Autologous Chondrocyte Implantation

Policy Number: 2015M0085A
Effective Date: 5/14/2018
Review Date: 4/27/2018
Next Review Date: 5/14/2020

Important Information - Please Read Before Using This Policy

UCare has developed medical policies to assist in the determination of coverage of a clinical service (such as a procedure, therapy, diagnostic test, medical device, etc.), when coverage requires determination of medical necessity.

UCare medical policies are published on this website for informational purposes and do not constitute medical advice, explanation of benefits or guarantee of payment.

Coverage is determined by federal and state regulation and is subject to the benefits or restrictions of the member’s specific plan, which will supersede this medical policy when applicable. Please refer to member’s contract materials, such as the Evidence of Coverage (EOC), Member Contract, or Member Handbook.

In addition to using UCare-authored medical policies, UCare determines medical necessity using clinical criteria and guidelines developed by authoritative external sources, such as InterQual®, Magellan Care Guidelines, and the National Comprehensive Cancer Network. These criteria and guidelines are not a substitute for clinical judgment by a qualified health care professional and do not constitute the practice of medicine or medical advice. The treating health care professional remains responsible for diagnosis and treatment. Patients should always consult their treating health care professional before making decisions about medical care.

Administrative Procedure

Prior authorization is not required for autologous chondrocyte implantation. UCare may review medical records after the procedure to confirm that medical necessity criteria were met. The CPT® codes are listed below in the codes section.

Choices plan coverage may vary, please refer to the plan documents. CPT® codes are listed below in the codes section.

Although prior authorization is not required, providers may submit clinical information to confirm medical necessity criteria are met using the prior authorization form below.

UCare prior authorization form is available here: https://www.UCare.org/providers/Eligibility-Authorizations/Pages/EligibilityAuth.aspx
Medical Necessity Criteria

AUTOLOGOUS CHONDROCYTE IMPLANTATION

UCare considers autologous chondrocyte implantation (ACI) of the KNEE as MEDICALLY NECESSARY for articular cartilage defects when ALL of the following criteria are met:

1. Severe, disabling pain and a loss of knee function that interferes with the ability to carry out age appropriate activities of daily living and/or demands of employment.
2. Patient is between ages of 15 (or documented skeletal maturity) to 55 years who will return to high activity level.
3. Single, contained (no lesion on opposing surface), full-thickness defect on the distal femoral articular surface (knee) that is >2 cm²
4. Failure of nonsurgical management for more than 3 months. (braces, physical therapy, and/or non-steroidal anti-inflammatory drugs.
5. No significant bone loss of the knee.
6. Knee physical exam: full range of motion, intact ligaments, and physiologically correct lower limb axis (corrective procedures may be performed in combination with or prior to ACI).
7. No autoimmune connective tissue disease, active rheumatoid arthritis, or malignancy.
8. Absence of a corresponding tibial or patellar lesion.
9. BMI gr≤35 kg/m²
10. Willing to comply with rigorous rehabilitation program.

UCare considers autologous chondrocyte implantation, also called autologous chondrocyte transplantation NOT MEDICALLY necessary for joints other than the knee (hip, shoulder, elbow, back) or any indication not listed above:

1. Joints other than the knee. (e.g. hip, shoulder, elbow)
2. Cartilage defects in locations other than the femoral condyle of the knee.
3. Patients who have had a prior total meniscectomy of the knee.
4. Patients with a cartilaginous defects of the knee associated with osteoarthritis or inflammatory diseases or where an osteoarthritic or inflammatory process significantly and adversely affects the quality of the peri-lesional cartilage.
5. Patients with osteochondritis dissecans lesions.
6. Pre-existing conditions of the knee including meniscus tears, joint instability, or mal-alignment, unless these conditions are assessed and treated prior to or concurrent with autologous chondrocyte implantation.

