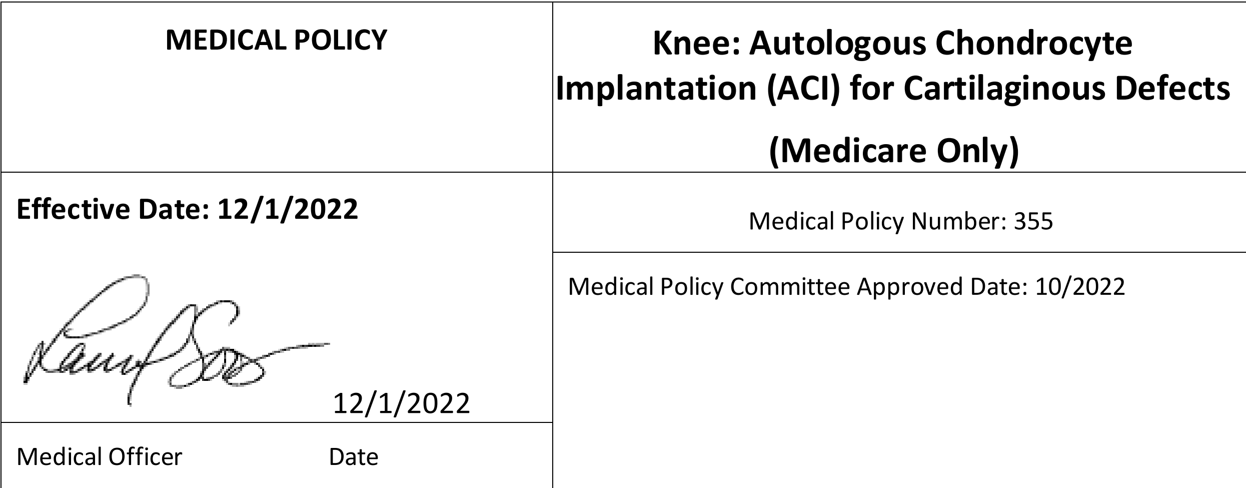

MEDICAL POLICY	Knee: Autologous Chondrocyte Implantation (ACI) for Cartilaginous Defects (Medicare Only)
Effective Date: 12/1/2022	Medical Policy Number: 355
12/1/2022	Medical Policy Committee Approved Date: 10/2022
Medical Officer Date	

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

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
Autologous Chondrocyte Implantation (ACI) for Cartilaginous Defects of the Knee	Company medical policy for Knee: Autologous Chondrocyte Implantation (ACI) for Cartilaginous Defects (All Lines of Business Except Medicare) I. These services may be considered **medically necessary** for Medicare when the Company medical policy criteria are met. II. These services are considered **not medically necessary** for Medicare Plan members either when the Company medical policy criteria are **not** met ***or*** when a service is deemed “investigational” by the Company 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 Medicare 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

General

There are a number nonspecific arthrotomy and arthroscopy codes that are not appropriate for autologous chondrocyte implantation (ACI), including but not limited to 27330, 27331, 27334, and 29879. Of note, 29879 should not be billed in conjunction with ACI unless performed in a different compartment of the knee.

Many of the codes in this policy are not specific to autologous chondrocyte implantation (ACI) and may be used for other restorative procedures for the knee, which are addressed in other medical policies. For example: 27415, 27416, 29866 and/or 29867 may also be requested for osteochondral autografting (mosaicplasty or OATS) or allografting. Please see the Cross References section below for applicable medical policies.

HCPCS Code S2112

Like all S-codes, the *National Physician Fee Schedule Relative Value File (NPFSRVF)*, which is published by Medicare[1], indicates HCPCS code S2112 has been assigned a Status Indicator of "I." This is defined as "Not valid for Medicare purposes." In addition, HCPCS code S2112 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, it will be denied as not covered.

CPT/HCPCS CODES

Medicare Only	
Prior Authorization Required	
27412	Autologous chondrocyte implantation, knee
27415	Osteochondral allograft, knee, open
27416	Osteochondral autograft(s), knee, open (eg, mosaicplasty) (includes harvesting of autograft[s])
29866	Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the autograft[s])
29867	Arthroscopy, knee, surgical; osteochondral allograft (eg, mosaicplasty)
J7330	Autologous cultured chondrocytes, implant
No Prior Authorization Required Note: Inclusion of a code in this section does not guarantee reimbursement or coverage. The following codes do not require routine review for medical necessity, but they may be subject to audit or benefit denial.	
27332	Arthrotomy, with excision of semilunar cartilage (meniscectomy) knee; medial OR lateral
27333	Arthrotomy, with excision of semilunar cartilage (meniscectomy) knee; medial AND lateral
29870	Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)
29871	Arthroscopy, knee, surgical; for infection, lavage and drainage
29874	Arthroscopy, knee, surgical; for removal of loose body or foreign body (eg, osteochondritis dissecans fragmentation, chondral fragmentation)
29877	Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty)
Not Covered	
S2112	Arthroscopy, knee, surgical for harvesting of cartilage (chondrocyte cells)

Unlisted Codes 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 **prior-authorization is required.**	
27599	Unlisted procedure, femur or knee
29999	Unlisted procedure, arthroscopy

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.

MEDICAL POLICY CROSS REFERENCES

- Knee: Meniscal Allograft Transplantation and Other Meniscal Implants (Medicare Only), MP356
- Knee: Osteochondral Allografts and Autografts for Cartilaginous Defects (Medicare Only), MP357

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