

02-20000-65

Original Effective Date: 10/15/16

Reviewed: 06/27/19

Revised: 10/15/19

Subject: Knee Arthroscopy and Open, Non-Arthroplasty Knee Repair

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DESCRIPTION:

This guideline describes surgical indications of both arthroscopy as well as open, non-arthroplasty knee surgery. Arthroscopy introduces a fiber-optic camera into the knee joint through a small incision for diagnostic visualization purposes. Other instruments may then be introduced to remove, repair, or reconstruct intra-articular and extra-articular joint pathology. Surgical indications are based on relevant subjective clinical symptoms, objective physical exam and radiologic findings, and response to previous non-operative treatments when medically appropriate. Open, non-arthroplasty knee surgeries are performed instead of an arthroscopy as dictated by the type and severity of injury and/or disease, and surgeon skill and experience.

POSITION STATEMENT:

General criteria for elective knee surgery

Elective open or arthroscopic surgery of the knee **meets the definition of medical necessity** if the following general criteria are met:

- There is clinical correlation of subjective complaints with objective exam findings and/or imaging (when applicable)
- Knee pain with documented loss of function, deviation from normal knee function which may include painful weight bearing, and/or inadequate range of motion (>10 degrees flexion contracture or <110 degrees flexion, or both) to accomplish age-appropriate activities of daily living (ADLs), and/or occupational or athletic requirements)
- Medically stable with no uncontrolled comorbidities

- Does not have an active local or systemic infection
- Does not have active, untreated drug dependency (including but not limited to narcotics, opioids, or muscle relaxants) unless engaged in treatment program

Clinical notes should address:

- Symptom onset, duration, and severity
- Loss of function and/or limitations
- Type and duration of non-operative management modalities (where applicable)

***Non-operative management must include at least 2 of the following, unless otherwise specified:**

- Rest or activity modifications/limitations
- Ice/heat
- Protected weight bearing
- Pharmacologic treatment: oral/topical NSAIDS, acetaminophen, analgesics, tramadol
- Brace/orthosis
- Physical therapy modalities
- Supervised home exercise
- Weight optimization
- Injections (e.g., corticosteroid)

Diagnostic Knee Arthroscopy

Diagnostic knee arthroscopy **meets the definition of medical necessity** when **ALL** of the following are met:

- At least 3 months of knee pain with documented loss of function
- Failure of at least 12 weeks of non-operative management
- Clinical documentation of painful weight bearing, joint line tenderness, effusion and/or limited motion compared to pre-symptomatic joint range
- Indeterminate radiographs **AND** MRI findings
- No radiographic or MRI evidence of any of the following:
 - Kellgren-Lawrence Grade 3-4 changes (based on standing or weight-bearing radiographs)
 - Meniscus tears
 - Loose bodies
 - Stress fractures (including insufficiency fractures)
 - Patellofemoral instability (lateral patellar tilt).

Debridement Chondroplasty

Debridement for non-patellofemoral (femoral condyle and tibial plateau) articular cartilage **meets the definition of medical necessity** when **ALL** of the following are met:

- Knee pain with documented loss of function
- Failure of at least 12 weeks of non-operative management
- MRI results show evidence of unstable chondral flap
- Recurrent (more than 2) or persistent effusions

Debridement chondroplasty for patellofemoral chondrosis **meets the definition of medical necessity** when **ALL** of the following are met:

- Anterior knee pain with documented loss of function
- Other extra-articular or intra-articular sources of pain or dysfunction have been excluded (referred pain, radicular pain, tendinitis, bursitis, neuroma)
- Physical exam localizes tenderness to the patellofemoral joint with pain aggravated by activities that load the joint (single leg squat, ascending > descending stairs, and being in seated position for extended periods of time with knee flexed)
- Failure of at least 12 weeks of non-operative management
- No evidence of moderate to severe osteoarthritis (Kellgren-Lawrence** grade 3 to 4 based on standing or weight-bearing radiographs and patellofemoral views)

Arthroscopic debridement for arthrofibrosis **meets the definition of medical necessity** when **ALL** of the following are met:

- Arthrofibrosis, as evidenced by physical exam findings of painful stiffness and loss of motion due to proliferation of scar tissue in and around the joint
- Failure of at least 6 weeks of supervised or self-directed physical therapy

NOTE: Arthroscopic debridement with or without chondroplasty for osteoarthritis of the knee **does not meet the definition of medical necessity**.

