

Surgery of the Elbow

Policy Number: 2023T0551X
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Application

UnitedHealthcare Commercial

This Medical Policy applies to all UnitedHealthcare Commercial benefit plans.

UnitedHealthcare Individual Exchange

This Medical Policy applies to Individual Exchange benefit plans in all states except for Colorado.

Coverage Rationale

Surgery of the elbow is proven and medically necessary in certain circumstances. For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures:

- Arthroscopy, Diagnostic, +/- Synovial Biopsy, Elbow
- Arthroscopy, Surgical, Elbow
- Joint Replacement, Elbow
- Removal or Revision, Arthroplasty, Elbow

Click [here](#) to view the InterQual® criteria.

Documentation Requirements

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The documentation requirements outlined below are used to assess whether the member meets the clinical criteria for coverage but do not guarantee coverage of the service requested.

CPT Codes*	Required Clinical Information
Surgery of the Elbow	
24360	Medical notes documenting the following, when applicable:
24361	
24362	

CPT Codes*	Required Clinical Information
Surgery of the Elbow	
24363	<p>surgery is being requested, which may include MRI, CT scan, X-ray, and/or bone scan; consultation with requesting surgeon may be of benefit to select the optimal images</p> <ul style="list-style-type: none"> ○ Diagnostic images must be labeled with: <ul style="list-style-type: none"> ▪ The date taken ▪ Applicable case number obtained at time of notification, or member's name and ID number on the image(s) ○ Submission of diagnostic imaging is required via the external portal at www.uhcprovider.com/paan; faxes will not be accepted ● Diagnostic image report(s) ● Reports of all recent imaging studies and applicable diagnostic tests) <ul style="list-style-type: none"> ○ Microbiological findings ○ Synovial fluid exam ○ Erythrocyte sedimentation rate (ESR) ○ C-reactive protein (CRP) ● Pertinent physical examination of the relevant joint Pain severity, circadian patterns of pain, location of pain, and details of functional disability(ies) interfering with activities of daily living (preparing meals, dressing, driving) ● Prior therapies/treatments tried, failed, or contraindicated; include the dates, duration, and reason for discontinuation ● Physician's treatment plan, including pre-op discussion ● For revision surgery, also include: <ul style="list-style-type: none"> ○ Details of complication ○ Complete (staged) surgical plan
24365	
24370	
24371	
29830	
29834	
29835	
29836	
29837	
29838	

*For code descriptions, refer to the [Applicable Codes](#) section.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
Arthroscopy, Surgical, Elbow	
29830	Arthroscopy, elbow, diagnostic, with or without synovial biopsy (separate procedure)
29834	Arthroscopy, elbow, surgical; with removal of loose body or foreign body
29835	Arthroscopy, elbow, surgical; synovectomy, partial
29836	Arthroscopy, elbow, surgical; synovectomy, complete
29837	Arthroscopy, elbow, surgical; debridement, limited
29838	Arthroscopy, elbow, surgical; debridement, extensive
Arthroplasty, Joint Replacement, Elbow	
24360	Arthroplasty, elbow; with membrane (e.g., fascial)
24361	Arthroplasty, elbow; with distal humeral prosthetic replacement
24362	Arthroplasty, elbow; with implant and fascia lata ligament reconstruction
24363	Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (e.g., total elbow)
24365	Arthroplasty, radial head

CPT Code	Description
Arthroplasty, Joint Replacement, Elbow	
24366	Arthroplasty, radial head; with implant
24370	Revision of total elbow arthroplasty, including allograft when performed; humeral or ulnar component
24371	Revision of total elbow arthroplasty, including allograft when performed; humeral and ulnar component

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U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

Surgeries of the elbow are procedures and, therefore, not regulated by the FDA. However, devices and instruments used during the surgery may require FDA approval. Refer to the following website for additional information:

<http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm>. (Accessed July 14, 2023)

Policy History/Revision Information

Date	Summary of Changes
11/01/2023	<p>Documentation Requirements</p> <ul style="list-style-type: none"> Updated list of required clinical information; replaced “prior therapies/treatments tried, failed, or contraindicated; include the dates and reason for discontinuation” with “prior therapies/treatments tried, failed, or contraindicated; include the dates, <i>duration</i>, and reason for discontinuation” <p>Supporting Information</p> <ul style="list-style-type: none"> Archived previous policy version 2023T0551W

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

This Medical Policy may also be applied to Medicare Advantage plans in certain instances. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence ([Medicare IOM Pub. No. 100-16, Ch. 4, §90.5](#)).

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.