Medical Coverage Policy

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Miscellaneous Musculoskeletal Procedures

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Coverage Policy

Articular Cartilage Repair
Each of the following procedures* is considered experimental, investigational or unproven for treatment of articular cartilage defects in locations other than the distal femur of the knee:

- autologous chondrocyte implantation (e.g., Carticel®, MACI® [Vericel Corporation, Cambridge, MA])
- osteochondral allograft transplantation
- osteochondral autograft transplantation

*Note: Please reference the Cigna Medical Policy - Musculoskeletal “CMM 312 Knee Surgery: Arthroscopic and Open Procedures” for medical necessity criteria for defects within the knee.

Bone or Cartilage Filler Materials
Each of the following bone or cartilage filler materials is considered experimental, investigational or unproven for the treatment of articular cartilage defects:

- synthetic resorbable polymers (e.g., PolyGraft™, BGS, TruFli® [cylindrical plug], TruGraft™ [granules])
- juvenile cartilage allograft tissue implantation, including minced cartilage (e.g., DeNovo® NT Natural Tissue Graft, DeNovo® ET™ Engineered Tissue Graft [ISTO Technologies, Inc., St. Louis, MO / Zimmer, Inc., Warsaw IN]; BioCartilage® [Arthrex, Naples, Florida])
- decellularized osteochondral allograft implant (e.g., Chondrofix® Osteochondral Allograft [Zimmer Biomet, Warsaw, IN])
**Ligament/Meniscus Reconstruction**
Each of the following is considered experimental, investigational or unproven when used alone or as part of a ligament or meniscus reconstruction, regeneration, or transplantation:

- autologous platelet-derived growth factors (e.g., platelet rich plasma)
- bioactive scaffolds (e.g., collagen meniscal implants)
- bioresorbable porous polyurethane
- Healing Response Technique
- meniscal prosthesis
- tissue-engineered menisci
- xenografts

**Miscellaneous Knee Replacement Procedures**
Each of the following is considered experimental, investigational or unproven:

- knee replacement procedures customized to the individual, including ANY of the following:
  - customized templates, and/or instrumentation
  - customized knee implant
  - gender specific implant
- minimally invasive knee replacement
- focal resurfacing of a single knee joint defect (e.g., HemiCAP™, UniCAP™)

**Preoperative Imaging**
Pre-operative advanced imaging studies (e.g., CT scans, MRI) associated with customized knee replacement are considered experimental, investigational or unproven.

Pre-operative advanced imaging studies (e.g., CT scans, MRI) associated with intraoperative navigation (e.g., MAKOplasty) are considered not medically necessary.

**Overview**
This Coverage Policy addresses miscellaneous musculoskeletal procedures, including but not limited to custom and/or minimally invasive knee replacement procedures, focal resurfacing of a knee joint and articular cartilage repair involving joint surfaces in other than the knee.

**General Background**

**Articular Cartilage Repair**
Autologous chondrocyte implantation (ACI), also referred to as autologous chondrocyte transplantation (ACT), utilizes a patient’s own cells in an effort to repair damage to articular cartilage with the goal of improving joint function and reducing pain. The procedure involves the collection and culture of articular cartilage cells (i.e., chondrocytes) that are then implanted into the cartilage defect with the intent that the cultured cells will contribute to the regeneration and repair of the articular surface.

Normal articular cartilage is a complex tissue composed of matrix, chondrocytes and water. The chondrocytes are responsible for synthesizing the matrix, which is composed primarily of collagen fibers, hyaluronate, and sulfated proteoglycans. Cartilage has a poor intrinsic ability to heal itself. When a full-thickness cartilage injury occurs, the articular surface does not usually regenerate on its own. Pain, effusion, and mechanical symptoms are associated with cartilaginous defects.

According to the American Academy of Orthopaedic Surgeons (AAOS), two procedures commonly used to restore articular cartilage include autologous chondrocyte implantation and osteochondral autograft/allograft transplantation (AAOS, 2009).
**Autologous Chondrocyte Repair**

Autologous chondrocyte implantation (ACI), a type of tissue engineering, is proposed as surgical treatment for individuals with deep cartilage defects in the knee and involves replacing the defective cartilage with cultured chondrocytes that will produce articular cartilage similar in composition and properties to the original tissue. Based on the available evidence, guidelines, and FDA indications for use, ACI should be limited to use as a second-line treatment for carefully selected symptomatic individuals with defects of the femoral condyle caused by acute or repetitive trauma who have had an inadequate response to prior arthroscopic or other surgical repair.

**U.S. Food and Drug Administration (FDA):** Until recently, Carticel® (Vericel Corporation, Cambridge, MA) was the only technology that received FDA approval for the culturing of chondrocytes. In December 2016, MACI® (autologous cultured chondrocytes on porcine collagen membrane) (Vericel Corporation, Cambridge, MA) received approval from the U.S. Food and Drug Administration as an autologous cellularized scaffold indicated for repair of single or multiple symptomatic, full-thickness cartilage defects of the knee with or without bone involvement in adults. The safety and effectiveness of MACI Implant in joints other than the knee and in individuals over age 55 has not been established.

**Literature Review:** Although there is sufficient evidence to support improved clinical outcomes using ACI for a subset of individuals with articular cartilage defects of the knee joint, evidence in the medical literature is insufficient to support the use of ACI for articular cartilage lesions of other joints, including but not limited to the tibia/patella, ankle, hip or shoulder. Additionally, published evidence does not support clinical utility for the treatment of generalized osteoarthritis (Brown, et al., 2005; Washington State Department of Labor and Industries, 2004, updated 2012). Hayes, Inc. noted in an updated Medical Technology Directory Report evaluating ACI of the knee (Hayes, 2016) evidence is insufficient to support safety and effectiveness of ACI for multiple defects of a femoral chondyle, defects of the patella or trochlea, and osteochondritis dissecans.

