Medicare Medical Policy

Knee Arthroscopy and Meniscal Repair

MEDICARE MEDICAL POLICY NUMBER: 435

Effective Date: 7/1/2025

Last Review Date: 5/2025

Next Annual Review: 5/2026

INSTRUCTIONS FOR USE: Company Medicare Medical Policies serve as guidance for the administration of plan benefits and do not constitute medical advice nor a guarantee of coverage. Company Medicare Medical Policies are reviewed annually to guide the coverage or non-coverage decision-making process for services or procedures in accordance with member benefit contracts (otherwise known as Evidence of Coverage or EOCs) and Centers of Medicare and Medicaid Services (CMS) policies, manuals, and other CMS rules and regulations. In the absence of a CMS coverage determination or specific regulation for a requested service, item or procedure, Company policy criteria or applicable utilization management vendor criteria may be applied. These are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. 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.

The Company reserves the right to determine the application of Medicare Medical Policies and make revisions to these policies at any time. Any conflict or variance between the EOC and Company Medical Policy will be resolved in favor of the EOC.

SCOPE: Providence Health Plan, Providence Health Assurance, and Providence Plan Partners as applicable (referred to individually as “Company” and collectively as “Companies”).

PRODUCT AND BENEFIT APPLICATION

☒ Medicare Only

MEDICARE COVERAGE CRITERIA

IMPORTANT NOTE: More than one Centers for Medicare and Medicaid Services (CMS) reference may apply to the same health care service, such as when more than one coverage policy is available (e.g., both an NCD and LCD exist). All references listed should be considered for coverage decision-making. The Company uses the most current version of a Medicare reference available at the time of publication; however, these websites are not maintained by the Company, so Medicare references and their corresponding hyperlinks may change at any time. If there is a conflict between the Company Medicare Medical Policy and CMS guidance, the CMS guidance will govern.

Notes: This policy does not address all knee arthroscopy services. It is limited to the procedures listed in the "Code" table below. Unless addressed in a separate Medicare medical policy, arthroscopic knee procedures **not** addressed in this medical policy may be considered medically necessary.

Service	Medicare Guidelines
Arthroscopic Lavage and Arthroscopic Debridement for Osteoarthritic Knee	National Coverage Determination (NCD): Arthroscopic Lavage and Arthroscopic Debridement for the Osteoarthritic Knee (150.9) **NOTES:** 1. According to this NCD, "the following procedures **are not considered reasonable or necessary** in treatment of the osteoarthritic knee **and are not covered** by the Medicare program: • Arthroscopic lavage used alone for the osteoarthritic knee; • Arthroscopic debridement for osteoarthritic patients presenting with knee pain only; or, • Arthroscopic debridement and lavage with or without debridement for patients presenting with severe osteoarthritis (Severe osteoarthritis is defined in the Outerbridge classification scale, grades III and IV. Outerbridge is the most commonly used clinical scale that classifies the severity of joint degeneration of the knee by compartments and grades. Grade I is defined as softening or blistering of joint cartilage. Grade II is defined as fragmentation or fissuring in an area <1 cm. Grade III presents clinically with cartilage fragmentation or fissuring in an area >1 cm. Grade IV refers to cartilage erosion down to the bone. Grades III and IV are characteristic of severe osteoarthritis.)" 2. However, "**all other indications** of debridement for the subpopulation of patients without severe osteoarthritis of the knee who present with symptoms other than pain alone; i.e., (1) mechanical symptoms that include, but are not limited to, locking, snapping, or popping (2) limb and knee joint alignment, and (3) less severe and/or early degenerative arthritis, remain at local contractor discretion." Since

	there is no local contractor LCD, then our Company policy will be used below for these indications.

Medicare Coverage Criteria: "MA organizations may create publicly accessible internal coverage criteria… when coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs." *(§ 422.101(b)(6) – see Policy Guidelines below*)

- **Medicare Coverage Manuals:** Medicare does not have criteria for knee arthroscopy or meniscal repair in a coverage manual.
- **National Coverage Determination (NCD):** Medicare has an NCD for *Arthroscopic Lavage and Arthroscopic Debridement for the Osteoarthritic Knee* (150.9). This NCD provides non-covered indications for arthroscopic lavage and debridement, but it also states, "all other indications of debridement… remain at local contractor discretion." This NCD is considered "not fully established" under CFR § 422.101(6)(i)(B) as it provides explicit flexibility for coverage decisions beyond the NCD.
- **Noridian J-F Local Coverage Determination (LCD)/Local Coverage Article (LCA):** As of the most recent policy review, no Medicare Administrative Contractors (MACs) have LCDs for knee arthroscopy or meniscal repair procedures.
- Therefore, in the absence of **fully established** Medicare coverage criteria in a manual, NCD, LCD, or other regulatory guidance for the health plan's service area, Company criteria below are applied for medical necessity decision-making. In this case, Medicare coverage criteria are considered "not fully established" as defined under CFR § 422.101(6)(i)(B) as the available Medicare coverage policies provide flexibility for coverage decisions beyond the NCD and LCD. Use of this medical policy is intended to improve long-term outcomes following arthroscopic treatment of the knee by ensuring that conservative therapies are initiated before the surgical procedure.
- ***NOTE:*** *The summary of evidence, as well as the list of citations/references used in the development of the Company's internal coverage criteria, are publicly available and can be found using the Company medical policy link below [CFR § 422.101(6)(ii)(A) and (B)].*