Meniscectomy/Menisal Repair

Meniscectomy and/or meniscal repair **meets the definition of medical necessity** when the following are met:

- Symptomatic meniscal tear confirmed by MRI results that show a peripheral longitudinal tear in the vascular zone
- Pain localized to the corresponding compartment, upon physical exam

OR

- When **BOTH** of the following are met:
 - Pediatric or adolescent individual has pain and mechanical symptoms upon physical exam
 - MRI results show unstable tear

OR

- When **ALL** of the following are met:
- History of acute injury/onset of symptoms with a locked knee and/or mechanical symptoms of locking
- Physical examination demonstrates 2 of the following: joint line TTP, positive McMurray's test localized to the correct compartment, pain with full flexion or pain with full extension
- MRI demonstrates a bucket-handle tear of the meniscus. (Does not include an extruded meniscus or flap tears)

OR

- At least 2 of the following 5 criteria are present:
 1. History of "catching" or "locking" as reported by the individual
 2. Knee joint line pain with forced hyperextension upon physical exam
 3. Knee joint line pain with maximum flexion upon physical exam
 4. Knee pain, crepitus, or an audible or palpable click with the McMurray's test or Apley grind test, upon physical exam
 5. Joint line tenderness to palpation upon physical exam
- Failure of at least 6 weeks of non-operative management
- One of the following radiographic findings:
 - Weight-bearing x-ray(s) that demonstrate no moderate or severe osteoarthritic changes (Kellgren-Lawrence** Grade 3-4)
 - MRI results confirm meniscal tear in individuals < 40 years of age
 - MRI results confirm a frank meniscal tear (not simply degenerative changes, such as fraying) (any age)

OR

- Meniscus tear encountered during other medically necessary arthroscopic procedure

Meniscectomy and meniscal repair contraindications:

- Presence of Kellgren-Lawrence** grade 4 osteoarthritis (absolute contraindication)
- The presence of Kellgren-Lawrence** grade 3 osteoarthritis, unless there has been an acute onset with an effusion and locking (**NOTE:** locking does not include catching, popping, cracking, etc.), **AND** MRI evidence of bucket-handle or displaced meniscal fragment that correlates with the correct compartment (i.e. medial tenderness and locking for a medial tear) (relative contraindication)
- If grade 3 changes are present, only a meniscectomy may be indicated, not a meniscal repair. If there is evidence of meniscal extrusion on coronal MRI with or without subchondral edema, arthroscopy is relatively contraindicated, even if a tear is present (relative contraindication)
- BMI > 35 (relative contraindication)

Ligament Reconstruction/Repair

Anterior Cruciate Ligament (ACL) Reconstruction with Allograft or Autograft

ACL reconstruction or repair **meets the definition of medical necessity** when **ALL** of the following are met:

- Knee instability (defined subjectively as "giving way", "giving out", "buckling", or two-fist sign) with clinical findings of instability (Lachman's 1A, 1B, 2A, 2B, 3A, 3B; anterior drawer,, pivot shift test, or instrumented (KT-1000 or KT-2000) laxity of greater than 3mm side-side difference)
- MRI results confirm complete ACL tear
- No evidence of severe arthritis (Kellgren-Lawrence** grade 3 or 4)

OR

- When **ONE** of the following are met:
 - MRI results confirm ACL tear associated with other ligamentous instability or repairable meniscus
 - MRI results confirm partial or complete ACL tear **AND** has persistent symptoms despite at least 12 weeks of non-operative management
 - Acute ACL tear confirmed by MRI in a high demand occupation or competitive athlete [as quantified by Marx activity score***** for athletics (any score greater than 4), and Tegner activity score***** for athletics and/or occupation (any score greater than 2)]
 - No evidence of severe arthritis (Kellgren-Lawrence** grade 3 or 4)
- Tears in those less than age 13 will be reviewed on a **case by case basis**

Posterior Cruciate Ligament (PCL) Reconstruction

Posterior cruciate ligament (PCL) reconstruction or repair **meets the definition of medical necessity** when **ALL** of the following are met:

- Knee instability (defined subjectively as "giving way", "giving out", "buckling", or two-fist sign) with clinical findings of any of the following signs/tests: positive posterior drawer, posterior sag, quadriceps active, dial test at 90 degrees knee flexion, or reverse pivot shift test
- MRI results confirm complete PCL tear
- Failure of at least 12 weeks of non-operative management (including bracing and physical therapy emphasizing quadriceps strengthening)
- Absence of medial and patellofemoral Kellgren-Lawrence** grade 3 to 4 changes in chronic tears

The following clinical scenarios will be considered on a case by case basis:

- Pediatric and adolescent tears in individuals with open physes or open growth plates
- Symptomatic partial tears with persistent instability despite non-operative management*
- Incidental Kellgren-Lawrence** grade 2 to 3 osteoarthritis in acute/subacute tears with unstable joint
- Acute PCL repair or reconstruction when surgery is also required for the ACL, MCL or LCL

- Tears in those less than age 13

Collateral Ligament Repair or Reconstruction

Collateral ligament repair or reconstruction should rarely occur independent of additional ligament repair or reconstruction surgery (ACL, MCL, LCL).