**Use Outside of the US:** MACI has been available for use in Europe and Australia.

**Osteochondral Autograft**

Osteochondral autologous transplant involves the placement of viable hyaline cartilage grafts obtained from the individual into a cartilage defect. The grafts are harvested from a nonweight-bearing region of the joint during an open or arthroscopic procedure and then transplanted into a cartilage defect to restore the articular surface of the bone. Osteochondral autologous transfers are performed mainly to treat small and medium-size focal chondral and osteochondral defects of the weight-bearing surfaces of the knee joint (i.e., distal femur) but have also been used in the ankle, patella, elbow and tibia. The most common donor sites, whether the recipient site is in the knee or another joint, are the medial and lateral trochlea and the intercondylar notch.

The advantages of using autograft include graft availability, the absence of possible disease transmission risk, and that the procedure is a single-stage procedure. Disadvantages reported include donor site morbidity and limited available graft volume. In addition, tissue may have to be harvested from two different donor sites in order to provide enough material for a large defect without compromising the donor site.

There are two forms of osteochondral autografting addressed in the medical literature: mosaicplasty and the osteochondral autograft transplantation system (OATS®) procedure.

The mosaicplasty procedure consists of harvesting cylindrical bone-cartilage grafts and transplanting them into focal chondral or osteochondral defects in the knee. A recipient tunnel is created and sized with a drill bit slightly larger than the length of the graft. The harvested graft is placed in the tunnel by a press-fit method. All subsequent grafts are inserted in a similar pattern. Donor sites are routinely left open and fill with cancellous bone and fibrocartilage within 4–8 weeks. Authors claim that mosaicplasty reduces the possibility of donor-site morbidity and produces a more even surface (Scapinelli, et al., 2002).

The OATS procedure is similar to mosaicplasty, involving the use of a larger, single plug that fills an entire defect. It is often performed to graft chondral defects that are also associated with anterior cruciate ligament (ACL) tears. Increased donor-site morbidity has been reported by some authors with the use of larger, single plugs.
**Patella:** Osteoarthritis conditions may affect the patella. Osteoarthritis dissecans may occur on the medial or lateral facet and the central ridge or the medial or lateral aspect of the trochlea. Treatments for osteoarthritis of the patella typically include patellectomy, realignment procedures, arthroplasty, and resurfacing methods, all of which have varying degrees of success. When mechanical symptoms persist with pain and swelling despite conservative treatment or microfracture, some authors recommend autologous osteochondral transplant. Nevertheless, patella cartilage is thicker than cartilage in other areas of the knee, and the differences between the donor cartilage and patella cartilage may lead to suboptimal clinical outcomes (Nho, et al., 2008).

There are few studies that specifically report on autologous osteochondral transplantation of the patella and much of the evidence is in the form of case reports or case series lacking control groups and statistical evaluation (Nho, et al., 2008; Visona, et al., 2010; Astur, et al., 2014). The reported clinical outcomes have not been as encouraging compared to those of the femoral condyles although some studies do support improvement in knee function scores following surgery. One group of authors reported that the results of patellar and trochlear osteochondral plug transfers had 79% good to excellent results compared to 92% good to excellent results in a femoral condyle group (Hangody and Fules, 2003). Another group of authors compared autologous chondrocyte implantation to mosaicplasty for treatment of femoral condyle lesions or patellar lesions. They reported that patients who underwent patellar mosaicplasty had fair to poor arthroscopic appearance in addition to 60% good to excellent results. This group of authors indicated the primary reason for failure may have been due to differences in articular cartilage thickness and concluded that the procedure was contraindicated for chondral lesions of the patella (Bentley, et al., 2003). Evidence in the published scientific literature evaluating patella osteochondral autografts is limited, the reported clinical outcomes are mixed, sample populations are small and patient selection criteria have not been clearly defined. At present, there is insufficient data to support the clinical efficacy of osteochondral autograft transplant for the patella.

**Ankle:** Older patients and those with severe arthritis or large lesions of the ankle generally undergo ankle fusion or replacement as standard treatment. Ankle replacement has not been successful in many patients, and ankle fusion, while associated with pain relief, may result in functional limitations. Osteochondral autografting has been proposed as an alternative method of treatment for individuals with lesions of the ankle. Although patient selection criteria are not clearly defined, osteochondral autograft of the talus has been recommended for individuals with advanced disease, continued pain and decreased function despite prior conservative management and/or prior arthroscopic procedures, and who are not considered candidates for ankle arthrodesis. Proponents additionally recommend absence of ankle arthritis, infection, bipolar lesions and/or diffuse osteonecrosis of the talar dome.

Preliminary clinical trials demonstrated encouraging results for patients who underwent osteochondral autograft transplant for treatment of symptomatic osteochondral defects of the talus (Hangody, et al., 2001; Mendicino, et al., 2001; Al Shaihk, et al., 2002). Despite these early results, it has been noted in the medical literature that there are some challenges with this method of treatment. Reported concerns include the differences in the characteristics between knee and ankle cartilage, associated donor site morbidity, and complications which may arise from medial and lateral osteotomies (Easley and Scranton, 2003).

