

Medicare Medical Policy

Joint Resurfacing

MEDICARE MEDICAL POLICY NUMBER: 353

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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.

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

Service	Medicare Guidelines
Joint Resurfacing (except for the hip)	There is no Medicare guidance for joint resurfacing for the plan's service area. Apply the Company medical policy for Joint Resurfacing I. These services are considered not medically necessary for Medicare based on the Company medical policy. <u>See Policy Guidelines below.</u>

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

None

The full Company portfolio of Medicare Medical Policies is available online and can be [accessed here](#).

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)*.

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.

During the MAO review, an evidence-based process must be used. This includes using authoritative evidence, such as studies performed by government agencies (i.e., the FDA), well-designed clinical studies that appeared in peer reviewed journals, and evaluations performed by independent technology assessment groups. (*Medicare Managed Care Manual, Ch. 4, §90.5*) In addition to review of the quality of the body of studies and the consistency of the results, additional consideration may be given to determine if the evidence can be generalized to the Medicare population.

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

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.

As indicated in the relevant Company policies (Reimbursement Policy for *Robotic Surgical Systems* [UM1] **and** Medical Policy for *Computer-Assisted Navigation (Medicare Only)* [MP376]), the use of robotic or computer assistance for musculoskeletal procedures (i.e., MAKOplasty), regardless of code used (e.g., 0054T, 0055T, 20985, S2900, an unlisted code, etc.) will not be allowed coverage or separate payment, whether the primary surgical procedure is considered medically necessary or not.

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 as an associated service to a non-covered surgery:

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

CODES*		
CPT	23929	Unlisted procedure, shoulder
	27599	Unlisted procedure, femur or knee
	28899	Unlisted procedure, foot or toes
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
10/2022	New Medicare Advantage medical policy (converted to new format 2/2023)
4/2023	Interim update, changes to “Billing Guidelines”
10/2023	Annual review, no changes