Applicable Codes

The Current Procedural Terminology (CPT®) codes and HCPCS codes listed in this policy are for reference purposes only. Listing of a service or device code in this policy does not imply that the service described by this code is a covered or non-covered health service. The inclusion of a code does not imply any right to reimbursement or guarantee claims payment. Other medical policies and coverage determination guidelines may apply.
### CPT® Code Ranges Applicable To This Policy

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>27412</td>
<td>Autologous chondrocyte implantation, knee</td>
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<tr>
<td>29870</td>
<td>Arthroscopy, knee, diagnostic; with or without synovial biopsy (separate procedure)</td>
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<tr>
<td>27416</td>
<td>Osteochondral autograft(s), knee, open (Includes harvesting of autograft), (not covered in combination with autologous chondrocyte implantation)</td>
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<tr>
<td>27447</td>
<td>Arthroplasty, knee, condyle and plateau; medical AND lateral compartments with or without patella surfacing (total knee arthroplasty)</td>
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<tr>
<td>29866</td>
<td>Arthroscopy, knee, surgical; implantation of osteochondral autograft(s) (includes harvesting of autografts) (no not covered in combination with autologous chondrocyte implantation)</td>
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<tr>
<td>29871</td>
<td>Arthroscopy, knee, surgical; for infection, lavage and drainage</td>
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<tr>
<td>29874</td>
<td>For removal of loose body or foreign body (eg., osteochondritis dissecans fragmentation, chondral fragmentation)</td>
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<tr>
<td>29877</td>
<td>Debridement/shaving of articular cartilage (chondroplasty)</td>
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<tr>
<td>29879</td>
<td>Abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture</td>
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### HCPCS Codes

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<tr>
<th>Code</th>
<th>Description</th>
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<tr>
<td>J7330</td>
<td>Autologous Cultured chondrocytes, implant</td>
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<tr>
<td>S2112</td>
<td>Arthroscopy, knee, surgical, for harvesting of cartilage (chondrocyte cells)</td>
</tr>
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### How Coverage Is Determined In Specific UCare Plans

- **Commercial: UCare Choices/Fairview UCare Choices:**
  Coverage is determined by the Member Contract. If there is a conflict between this medical policy and the individual Member Contract, the provisions of the Member Contract will govern.

- **Medicare Advantage: UCare for Seniors (HMO Point-of-Service) and EssentiaCare (Preferred Provider Organization):**
  Coverage is determined by guidance from the Centers for Medicare & Medicaid Services (CMS) National Coverage Determination (NCD) or applicable CMS Local Coverage Determination (LCD) and the applicable UCare Evidence of Coverage (EOC). This medical policy applies in the absence of CMS guidance and/or EOC language.

- **Medicaid – MinnesotaCare: Prepaid Medical Assistance Program (PMAP), UCare Connect (non-SNP/non-integrated), Minnesota Senior Care Plus (MSC+), and MinnesotaCare:**
  Coverage is determined by the applicable Evidence of Coverage (also known as the “Member Handbook”) and guidance from the Minnesota Department of Human Services (DHS) Minnesota Health Care Programs (MHCP) Provider Manual. This medical policy applies if DHS coverage criteria are not available.
MEDICAL POLICY

- **Medicare Advantage – Dual Eligible Special Needs Plan: UCare Connect + Medicare and Minnesota Senior Health Options (MSHO)**

  Medicare coverage is determined by the applicable Member Handbook (MSHO) or Evidence of Coverage (UCare Connect + Medicare) and guidance from the Centers for Medicare & Medicaid Services (CMS). This medical policy applies in the absence of CMS guidance and/or EOC language.

  Medicaid coverage is determined by the applicable Member Handbook (MSHO) or Evidence of Coverage (UCare Connect + Medicare), and guidance from the DHS MHCP Provider Manual. This medical policy applies if coverage criteria have not been determined by DHS.

**Revision History**

8/1/2015  2015M0085A
4/27/2018