Evidence evaluating use in ankles is limited to retrospective and prospective case series and few randomized controlled trials, nonrandomized controlled trials involving small patient populations and published reviews (Kolker, et al., 2004; Giannini, et al., 2005; Kruetz, et al., 2005; Balzer and Arnold, 2005; Scranton, et al., 2006; Gobbi, et al., 2006; Reddi, et al., 2006; Saxena and Elkin, 2007; Zengerink, et al., 2010; Berlet, et al., 2011; Imhoff, et al., 2011; Emre, et al., 2012; Paul, et al, 2012; Hayes, 2014; Yoon, et al., 2014; Giorgiannos, Bisbinas, 2014). The evidence base is not as robust when compared to that evaluating the knee, although reported clinical outcomes extend short-to intermediate-term; on average two to eight years post-operatively. In general, the clinical outcomes have been mixed regarding improvement in postoperative pain and function, with some authors reporting high failure rates and the need for further surgery. In 2004 Kolker et al. reported their concern as to the overall efficacy of the procedure when used in the treatment of full-thickness, advanced, osteochondral defects of the talar dome. Open bone grafting did not predictably improve symptoms and yielded poor results in the patient population studied. Authors have acknowledged further well-designed studies with larger sample size are needed to assess improved long-term outcomes (Balzer and Arnold, 2005; Scranton, et al., 2006).
recent literature continues to support clinical outcomes that are mixed (Zengerink, et al., 2010; Yoon et al., 2014).

**Elbow:** There is insufficient evidence in the peer-reviewed, published scientific literature evaluating the use of osteochondral autograft transplantation to treat lesions of the elbow. Many of the trials consist of small patient populations, lack control or comparative groups and evaluate short-term outcomes (Shimada, et al., 2005; Tsuda, et al., 2005; Yamamoto, et al., 2006; Iwasaki, et al., 2006; Ansah, et al., 2007, Oveson, et al., 2011; Shimada, et al, 2012). Mid to long-term outcomes have been reported (Vogt, et al, 2011), however the sample population of this trial were small and the study was not designed to be comparative. The results of some studies demonstrate improved pain scores in addition to radiograph confirmation of graft incorporation (Shimada, et al., 2005; Iwasaki, et al., 2006; Ansah, et al., 2007, Iwasaki, et al., 2009, Shimada, et al, 2012). Few studies reported that radiographs showed no signs of degenerative changes or osteoarthritis at follow-up (Ansah, et al., 2007). de Graaf et al. (2011) conducted a systematic review of articles (case series) evaluating osteochondral autograft for treatment for osteochondritis dissecans of the elbow and reported the quality of the evidence was methodologically poor. The outcomes reported regarding pain, return to sports and elbow function were satisfactory however the authors noted further long-term clinical trials supporting efficacy are needed. Larger clinical trials evaluating long-term outcomes compared to conventional methods of treatment are needed to support widespread use of this procedure.

**Shoulder:** Focal osteochondral lesions of the shoulder are less common than those of the knee or ankle. Although evidence is limited, authors have reported on osteochondral autologous transplant as a method of treatment for full-thickness osteochondral lesions of the shoulder. Evidence consists primarily of case reports and small case series evaluating outcomes that, on average, extend two to four years (Schiebel, et al., 2004; Park, et al., 2006). One group of authors (Kircher, et al., 2009) reported results at a mean follow-up of 8.75 years for a group of seven individuals; (short-term results for this same group were previously reported by Schiebel, et al., 2004). The authors noted that there was no deterioration and no complications. Arthritis of the shoulder developed in all patients although findings were not matched by functional restriction, pain or loss of patient satisfaction. The authors acknowledged further studies are needed evaluating long term outcomes and comparing results of other bone-stimulation techniques. At present, there is insufficient data to support the efficacy of osteochondral autograft transplant for the shoulder.

**Osteochondral Allograft**

The use of allograft cartilage has the advantage of providing osteochondral segments that are able to survive transplant, having the ability to heal to recipient-site tissue, and no associated donor site morbidity. Small grafts have been used for damaged regions of articular cartilage in young, physically active patients.

Allograft size is not well delineated in the medical literature. Osteochondral allografts can be either dowel grafts (i.e., cylindrical) or shell grafts (i.e., noncylindrical). Dowel grafts are inserted by press fit and are similar to the OATS procedure. Shell grafts are not limited by size or shape, are formed to match the size or contour of the defect and require supplemental fixation. Sizing of allografts can be difficult although some authors recommend using allografts for defects greater than 2.5 cm (Caldwell and Shelton, 2005). Furthermore, while surgeons generally restrict the use of autografts to lesions less than 2 cm, dowel grafts may be applicable to lesions up to 35 mm. Some surgeons have used allografts to treat lesions that are 1 cm², although many experts suggest lesion size of 2–3 cm² or greater (Alford and Cole, 2005).

