Medical Necessity Guidelines: Meniscal Allograft Transplantation of the Knee

Effective: August 10, 2016

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Applies to:
☒ Tufts Health Plan Commercial Plans products; Fax: 617.972.9409
☒ Tufts Health Direct — Health Connector; Fax: 888.415.9055
☒ Tufts Health Together — A MassHealth Plan; Fax: 888.415.9055
☐ Tufts Health Unify — OneCare Plan; Fax: 781.393.2607
☒ Tufts Health RITogether — A Rhode Island Medicaid Plan; Fax: 857.304.6404
☒ Tufts Health Freedom Plan products; Fax: 617.972.9409

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

OVERVIEW
Meniscal allograft transplantation is a surgical procedure that involves grafting a donor meniscus into the knee of a recipient. The objective of a meniscal allograft transplantation is to preserve the important role that the meniscus plays in knee stability and functioning by replacing a damaged meniscus with a transplanted one, or to reintroduce a meniscus in cases of an unsatisfactory meniscectomy outcome (Hayes, 2011).

COVERAGE GUIDELINES
Tufts Health Plan may authorize the coverage of meniscal allograft transplantation of the knee when ALL of the following are met:
- The Member is < 55 years old.
- The Member has a BMI of less than 35kg/m2.
- The meniscus is absent.
- There is pain in the involved compartment of the knee that has failed to respond to six weeks of conservative treatment including rest, anti-inflammatory medication, physical therapy and joint support.
- The knee is otherwise stable or an ACL repair is planned at the time of the transplant.
- There is no evidence or only minimal evidence of degenerative changes in the knee. This will be based upon a Kellgren Grade of 1 or Grade 2.

Kellgren-Lawrence scale

<table>
<thead>
<tr>
<th>Grade</th>
<th>Osteoarthrosis</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Grade 0</td>
<td>None</td>
<td>No radiographic features of osteoarthritis are present</td>
</tr>
<tr>
<td>Grade 1</td>
<td>Doubtful</td>
<td>Doubtful joint space narrowing (JSN) and possible osteophytic lipping</td>
</tr>
<tr>
<td>Grade 2</td>
<td>Minimal</td>
<td>Definite osteophytes and possible JSN on anteroposterior weight-bearing radiograph</td>
</tr>
<tr>
<td>Grade 3</td>
<td>Moderate</td>
<td>Multiple osteophytes, definite JSN, sclerosis and possible bony deformity</td>
</tr>
<tr>
<td>Grade 4</td>
<td>Severe</td>
<td>Large osteophytes, marked JSN, severe sclerosis and definitely bony deformity</td>
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CODES
The following CPT code requires prior authorization:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>Code</td>
<td>Description</td>
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<tr>
<td>-------</td>
<td>-----------------------------------------------------------------------------</td>
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<tr>
<td>29868</td>
<td>Arthroscopy, knee, surgical; meniscal transplantation (includes arthrotomy for meniscal insertion), medial or lateral</td>
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</tbody>
</table>

**REFERENCES**


**APPROVAL HISTORY**

May 14, 2014: Reviewed by Integrated Medical Policy Advisory Committee (IMPAC) for an October 1, 2014 effective date.

Subsequent endorsement date(s) and changes made:
- October 8, 2014: Reviewed by IMPAC, renewed without changes.
- September 9, 2015: Reviewed by IMPAC, renewed without changes.
- September 2015: Branding and template change to distinguish Tufts Health Plan products in "Applies to" section. Added Tufts Health Freedom Plan products, effective January 1, 2016.
- October 14, 2015. Reviewed by IMPAC. Clarifications to Kellgren-Lawrence scale.
- August 10, 2016: Reviewed by IMPAC, renewed without changes.
- April 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017.

**Background, Product and Disclaimer Information**

Medical Necessity Guidelines are developed to determine coverage for benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member’s benefit document, and in coordination with the Member’s physician(s) on a case-by-case basis considering the individual Member’s health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

Medical Necessity Guidelines apply to the fully insured Commercial and Medicaid products when Tufts Health Plan conducts utilization review unless otherwise noted in this guideline or in the Member’s benefit document, and may apply to Tufts Health Unify to the same extent as Tufts Health Together. This guideline does not apply to Tufts Medicare Preferred HMO, Tufts Health Plan Senior Care Options or to certain delegated service arrangements. For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern. Applicable state or federal mandates or other requirements will take precedence. For CareLink<sup>SM</sup> Members, Cigna conducts utilization review so Cigna’s medical necessity guidelines, rather than these guidelines, will apply.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of these guidelines is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.