Articular Cartilage Restoration/Repair

Skeletally Immature Indications

Articular cartilage restoration or repair **meets the definition of medical necessity:**

- When **ALL** of the following are met:
 - Skeletally immature
 - Symptomatic (pain, swelling, mechanical symptoms of popping, locking, catching, or limited range of motion)
 - Radiographic findings (radiograph **AND** MRI) of a displaced lesion

OR

- When **ALL** of the following are met:
 - Skeletally immature
 - Symptomatic (pain, swelling, mechanical symptoms of popping, locking, catching, or limited range of motion)
 - Failure of at least 12 weeks of non-operative management
 - Radiographic findings (radiograph **AND** MRI) of a stable osteochondral lesion

OR

- When **ALL** of the following are met:
 - Skeletally immature
 - Asymptomatic
 - Failure of at least 12 weeks of non-operative management
 - Radiographic findings (radiograph **AND** MRI) of an unstable osteochondral lesion

Articular cartilage restoration and repair for skeletally immature individuals **does not meet the definition of medical necessity** when:

- There is evidence of meniscal deficiency and/or malalignment, **IF** these are not being addressed (meniscal transplant and/or lateral release/patellar realignment procedure) at the same time as the cartilage restoration procedure

Skeletally Mature Indications

Reparative Marrow Stimulation

Reparative marrow stimulation techniques such as microfracture & drilling **meet the definition of medical necessity** when **ALL** of the following are met:

- Skeletally mature adult
- MRI confirms a full-thickness weight-bearing lesion that is < 2.5 sq.cm
- Symptomatic (pain, swelling, mechanical symptoms of popping, locking, catching, or limited range of motion)
- Less than age 50
- BMI < 35
- Physical exam findings and/or imaging results confirm knee has stable ligaments
- No evidence of prior meniscectomy in same compartment (medial femoral condyle full thickness lesion and prior medial meniscectomy) unless concurrent meniscal transplant performed

Restorative Marrow Techniques

Restorative techniques (osteoarticular transfer system or osteochondral autograft transfer system (OATS), mosaicplasty, osteochondral allograft implantation) **meet the definition of medical necessity** when **ALL** of the following are met:

- Skeletally mature adult
- MRI results confirm a full thickness chondral or osteochondral lesion of the femoral condyles or trochlea > 2.5 cm²
- Less than 50 years of age
- Symptomatic (pain, swelling, mechanical symptoms of popping, locking, catching, or limited range of motion) for at least 6 months
- Failure of at least 6 months of non-operative management
- MRI and/or physical findings confirm knee has normal alignment, defined as +/- 3 degrees from neutral on full-length mechanical axis long-leg x-ray (unless concurrent or staged tibial or femoral osteotomy planned/performed), and stability (unless concurrent ligamentous repair or reconstruction planned/performed)
- BMI < 35
- MRI shows no evidence of osteoarthritis (greater than Kellgren-Lawrence** grade 2)
- No prior meniscectomy in same compartment (unless concurrent or staged meniscal transplant planned/performed)

Patellofemoral Chondrosis

Surgical intervention for the treatment of patellofemoral chondrosis (osteochondral autograft transfer or transplantation (OATS), microfracture, osteochondral allograft implantation, tibial tubercle osteotomy) **meets the definition of medical necessity** when **ALL** of the following are met:

- Anterior knee pain and loss of function

- Other extra-articular or intra-articular sources of pain or dysfunction have been excluded (referred pain, radicular pain, tendinitis, bursitis, neuroma)
- Physical exam localizes tenderness to the patellofemoral joint with pain aggravated by activities that load the joint (single leg squat, descending > ascending stairs or stair climbing, and being in seated position for extended periods of time with knee flexed)
- Radiologic imaging shows patellofemoral chondrosis grade III or IV by the Outerbridge Classification*** or grade 3 or 4 by the ICRS**** classification, documented by prior arthroscopic evaluation)
- Failure of at least 6 months of non-operative management
- No evidence of osteoarthritis (defined as Kellgren-Lawrence** grade 3 to 4 based on standing or weight-bearing radiographs) in the medial/lateral compartments