To ensure cellular viability, osteochondral allografts are generally implanted fresh (Brautigan, et al., 2003). The osteochondral allograft procedure typically involves an arthrotomy incision rather than arthroscopic, with the transplantation of a piece of articular cartilage and attached chondrocytes from a cadaver donor to the damaged region of the articular surface of the joint. Cryopreservation often damages the cartilage matrix and kills the chondrocytes. Chondrofix® (Zimmer Biomet, Warsaw, IN) is an osteochondral allograft composed of decellularized hyaline cartilage and cancellous bone. Chondrofix is a donated human tissue graft regulated by the FDA which undergoes proprietary processing to remove lipids and decontaminate the tissue, preserving hyaline cartilage (Gomoll, 2016; Farr, et al., 2016). The allograft material can be used off-the-shelf, can be stored up to 24 months at less than 40 degrees C, and is not to be frozen. Purportedly Chondrofix offers structural and osteoconductivity benefits similar to an OATS procedure, removes associated donor site morbidity and eliminates wait time for a fresh allograft (Degen, et al., 2016). Evidence in the peer-reviewed published scientific literature evaluating decellularized cartilage for treatment of osteochondral cartilage defects is limited. Farr et al.
(2016) reported the results of a retrospective case series (n=32) evaluating the use of decellularized allograft for treatment of osteochondral cartilage defects. The authors reported failure in 72% of the subjects (n=23) within two years of implantation. Failure was defined as structural damage to the allograft plug using MRI or arthroscopic evaluation demonstrating evidence of subchondral collapse or loss of > 50% of the articular cartilage cap of a plug. Whether or not implantation of decellularized cartilage promotes cell remodeling and repair has not been firmly established in the published scientific literature.

Evidence in the published scientific literature evaluating allograft transplant primarily addresses defects of the knee and ankle, is limited and evaluates short- to intermediate-term outcomes. Authors have reported that treatment of talus lesions in particular, is technically challenging but may allow patient’s avoidance of other end-stage procedures, similar to indications for osteochondral autografts. Allograft of the talus however is generally reserved for larger extensive lesions and/or when autograft is not available. Evidence regarding defects of other joints (e.g., elbow, shoulder) is also limited and does not allow strong conclusions regarding the efficacy of the procedure.

**Ankle:** Evidence in the published medical literature evaluating allografts as a method of treatment for osteochondral lesions of the ankle is inconsistent. Data from well-designed controlled clinical trials that compare osteochondral allografting of the ankle with accepted standards of care (i.e., ankle fusion, ankle arthroplasty) are lacking. Many of the studies are retrospective or prospective case series involving small patient populations and lack controls (Gross, et al., 2001; Kim, et al., 2002; Tontz, et al., 2003; Rodriguez, et al., 2003; Meehan, et al., 2005; Jeng, et al., 2008; Valderrabano, et al., 2009; Hahn, et al, 2010; Gortz, et al., 2010; Adams, et al., 2011; Haene, et al., 2011, Galli, et al., 2014). Some authors have reported clinical outcomes extending as long as 12 years, (Gross, et al., 2001; Kim, et al., 2002) but in general follow-up extends on average to two years. Some studies have demonstrated a trend toward short-term improvement in pain and function, however high failure rates have also been reported (Kim, et al., 2002; Jeng, et al., 2008; Haene, et al., 2011, Haene, et al, 2012; Bugbee, et al 2013). Few studies reporting long term clinical outcomes are available.

Clinical failure and reported reoperation rates are high. One group of authors (Valderrabano et al., 2009) reported the results of a case series (n=21) and acknowledged long-term clinical outcomes were moderate. At a mean of 72 months, 12 patients were available for follow-up—radiologically recurrent lesions were noted in 10 of 10 cases and in all 12 there was some degree of cartilage degeneration and discontinuity of the subchondral bone. Short-term subjective outcomes were reported as good to excellent. In 2013 Bugbee et al. published the results of a case series with mean follow-up of 5.3 years. Patients with intact grafts showed improvement in ankle pain and function in addition to high levels of satisfaction with the procedure at average follow-up of 5.3 years. However, 36 of 82 ankles (42%) required further surgical procedures after allograft transplantation. A total of 25 (29%) were defined as clinical failures; 10 underwent revision of the graft, seven underwent arthrodesis and two underwent amputation due to persistent pain. Radiographs categorized 29 (46%) as failures (>50% joint space narrowing) at 3.5 years mean follow-up. At five years and 10 years, survivorship of the graft was 76% and 44% respectively. The authors acknowledged their reoperation and revision rates were higher than those reported for ankle arthrodesis or arthroplasty (Bugbee, et al, 2013).

In general, reported complications associated with allograft transplant of osteochondral ankle lesions include graft fracture, graft fragmentation, poor graft fit, graft subluxation, and non-union. Patients with unsuccessful outcomes after allografting have required ankle fusion or ankle arthroplasty (Gross, et al., 2001; Jeng, et al., 2008). As a result of these and other limitations of the medical literature, accurate conclusions cannot be made regarding the efficacy of osteochondral allografting for articular disorders of the ankle.

**Patella:** There are few studies evaluating osteochondral resurfacing of the patella (AAOS, 2001; Jamali, et al., 2005; Spak and Teitge, 2006; Gracitelli, et al., 2015). Much of the evidence consists of case series without controls and small sample populations; as such results can not be generalized to larger groups of patients. While some of the results have been successful with authors reporting good to excellent scores for pain relief, function and range of motion, overall the evidence is insufficient to draw reliable conclusions regarding efficacy. In one study the authors reported additional surgery was performed in 12 of the 14 knees; the most common reason being symptomatic hardware (Spak and Teitge, 2006).
**Professional Societies/Organizations:** In 2013 the American Orthopaedic Foot and Ankle Society (AOFAS, 2013) published a position statement supporting osteochondral transplantation for the treatment of osteochondral lesions of the talus when the individual has failed non-operative management, particularly for large diameter lesions (>15 mm in diameter) and cystic lesions (i.e., cyst in subchondral bone).

