair osteochondral defects of the knee or ankle
- Xenografts

Matrix-induced autologous chondrocyte implantation (MACI) is NOT COVERED for ANY of the following:

- As initial or first line of surgical therapy
- Growth plates have not closed
- elbow, shoulder, ankle or other joints except the knee
- Combination of autologous transplant and transfer for repair
- Cartilage defect associated with 1 or more of the following:
 - Osteoarthritis
 - Rheumatoid arthritis
 - Inflammatory diseases
 - Significant osteoarthritic or inflammatory process

Coding:

Medically necessary with criteria:

Coding	Description
27412	Autologous chondrocyte implantation, knee
27415	Osteochondral allograft, knee, open
27416	Osteochondral autograft(s), knee, open (eg, mosaicplasty) (includes harvesting of autograft[s])
28446	Open osteochondral autograft, talus (includes obtaining graft[s])
29866	Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the autograft[s])
29867	Arthroscopy, knee, surgical; osteochondral allograft (eg, mosaicplasty)
29868	Arthroscopy, knee, surgical; meniscal transplantation (includes arthrotomy for meniscal insertion), medial or lateral
29891	Arthroscopy, ankle, surgical, excision of osteochondral defect of talus and/or tibia, including drilling of the defect
J7330	Autologous cultured chondrocytes, implant
S2112	Arthroscopy, knee, surgical for harvesting of cartilage (chondrocyte cells)

Considered Not Medically Necessary:

Coding	Description
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G0428	Collagen meniscus implant procedure for filling meniscal defects (e.g., CMI, collagen scaffold, Menaflex)
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U.S. Food and Drug Administration (FDA) - approved only products only.

Document History:

Revised Dates:

- 2024: July – Expanded coverage to include osteochondral autograft or allograft of the talus
- 2022: July
- 2021: July
- 2020: January
- 2015: March, May
- 2013: August
- 2012: March, May, August
- 2011: May, December
- 2010: September
- 2009: December
- 2008: August
- 2001: August

Reviewed Dates:

- 2023: July
- 2020: July
- 2019: July
- 2018: June
- 2017: January, October
- 2015: August
- 2014: August
- 2011: August
- 2010: August
- 2009: August
- 2007: December
- 2005: October, December
- 2004: October
- 2003: March, October
- 2002: March
- 2001: February
- 2000: December
- 1999: November
- 1998: February

Effective Date:

- September 1997

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Special Notes: *

Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment, and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving, and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.

Services mean both medical and behavioral health (mental health) services and supplies unless We specifically tell You otherwise. We do not cover any services that are not listed in the Covered Services section unless required to be covered under state or federal laws and regulations. We do not cover any services that are not Medically Necessary. We sometimes give examples of specific services that are not covered but that does not mean that other similar services are covered. Some services are covered only if We authorize them. When We say You or Your We mean You and any of Your family members covered under the Plan. Call Member Services if You have questions.

Keywords:

Tissue Transplantation of the Knee, SHP Surgical 39, knee, tissue, transplant, transplantation, meniscus, meniscal, tendon, cruciate, ligament, cartilage, autologous, allograft, chondrocyte, DeNovo, autograft, Autologous Chondrocyte Transplantation, Denovo Cartilage Implant, Mosaicplasty, Osteoarticular Transfer System, OATS, Patellar Tendon Allograft, ACT, Bio-Gide, Meniscal Allograft Transplantation, femoral condyle, medial, lateral, trochlear, cartilaginous, Anterior Cruciate Ligament, ACL, Posterior Cruciate Ligament, PCL, Medial Collateral Ligament, MCL, Lateral Collateral Ligament, LCL