Synovectomy (major [2+ compartments], minor [1 compartment])

Synovectomy **meets the definition of medical necessity** when **ALL** of the following are met:

- Proliferative rheumatoid synovium (with established rheumatoid arthritis according to the American College of Rheumatology Guidelines*****)
- Not responsive to disease modifying drug (DMARD) therapy for at least 6 months
- Failure of at least 6 weeks of non-operative management
- At least one instance of aspiration of joint effusion and corticosteroid injection (if no evidence of infection)

OR

- Hemarthrosis from injury, coagulopathy or bleeding disorder confirmed by physical exam, joint aspiration, and/or MRI

OR

When **ALL** of the following are met:

- Proliferative pigmented villonodular synovitis, synovial chondromatosis, sarcoid synovitis, or similar proliferative synovial disease; traumatic hypertrophic synovitis confirmed by history, MRI or biopsy
- Failure of at least 6 weeks of non-operative management
- At least one instance of aspiration of joint effusion and injection of corticosteroid (if no evidence of infection)

OR

When **ALL** of the following are met:

- Detection of painful plica confirmed by physical exam and MRI findings
- Failure of at least 12 weeks of non-operative management
- At least one instance of aspiration of joint effusion **OR** single injection of corticosteroid (effusion may not be present with symptomatic plica)

Loose Body Removal

Loose body removal **meets the definition of medical necessity** when **BOTH** of the following are met:

- Documentation of mechanical symptoms that cause limitation or loss of function
- X-ray or MRI documentation of a loose body

Lateral Release/Patellar Realignment

Lateral Patellar Compression Syndrome

Surgical intervention for the treatment of lateral patellar compression syndrome **meets the definition of medical necessity** when **ALL** of the following are met:

- Evidence of lateral patellar tilt from radiologic images (patellofemoral view: merchant (45 degrees flexion); and/or skyline (60-90 degrees flexion); and/or sunrise (60-90 degrees flexion)
- Associated lateral patella facet Kellgren-Lawrence** changes grade 1, 2, or 3
- Reproducible isolated lateral patellofemoral pain with patellar tilt test
- Failure of at least 6 months of non-operative management (1 component of non-operative management must include quadriceps strengthening, appropriate hamstring/IT band stretching, and patellar mobilization techniques)
- No evidence of patellar dislocation without documented patellar tilt
- No evidence of medial patellofemoral changes (Kellgren-Lawrence** grade 2 osteoarthritis or higher)

Patellar Malalignment and/or Patellar Instability

Surgical intervention for the treatment of patellar malalignment and/or patellar instability **meets the definition of medical necessity** when the following are met:

- Acute traumatic patellar dislocation is associated with an osteochondral fracture, loose body, vastus medialis obliquus/medial patellofemoral ligament muscle avulsion, or other intra-articular injury that requires urgent operative management, **OR**
- Repeat (greater than 2) patellar dislocations or subluxations have occurred despite 6 months of non-operative management with radiologic confirmation of MPFL (medial patellofemoral ligament) deficiency, **OR**
- Physical exam has patellofemoral tenderness and abnormal articulation of the patella in the femoral trochlear groove (patellar apprehension with positive J sign), **AND**
 - CT scan or MRI rules out other abnormality to malalignment (tibial tubercle trochlear groove (TT-TG) distance > 20 millimeters), **AND**
 - Radiologic and advanced (CT or MRI) images rule out fracture or loose body, and show abnormal articulation, trochlear dysplasia, or other abnormality related to malalignment, **AND**
 - Failure of least 6 months of non-operative management (1 component of non-operative management must include at least 3 months of physical therapy)

Lysis of Adhesions for Arthrofibrosis of the knee

Surgical indications are based on relevant clinical symptoms, physical exam, radiologic findings, time from primary surgery, and response to conservative management when medically appropriate. Improved range of motion may be accomplished through arthroscopically-assisted or open lysis of adhesions with general anesthesia, regional anesthesia, or sedation.