The Washington State Health Care Authority technology assessment program published a technology assessment evaluating Osteochondral Allograft/Autograft Transplantation (2011). Regarding the evidence for the effectiveness of autograft OAT/mosaicplasty in the knee and ankle, there were substantial differences in patient populations, comparators, and outcome measures across all studies and given the high potential for bias, it was noted no firm conclusions could be drawn.

The American College of Rheumatology (ACR) Recommendations for the Medical Management of Osteoarthritis of the Hip and Knee (ACR, 2000) has noted that significant advances such as autologous chondrocyte transplantation, cartilage repair using mesenchymal stem cells, and autologous osteochondral plugs are being investigated; however, they do not recommend those procedures for the treatment of patients with osteoarthritis. There has been no update to the recommendations since the initial publication in 2000.

**Use Outside of the US:** No relevant statements.

**Articular Cartilage Repair Coding and Billing Information**

**Bone or Cartilage Filler Materials**

**Synthetic Resorbable Polymers**

Synthetic bone void fillers can be categorized into ceramics, polymers and composites. Ceramics are osteoconductive and are composed of calcium; total degradation time depends on the composition. Composite grafts combine osteoconductive matrix with bioactive agents that provide osteoinductive and osteogenic properties. Polymers are osteoconductive and when used with marrow could provide a biodegradable osteoinductive implant for repairing large defects. Synthetic bone void fillers have been proposed by some researchers as an alternative to allografting.

**U.S. Food and Drug Administration (FDA):** PolyGraft BGS (bone graft substitute), a resorbable bone void filler, was granted 510(k) marketing approval by the FDA in 2003 because it was considered to be substantially equivalent to another device already on the market (i.e., Wright Plaster of Paris Pellets [K963562] and ProOsteon 500R [K980817]). The device is a Class II device intended for filling bony voids or gaps caused by trauma or surgery that are not intrinsic to the stability of bony structure.

**Literature review:** Although synthetic resorbable polymers, such as PolyGraft, are available and have been proposed as bone graft substitute materials (Gardiner and Weitzel, 2007; Niederauer, et al., 2006), the available evidence for their use consists mainly of studies performed on animals. Human studies in the published scientific literature are limited and consist mainly of a few case reports and case series. Although some clinical outcomes are encouraging, poor clinical outcomes such as persistent pain, functional deficits and failure of graft incorporation have been reported and lend support to problems with biocompatibility when using synthetic implants for some individuals. Consequently, evidence in the medical literature is insufficient to support the potential value of synthetic resorbable polymers as an alternative to allograft or autograft for the repair of osteochondral defects.

**Minced Juvenile Cartilage Allograft (DeNovo® NT Natural Tissue Graft , DeNovo® ET™ Engineered Tissue Graft [ISTO Technologies, Inc., St. Louis, MO, Zimmer, Inc., Warsaw IN])**

Filling defects with minced articular cartilage (autologous or allogeneic), is a single-stage procedure that is being investigated for cartilage repair. DeNovo® NT Natural Tissue Graft is a juvenile cartilage allograft tissue intended for the repair of articular cartilage defects (e.g., knee, ankle, hip, shoulder, elbow, great toe). The DeNovo NT Graft consists of particulated natural articular cartilage with living cells. Tissues are recovered from juvenile donor joints. The cartilage is manually minced to help with cell migration from the extracellular matrix and facilitate fixation. During implantation, the minced cartilage is mixed in a fibrin glue adhesive. According to the National Institutes of Health Clinical trials.gov studies are being conducted to evaluate long-term outcomes, including pain relief and improvement of function, for both knee and ankle cartilage repair.
DeNovo® ET™ Engineered Tissue Graft (i.e., RevaFlex™) is a scaffold free tissue-engineered juvenile cartilage graft proposed for the treatment of articular cartilage lesions. DeNovo ET uses juvenile articular cartilage cells applied to defects of the joint surface using a protein-based adhesive.

Other cartilage matrices under investigation include the Cartilage Autograft Implantation System (CAIS, Johnson and Johnson, Phase III trial) that purportedly harvests cartilage and disperses chondrocytes on a scaffold in a single-stage treatment and BioCartilage® (Arthrex, Naples, Florida) which consists of a micronized allogeneic cartilage matrix that is intended to provide a scaffold for microfracture.

U.S. Food and Drug Administration (FDA): DeNovo NT is classified as minimally manipulated allograft tissue and is therefore not subject to the FDA premarket approval process. The FDA requires that the manufacturers of human allograft products be registered. Currently DeNovo NT is registered on the FDA’s Human Cell and Tissue-Based Products (HCT/P) list. No listing could be found for DeNovo ET.

Literature review: Evidence in the peer-reviewed published scientific literature is insufficient to support the safety and efficacy of DeNovo ET or DeNovo NT.

Professional Societies/Organizations
In 2013 the American Orthopaedic Foot and Ankle Society (AOFAS, 2013) published a position statement regarding osteochondral transplantation for the treatment of osteochondral lesions of the talus. According to this position statement the AOFAS does not consider the procedure, using either autograft or allograft, experimental when the individual has failed non-operative management, particularly for large diameter lesions (>15 mm in diameter) and cystic lesions (i.e., cyst in subchondral bone).

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Bone Filler Materials Coding and Billing Information

Ligament/Meniscus Reconstruction
The use of adjunctive treatments such as autologous platelet-derived growth factors (e.g., centrifuged platelet aggregates) and other methods of promoting vascularization (e.g., Healing Response Technique [stimulates blood clot and subsequent scar formation]) have been utilized to assist in healing of tissues, however, there is insufficient evidence in the medical literature at this time, in particular with ACL/PCL reconstruction using allograft tissue or meniscal transplant, to support any improvement in health outcomes with the use of these adjunctive treatments.

