| MEDICAL POLICY | Joint Resurfacing (Medicare Only) |
|---|---|
| **Effective Date: 10/1/2022**<br>  <br>10/1/2022<br>Medical Officer Date | Medical Policy Number: 353<br>Medical Policy Committee Approved Date: 9/2022 |

**See Policy CPT/HCPCS CODE section below for any prior authorization requirements**

## SCOPE:

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as "Company" and collectively as "Companies").

## APPLIES TO:

Medicare Only

## MEDICARE POLICY CRITERIA

**NOTE:** This medical policy does not address hip resurfacing which may be considered medically necessary.

The following Centers for Medicare & Medicaid Service (CMS) guidelines should be utilized for medical necessity coverage determinations. Click the link provided in the table below to access applicable medical necessity criteria. All listed guidelines apply.

| Service | Medicare Guidelines |
|---|---|
| *Joint Resurfacing* | There is no Medicare guidance for joint resurfacing for the plan's service area. Apply the Company medical policy for Joint Resurfacing (All Lines of Business Except Medicare)<br><br>I. These services are considered **not medically necessary** for Medicare based on the Company medical policy. *Services deemed "investigational" are considered not medically necessary for Medicare Plan members. See Policy Guidelines below.* |

# POLICY GUIDELINES

Medicare and Medical Necessity

The Company policy for *PHA Medicare Medical Policy Development and Application* (MP50) provides details regarding Medicare's definition of medical necessity and the hierarchy of Medicare references and resources during the development of medical policies, as well as the Plan's use of evidence-based processes for policy development. In the absence of Medicare coverage policies (e.g., manual, national coverage determination [NCD], local coverage determination [LCD], article [LCA], etc.) which addresses the medical necessity of a given medical service, Medicare regulatory guidelines do allow Medicare Advantage Organizations (MAOs) to make their own coverage determinations, as long as the MAO applies an objective, evidence-based process, based on authoritative evidence. *(Medicare Managed Care Manual, Ch. 4, §90.5)*

Following an evidence-based assessment of current peer-reviewed medical literature, the Company may consider certain medical services or technologies to be "investigational." The term "investigational" is not limited to devices or technologies which have not received the appropriate governmental regulatory approval (e.g., U.S. Food and Drug Administration [FDA]), but rather may also mean the procedure, device, or technology does not meet all of the Company's technology assessment criteria, as detailed within the Company policy for *Definition: Experimental/Investigational* (MP5).

For Medicare, only medically reasonable and necessary services or items which treat illness or injury are eligible for Medicare coverage, as outlined in *Title XVIII of the Social Security Act, §1862(a)(1)(A)*. Thus, services which lack scientific evidence regarding safety and efficacy because they are investigational are "not medically reasonable or necessary" for Medicare Plan members. *(Medicare Claims Processing Manual, Ch. 23, §30 A)*

# BILLING GUIDELINES

There are no specific codes to represent joint resurfacing of many joints, including joint resurfacing of the knee, shoulder, or metatarsal phalangeal (MTP) toe joint, therefore, an unlisted code should be used to report joint resurfacing procedures instead.

Arthroplasty codes (e.g., CPT 27447) may not be used to report joint resurfacing. If arthroplasty codes are billed in conjunction with joint resurfacing, other than the hip, then they will be denied as not medically necessary for Medicare Plan members.

If CPT code 20985 *(Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less (List separately in addition to code for primary procedure))* or 0055T *(Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on CT/MRI images (List separately in addition to code for primary procedure))*are billed in addition to other CPT codes reported for joint resurfacing (other than the hip) they will also be denied as not medically necessary for Medicare Plan members. Surgical procedures which use robotic surgical systems (HCPCS code S2900) are also not covered (see below for additional information).

The following HCPCS codes may be billed by the facility as part of the joint resurfacing procedure and are therefore not covered or separately reimbursable:

- C1776: Joint device (implantable)
- L8642: Hallux implant

HCPCS Code S2900

Like all S-codes, the *National Physician Fee Schedule Relative Value File (NPFSRVF)*, which is published by Medicare[1], indicates HCPCS code S2900 has been assigned a Status Indicator of "I." This is defined as "Not valid for Medicare purposes." In addition, HCPCS code S2900 is not recognized as a valid code for claim submission as indicated in the relevant Company Coding Policy *(HCPCS S-Codes and H-Codes,* 22.0*).* Providers need to use alternate available CPT or HCPCS codes to report for the service. If no specific CPT or HCPCS code is available, then an unlisted code may be used. Note that unlisted codes are reviewed for medical necessity, correct coding, and pricing at the claim level. Thus, if an unlisted code is billed related to a non-covered service addressed in this policy (including robotic surgical systems for a non-covered joint resurfacing procedure), it will be denied as not covered as well.

## CPT/HCPCS CODES

| Medicare Only | |
| --- | --- |
| Unlisted Codes<br>All unlisted codes will be reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is billed related to services addressed in this policy then it will be **denied as not covered.** | |
| 23929 | Unlisted procedure, shoulder |
| 27599 | Unlisted procedure, femur or knee |
| 28899 | Unlisted procedure, foot or toes |

## INSTRUCTIONS FOR USE

Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days notice of policy changes that are restrictive in nature.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement.

## REGULATORY STATUS

Mental Health Parity Statement

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

## REFERENCES

1. Medicare Physician Fee Schedule (PFS) Relative Value Files; Available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files