Lysis of adhesions for arthrofibrosis of the knee **meets the definition of medical necessity** when **ALL** of the following are met:

- Physical exam findings demonstrate inadequate range of motion of the knee, defined as less than 110 degrees of flexion
- Failure to improve range of motion of the knee despite 6 weeks (12 visits) of documented physical therapy
- More than 12 weeks after ligamentous or joint reconstruction, or resolved infection

OR

When **ALL** of the following are met:

- More than 12 weeks after trauma, or resolved infection
- Has native knee
- Manipulation under anesthesia is also performed

****Kellgren-Lawrence Grading System**

Grade 0: No radiographic features of osteoarthritis

Grade 1: Doubtful joint space narrowing and possible osteophytic lipping

Grade 2: Definite osteophyte formation with possible joint space narrowing on anteroposterior weight-bearing radiograph

Grade 3: Multiple osteophytes, definite narrowing of joint space, some sclerosis and possible bony deformity

Grade 4: Large osteophytes, marked narrowing of joint space, severe sclerosis and definite bony deformity

*****Outerbridge Arthroscopic Grading System**

Grade 0: Normal cartilage

Grade I: Softening and swelling/blistering

Grade II: Partial thickness defect, fissures < 1.5cm diameter/wide

Grade III: Fissures /defects down to subchondral bone with intact calcified cartilage layer, diameter > 1.5cm

Grade IV: Exposed subchondral bone

******The International Cartilage Research Society (ICRS)**

Grade 0: Normal cartilage

Grade I: Nearly normal. Superficial lesions.

- A. Soft indentation
- B. And/or superficial fissures and cracks

Grade II: Abnormal. Lesions extending down to <50% of cartilage depth

Grade III: Severely abnormal

- A. Cartilage defects extending down >50% of cartilage depth
- B. And down to calcified layer
- C. And down to, but not through the subchondral bone
- D. And blisters

Grade IV: Severely abnormal (through the subchondral bone)

- A. Penetration of subchondral bone but not across entire diameter of defect
- B. Penetration of subchondral bone across the full diameter of the defect

**** American College of Rheumatology Guidelines 2010	
ACR/EULAR: Classification Criteria for RA	
JOINT DISTRIBUTION (0-5)	
1 large joint	0
2-10 large joints	1
1-3 small joints (large joints not counted)	2
4-10 small joints (large joints not counted)	3
>10 joints (at least one small joint)	5
SEROLOGY (0-3)	
Negative RF AND negative ACPA	0
Low positive RF OR low positive ACPA	2
High positive RF OR high positive ACPA	3
SYMPTOM DURATION (0-1)	
<6 weeks	0

≥6 weeks 1	1
ACUTE PHASE REACTANTS (0-1)	
Normal CRP AND normal ESR	0
Abnormal CRP OR abnormal ESR	1
≥6 = definite RA	

*******Marx Scale**

Indicate how often you performed each activity in your healthiest and most active state, in the past year.

Activity/movement	Less than 1 time/month	One time/month	One time/week	2-3 times/week	4+ times/week
Running: running while playing a sport or jogging	0	1	2	3	4
Cutting: changing directions while running	0	1	2	3	4
Deceleration: coming to a quick stop while running	0	1	2	3	4
Pivoting: turning your body with your foot planted while playing sport; For example: skiing, skating, kicking, throwing , hitting a ball (golf, tennis, squash), etc.	0	1	2	3	4

*******Tegner Score**

Level	Activity description
Level 10	Competitive sports: soccer, football, rugby (national elite)
Level 9	Competitive sports: soccer, football, rugby (lower divisions), ice hockey, wrestling, gymnastics, basketball
Level 8	Competitive sports: racquetball or bandy, squash or badminton, track and field athletics
Level 7	Competitive sports: tennis, running, motorcars speedway, handball Recreational sports: soccer, football, rugby, bandy, ice hockey, basketball, squash, racquetball, running
Level 6	Recreational sports- tennis and badminton, handball, racquetball, down-hill skiing, jogging at least 5 times per week
Level 5	Work- heavy labor (construction, etc.) Competitive sports: cycling, cross-country skiing; Recreational sports- jogging on uneven ground at least twice weekly
Level 4	Work- moderately heavy labor (e.g. truck driving, etc.)
Level 3	Work- light labor (nursing, etc.)