Other options under investigation for meniscal regeneration and/or transplantation include tissue-engineered menisci, bioactive scaffolds (collagen meniscal implants, bioresorbable porous polyurethane), and synthetic devices (e.g., hydrogel) (Packer and Rodeo, 2009). Collagen meniscal implants have been proposed by some authors for filling defects of partial meniscectomy with functional repair tissue. Authors hypothesize the collagen meniscal implant may help prevent or delay the progression of osteoarthritis, protecting from degenerative joint disease. In addition, xenografts and meniscal prostheses are under investigation for use as an alternative approach to meniscal allograft transplantation (Verdonk, et al., 2007).

Autologous Platelet-derived Growth Factors (e.g., platelet rich plasma [PRP])
Platelet-rich plasma, derived from autologous blood, is being investigated for cartilage regeneration and for anterior ligament reconstruction. Theoretically, delivering high concentrations of growth factors, found in the platelet rich plasma, to focal areas may enhance healing, improve mechanical properties during the remodeling phase, and improve the rate of graft incorporation and maturation. One purported use involves autologous platelet-derived growth factors (e.g., centrifuged platelet aggregates, platelet rich plasma) with tendon and ligament repair. Nevertheless, the applicability for this use is controversial.

U.S. Food and Drug Administration (FDA): The systems used for preparing autologous platelet-derived growth factors are FDA approved under the 510(k) notification process. In general, the systems are approved to be used at the patient’s point of care and/or in a clinical laboratory to prepare autologous platelet-rich plasma (PRP)/platelet concentrate from the patient’s own blood.

Literature Review: The use of platelet rich plasma to enhance soft tissue healing such as with tendon and ligament repair continues to be investigated, however controlled clinical trials that support clinical improvement are lacking (Hall, et al., 2013). Regarding anterior cruciate ligament reconstruction in particular, Nin et al.(2009) reported the results of a randomized trial (n=100) evaluating the effect of platelet-enriched gel on the inflammatory process following primary ACL reconstruction with BPTB allograft by two year follow-up. The authors acknowledged the therapeutic role of platelet derived growth factor currently remains unclear. The results of a more recent randomized controlled clinical trial (n=150) comparing two different platelet rich plasma preparations to a non-gel control group as part of ACL reconstruction continues to support further clinical trials are needed. The results of this study demonstrate there were no statistically significant differences in functional outcome, graft healing on MRI, or complications; the authors reported there was no clinical or pain improvement compared with the control group (Valenti Azcarate, et al., 2014). In addition, multiple formulations with varying content of platelet rich plasma, platelets and white cells are available, resulting in inconsistent clinical outcomes among studies. There is insufficient evidence in the medical literature at this time, in particular with ACL/PCL reconstruction to support any improvement in health outcomes with the use of these adjunctive platelet-derived orthobiologic materials.

In 2013 the American Academy of Orthopaedic Surgeons published recommendations for treatment of osteoarthritis of the knee. Within these guidelines the Academy notes that they are unable to recommend for or against growth factor injections and/or platelet rich plasma for patients with symptomatic OA of the knee. The inconclusive recommendation is based on lack of compelling evidence that has resulted in an unclear balance between benefits and potential harm (AAOS, 2013).

NICE issued guidance (2014) for platelet rich plasma injections as treatment of osteoarthritis of the knees and concluded that the procedure should only be used with special arrangements for clinical governance, consent, and audit or research.

Meniscus Regeneration/Transplantation
The meniscus is a crescent-shaped wedge of fibrocartilage located in the knee joint between the femoral condyle and tibial plateau. Small meniscal tears can be sutured, however, management of more severe meniscal injury involves arthroscopic or open surgery, often with meniscal allograft transplant. Other options under investigation for meniscal regeneration and/or transplantation include tissue-engineered menisci, bioactive scaffolds (collagen meniscal implants, biodegradable porous polyurethane), and synthetic devices (e.g., hydrogel) (Packer and Rodeo, 2009). Collagen meniscal implants have been proposed by some authors for filling defects of partial meniscectomy with functional repair tissue. Authors hypothesize the collagen meniscal implant may help prevent or delay the progression of osteoarthritis, protecting from degenerative joint disease. In addition, xenografts and meniscal prostheses are under investigation for use as an alternative approach to meniscal allograft transplantation (Verdonk, et al., 2007).

U.S. Food and Drug Administration (FDA): Menaflex™ (ReGen Biologics, Inc., Hackensack, NJ), was granted a 510(k) approval from the FDA in December 2008. Menaflex is a resorbable collagen matrix regulated by the FDA as a Class II device. The collagen scaffold is used to reinforce weakened soft tissue and provides a resorbable scaffold that is replaced by the patient’s own tissue. According to the FDA, the scaffold was approved for the reinforcement and repair of soft tissue injuries of the medial meniscus (FDA, 2008); the device was not cleared for use in lateral meniscal injuries. However, in 2010 the FDA announced that the Menaflex device
should not have been cleared for marketing in the U.S. and implemented a rescission. A rescission is an action by the FDA to revoke a marketing clearance later determined to be erroneous. The FDA concluded that the Menaflex device is intended to be used for different purposes and is technologically different from predicate devices (i.e., devices already on the market); these differences can affect the safety and effectiveness of the device.