Arthroscopic Lavage/Arthroscopic Debridement for Indications Not Addressed by the NCD *Other Knee Arthroscopic Procedures* *Arthroscopically Assisted Knee Procedures* *Meniscal Repair Procedures*	Company medical policy for Knee Arthroscopy and Meniscal Repair 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 when the Company medical policy criteria are not met. *See Policy Guidelines below.*

IMPORTANT NOTICE: While some services or items may appear medically indicated for an individual, they may also be a direct exclusion of Medicare or the member's benefit plan. Such excluded services or items by Medicare and member EOCs include, but are not limited to, services or procedures considered to be cosmetic, not medical in nature, or those

considered not medically reasonable or necessary under *Title XVIII of the Social Security Act, §1862(a)(1)(A).* If there is uncertainty regarding coverage of a service or item, please review the member EOC or submit a pre-service organization determination request. Note that the Medicare Advance Beneficiary Notice of Noncoverage (ABN) form **cannot** be used for Medicare Advantage members. *(Medicare Advance Written Notices of Non-coverage. MLN006266 May 2021)*

POLICY CROSS REFERENCES

- Autologous Chondrocyte Implantation (ACI) for Cartilaginous Defects of the Knee, MP355

POLICY GUIDELINES

MEDICARE AND MEDICAL NECESSITY

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)*. MA organizations (MAOs) make medical necessity determinations based on coverage and benefit criteria, current standards of care, the member's unique personal medical history (e.g., diagnoses, conditions, functional status, co-morbidities, etc.), physician recommendations, and clinical notes, as well as involvement of a plan medical director, where appropriate. *(§ 422.101(c)(1))*

In addition:

> "MA organizations may create publicly accessible internal coverage criteria that are based on current evidence in widely used treatment guidelines or clinical literature when coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs. Current, widely-used treatment guidelines are those developed by organizations representing clinical medical specialties, and refers to guidelines for the treatment of specific diseases or conditions. Acceptable clinical literature includes large, randomized controlled trials or prospective cohort studies with clear results, published in a peer-reviewed journal, and specifically designed to answer the relevant clinical question, or large systematic reviews or meta-analyses summarizing the literature of the specific clinical question." *(§ 422.101(b)(6) and Medicare Managed Care Manual, Ch. 4, §90.5)*

The Plan's 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.

While the CMS NCD 150.9 provides noncovered indications for arthroscopic lavage and/or arthroscopic debridement of the osteoarthritic knee, there are not fully established coverage criteria for **other** knee arthroscopy or meniscal repair procedures, or for arthroscopic lavage and debridement for other indications available in applicable Medicare statutes, regulations, NCDs or LCDs, then Company medical policy criteria will be applied. See the Medicare Coverage Criteria table above for more information regarding the use of internal coverage criteria when Medicare coverage criteria are not fully established.

REGULATORY STATUS

U.S. FOOD & DRUG ADMINISTRATION (FDA)

While clearance by the Food and Drug Administration (FDA) is a prerequisite for Medicare coverage, the 510(k) premarket clearance process does not in itself establish medical necessity. Medicare payment policy is determined by the interaction of numerous requirements, including but not limited to, the availability of a Medicare benefit category and other statutory requirements, coding and pricing guidelines, as well as national and local coverage determinations and clinical evidence.

BILLING GUIDELINES AND CODING

GENERAL

This policy does not address all knee arthroscopy services. It is limited to the procedures listed below.

CODES*		
CPT	27422	Reconstruction of dislocating patella; with extensor realignment and/or muscle advancement or release (eg, Campbell, Goldwaite type procedure)
	27427	Ligamentous reconstruction (augmentation), knee; extra-articular
	27428	Ligamentous reconstruction (augmentation), knee; intra-articular (open)
	29870	Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)
	29871	Arthroscopy, knee, surgical; for infection, lavage and drainage
	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)
	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)
	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	None	

***Coding Notes:**

- The code list above is provided as a courtesy and may not be all-inclusive. Inclusion or omission of a code from this policy neither implies nor guarantees reimbursement or coverage. Some codes may not require routine review for medical necessity, but they are subject to provider contracts, as well as member benefits, eligibility and potential utilization audit. According to Medicare, "presence of a payment amount in the MPFS and the Medicare physician fee schedule database (MPFSDB) does not imply that CMS has determined that the service may be covered by Medicare." The issuance of a CPT or HCPCS code or the provision of a payment or fee amount by Medicare does **not** make a procedure medically reasonable or necessary or a covered benefit by Medicare. *(Medicare Claims Processing Manual, Chapter 23 - Fee Schedule Administration and Coding Requirements, §30 - Services Paid Under the Medicare Physician's Fee Schedule, A. Physician's Services)*
- All unlisted codes are reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is submitted for non-covered services addressed in this policy then it will be **denied as not covered**. If an unlisted code is submitted for potentially covered services addressed in this policy, to avoid post-service denial, **prior authorization is recommended**.
- **See the non-covered and prior authorization lists on the Company Medical Policy, Reimbursement Policy, Pharmacy Policy and Provider Information website for additional information.**
- HCPCS/CPT code(s) may be subject to National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) bundling edits and daily maximum edits known as "medically unlikely edits" (MUEs) published by the Centers for Medicare and Medicaid Services (CMS). This policy does not take precedence over NCCI edits or MUEs. Please refer to the CMS website for coding guidelines and applicable code combinations.

REFERENCES

None

POLICY REVISION HISTORY

DATE	REVISION SUMMARY
7/2025	New Medicare Advantage medical policy