Level 2	Work: light labor Walking on uneven ground possible, but impossible to back pack or hike
Level 1	Work- sedentary (secretarial, etc.)
Level 0	Sick leave or disability pension because of knee problems

BILLING/CODING INFORMATION:

CPT Coding

27332	Arthrotomy, with excision of semilunar cartilage (meniscectomy) knee; medial OR lateral
27333	Arthrotomy, with excision of semilunar cartilage (meniscectomy) knee; medial AND lateral
27403	Arthrotomy with meniscus repair, knee
27405	Repair, primary, torn ligament and/or capsule, knee; collateral
27407	Repair, primary, torn ligament and/or capsule, knee; cruciate
27409	Repair, primary, torn ligament and/or capsule, knee; collateral and cruciate ligaments
27415	Osteochondral allograft, knee, open
27416	Osteochondral autograft(s), knee, open (eg, mosaicplasty) (includes harvesting of autograft[s])
27418	Anterior tibial tubercleplasty (eg, Maquet type procedure)
27420	Reconstruction of dislocating patella; (eg, Hauser type procedure)
27422	Reconstruction of dislocating patella; with extensor realignment and/or muscle advancement or release (eg, Campbell, Goldwaite type procedure)
27424	Reconstruction of dislocating patella; with patellectomy
27425	Lateral retinacular release, open
27427	Ligamentous reconstruction (augmentation), knee; extra-articular
27428	Ligamentous reconstruction (augmentation), knee; intra-articular (open)
27429	Ligamentous reconstruction (augmentation), knee; intra-articular (open) and extra-articular
29866	Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the autograft[s])
29867	Arthroscopy, knee, surgical; osteochondral allograft (eg, mosaicplasty)
29870	Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)
29873	Arthroscopy, knee, surgical; with lateral release
29874	Arthroscopy, knee, surgical; for removal of loose body or foreign body (eg, osteochondritis dissecans fragmentation, chondral fragmentation)
29875	Arthroscopy, knee, surgical; synovectomy, limited (eg, plica or shelf resection) (separate procedure)
29876	Arthroscopy, knee, surgical; synovectomy, major, 2 or more compartments (eg, medial or lateral)
29877	Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty)
29879	Arthroscopy, knee, surgical; abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture
29880	Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed
29881	Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed
29882	Arthroscopy, knee, surgical; with meniscus repair (medial OR lateral)

29883	Arthroscopy, knee, surgical; with meniscus repair (medial AND lateral)
29884	Arthroscopy, knee, surgical; with lysis of adhesions, with or without manipulation (separate procedure)
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
29889	Arthroscopically aided posterior cruciate ligament repair/augmentation or reconstruction

HCPCS Coding

G0289	Arthroscopy, knee, surgical, for removal of loose body, foreign body, debridement/shaving of articular cartilage (chondroplasty) at the time of other surgical knee arthroscopy in a different compartment of the same knee
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REIMBURSEMENT INFORMATION:

Refer to section entitled [POSITION STATEMENT](#).

PROGRAM EXCEPTIONS:

Federal Employee Program (FEP): Follow FEP guidelines.

State Account Organization (SAO): Follow SAO guidelines.

Medicare Advantage products: The following National Coverage Determination (NCD) was reviewed on the last guideline review date: Arthroscopic Lavage and Arthroscopic Debridement for the Osteoarthritic Knee (150.9), located at cms.gov.

DEFINITIONS:

No guideline specific definitions apply.

RELATED GUIDELINES:

[Autologous Chondrocyte Implantation \(ACI\), 02-20000-17](#)

[Meniscal Allograft Transplantation, 02-20000-25](#)

[Knee Arthroplasty, 02-20000-60](#)

OTHER:

None applicable.

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COMMITTEE APPROVAL:

This Medical Coverage Guideline (MCG) was approved by the Florida Blue Medical Policy & Coverage Committee on 06/27/19.

GUIDELINE UPDATE INFORMATION:

10/15/16	New Medical Coverage Guideline.
04/15/17	Revision: minor changes to lateral release/patellar realignment criteria (mercer merchant view changed to 45 degrees flexion). Updated references.
07/15/18	Scheduled review. Added general criteria for elective surgery of the knee. Revised criteria for diagnostic knee arthroscopy; debridement with/without chondroplasty; meniscectomy/meniscal repair; anterior cruciate ligament (ACL) reconstruction with allograft or autograft; posterior cruciate ligament (PCL) reconstruction; articular cartilage restoration/repair; loose body removal; lateral release/patellar realignment. Added Marx scale and Tegner score. Updated references.
07/15/19	Scheduled review. Revised criteria for diagnostic knee arthroscopy, meniscectomy/meniscal repair, lateral release/patellar realignment, and patellar malalignment and/or patellar instability. Updated references.
10/15/19	Revision; added clarifying language for relative versus absolute contraindications for meniscectomy and meniscal repair.