**Literature Review:** Evidence evaluating the safety and efficacy of collagen meniscal implants generally involve small patient populations. Some of the preliminary results are encouraging, suggesting meniscus regeneration occurs with an associated reduction in patient symptoms (Zaffagnini, et al., 2007). One prospective randomized trial (n=311) conducted by Rodkey et al. (2008) demonstrated the use of a collagen meniscus implant appeared safe, supported new tissue ingrowth and improved clinical outcomes (e.g., pain scores, Lysholm scores and patient assessment scores) in patients with chronic meniscal injury at an average follow-up of 59 months. The authors noted that patients who received the implant regained significantly more of their lost activity when compared to a group of patients who underwent repeat partial meniscectomy. A technology assessment conducted by the California Technology Assessment Forum (2010) concluded that the collagen meniscal implant for irreparable medial meniscus injury did not meet CTAF technology assessment criterion. The published evidence did not support improvement in health outcomes or that clinical improvement was attainable outside of the investigational setting. Although promising, long-term data supporting safety, efficacy and improved clinical outcomes, including prevention of osteoarthritis, are not yet available to support widespread use of this bioactive scaffold for meniscal regeneration.

There is a paucity of evidence in the peer-reviewed published scientific literature evaluating meniscal scaffolds and implants (Zaffagnini, et al., 2007; Rodkey et al., 2008; California Technology Assessment Forum, 2010). For other emerging technologies, much of the evidence is in the form of animal, cadaveric or short-term clinical trials and does not support safety and efficacy. Additionally there is no consensus opinion with regard to their widespread clinical application.

**Use Outside of the US:** Meniscal implant devices are available for use in countries outside the U.S. For example, Actifit™ (Orteq® LTD, United Kingdom), a biodegradable polyurethane scaffold designed to help repair meniscal tears, is currently approved for use in Europe. According to the manufacturer, NUsurface® Meniscus Implant (Active Implants® LLC, Memphis TN), a free-floating non-degradable polycarbonate-urethane device intended for total meniscal replacement, is also undergoing clinical trials in Europe, Israel, France, Germany, Belgium, the Netherlands, United Kingdom and Sweden.

**Healing Response Technique**
The Healing Response Technique is a treatment method that theoretically promotes vascularity by stimulating blood clot and subsequent scar formation. The technique has been utilized to assist in healing of tissues.

**U.S. Food and Drug Administration (FDA):** Healing Response Technique is a procedure and as such is not regulated by the US FDA.

**Literature review:** There is insufficient evidence in the medical literature at this time, in particular with ACL/PCL reconstruction using allograft tissue or meniscal transplant, to support any improvement in health outcomes with the use of this adjunctive treatment.

**Use Outside of the US:** No relevant statements.
knee prostheses (e.g., Gender Solutions™ High Flex Knee [Zimmer Inc., Warsaw, IN]), all of which are currently under investigation. In general, during knee replacement surgery a portion of the knee is resected using instrumentation guided by templates or cutting devices. Prosthetic devices are then used to replace the joint components. Customized implants, patient-specific templates and/or instrumentation devices are being investigated as an alternative to standard equipment for both total and partial knee replacement to aid in more properly designing and aligning the implants. These devices are used to assist with marking an area before cutting the bone and then positioning of the knee components. Gender-specific implants are implants that are designed to fit more accurately than a non-gender specific implant, and theoretically improve clinical outcomes. Typically with these techniques a few weeks prior to surgery preoperative images are obtained using computed tomography or magnetic resonance imaging for the development of a knee model which is then used to develop specially sized prosthetic components, implants and instruments based on an individual’s anatomy. In addition, intraoperative navigation systems (e.g., MAKOplasty® [MAKO Surgical Corporation®, Fort Lauderdale, FL]) that employ preoperative imaging and 3-dimensional views during surgery to improve alignment are under development.

**U.S. Food and Drug Administration (FDA):** Various instrumentation systems and software systems for developing patient specific templates/instrumentation are currently available. These devices are regulated by the U.S. Food and Drug Administration (FDA) through the 510(k) marketing process. Devices that have received FDA approval include but are not limited to the following: TruMatch Solutions (DePuy Orthopaedics, Inc.), Visionaire Patient matched Cutting Blocks (Smith and Nephew, Inc) and Stryker Patient Specific Cutting Guide (Stryker Corporation). In addition, various customized and/or gender specific knee implants have been approved by the FDA through the 510(k) process.

**Literature Review:** Evidence in the peer reviewed published literature is conflicting, some studies support there is improvement in outcomes such as better mechanical alignment with the use of customization (Ng, et al., 2012; Noble, et al., 2012; Spencer, et al., 2009). However, authors have also reported there is minimal to no relevant difference in alignment (Cheng, et al, 2014; Abdel, et al., 2014; Kerens, et al., 2014). Published evidence suggests the clinical benefit of patient specific instrumentation compared to standard instrumentation has yet to be proven (Nam, et al., 2016a; Nam, et al., 2016b; Lee, et al., 2016; Voleti, et al., 2014; Chotanaphuti, et al., 2014). Overall effects for improvement of net health outcomes have yet to be determined; published data supporting improved functional and clinical outcomes is lacking.

Hayes published a search and summary report in August evaluating the iTotal customized total knee replacement and concluded there is insufficient published evidence to assess safety and/or impact to health outcomes of patient management of the iTotal customized total knee replacement (Hayes, 2017). In 2016 Hayes, Inc. published a Medical Technology Directory Report evaluating patient specific instrumentation for knee replacement. According to the report, when compared with conventional instrumentation there was no superior benefit regarding alignment and/or function when using patient specific instrumentation (Hayes, 2016b). Furthermore, it was noted by Hayes the published evidence suggests that any small reduction in surgical time or length of stay is insufficient, (on average), to confer a benefit and failed to address whether patient specific instrumentation results in lower reoperation rates. Hayes reported it is reasonable to assume that revision rates would not be reduced if neither alignment nor functional outcomes showed superiority over conventional instrumentation. In another technology report published by Hayes (2012, reviewed 2014) it was reported there is insufficient evidence to assess the safety and/or impact on health outcomes or patient management of customized total knee arthroplasty. Due to insufficient published scientific evidence available at this time the overall benefit of customized knee prostheses, patient-specific templates/instrumentation systems and/or imaging/navigation systems has yet to be determined.

The American Academy of Orthopaedics (AAOS) published the evidence based guideline “Surgical Management of Osteoarthritis of the Knee” (AAOS, 2015). Within this guideline the authors report strong evidence supports not using patient specific instrumentation compared to conventional instrumentation of total knee arthroplasty (TKA) because there is no difference in pain and functional outcomes. In addition, moderate evidence supports not using patient specific instrumentation for TKA because there is no difference in transfusions or complications. Strong evidence is defined as evidence from two or more “high” strength studies with consistent findings, and moderate evidence is defined as evidence from two or more moderate strength studies with consistent findings.
or from a single high quality study. Guideline recommendations for gender specific knee implants and customized knee implants were not found on the AAOS website.

**Minimally Invasive Knee Replacement**

Minimally invasive approaches to knee surgery have been investigated with the intention of limiting surgical dissection without compromising the surgical procedure or patient outcomes. Minimally invasive surgical (MIS) approaches involves two developments: a smaller incision and a new technology approach (Vail, 2004). The MIS TKR incision is 4–6 inches long (AAOS, 2014). The main difference between a traditional approach and the MIS approach is the method in which the surgeon exposes and gains access to the joint—a minimally invasive approach has a smaller incision and avoids patella eversion and quadriceps muscle splitting. Furthermore, a minimally invasive approach to the knee should not violate the extensor mechanism or the suprapatellar pouch (AAHKS, 2004; Haas, et al., 2004; Tria and Coon, 2003). Modifications of the medial parapatellar, subvastus and midvastus approaches applying MIS techniques have been published in the literature (Scuderi, et al., 2004); however, patient selection criteria have not been clearly established. Less invasive surgical implants (e.g., unicompartmental knee arthroplasty) use different components and incision methods and should be evaluated as a separate type of less invasive surgery.

Surgical techniques for minimally invasive approaches have been facilitated by the use of smaller instrumentation; nonetheless, choice of prosthetic type is limited. In addition, MIS methods involve the risk of inaccurate implant positioning and possible additional complications, due to a restricted operative field. Incorrect positioning or orientation of implants during TKR, poor soft tissue balancing, and improper alignment of the limb can lead to accelerated wear, loosening and decreased overall performance of the implant (DiGioia, et al., 2004). Malalignment alone can lead to abnormal patellar tracking, increased polyethylene wear, early loosening, and poor functional outcome (Chin, et al., 2007).

**Literature Review:** Minimally invasive surgical techniques are difficult to evaluate in the scientific literature because of the multiple definitions describing the techniques, various approaches, and lack of reported long-term data. Comparing clinical outcomes across studies is difficult. Evidence in the medical literature evaluating minimally invasive approaches to knee replacement includes randomized, controlled trials; both retrospective and prospective case series; and comparative studies, in addition to published literature reviews. Most studies involve small patient populations and evaluate short term outcomes, ranging from the immediate post-operative period to approximately two and a half years following surgery (Lai, et al., 2014; Essving, et al., 2012; Kim, et al., 2011; Kashyap and Ommersen, 2008; Juosposis, et al., 2008; McAllister and Stepanian, 2008; Schroer, et al., 2008; Huang, et al., 2007; Tashiro, et al., 2007; Kolisek, et al., 2007; Dalury and Dennis, 2005; Laskin, et al., 2005; Laskin, et al., 2004; Haas, et al., 2004; Muller, et al., 2004; Tria and Coon, 2003). Long-term health benefits are yet to be demonstrated and few studies have established a clear benefit from minimally invasive approaches of TKR.

When compared to traditional total knee replacement, studies have suggested that minimally invasive approaches result in faster functional recovery and improved knee range of motion (Bonutti, et al., 2010; Khanna, et al., 2009; Kashyap and Ommersen, 2008; Schroer, et al., 2008; Huang, et al., 2007; Tashiro, et al., 2007; Haas, et al., 2004; Muller, et al., 2004; Tria and Coon, 2003). However, these results are not consistently reported. The results of some studies suggest short term functional outcomes are comparable or not significantly different when compared to standard TKR (Karachalios, et al., 2008; Lüring, et al., 2008; McAllister and Stepanian, 2008; Kolisek, et al., 2007; Dalury and Dennis, 2005; Bonutti, et al., 2004).

Minimally invasive surgery is also associated with a learning curve and longer operative times for MIS TKR have been reported when compared to the standard approach (Khanna, et al., 2009; Karachalios, et al., 2008; Kolisek, et al., 2007; Tashiro, et al., 2007; Tria and Coon, 2003). Increased length of surgery may lead to a higher rate of complications in some patients (e.g., thromboembolism, infection). Ghandi et al. (2011) reported the results of meta-analysis of RCTs to compare complication rates between MIS TKR and standard TKR. A total of nine RCTs were included in the review. The authors noted a statistically significant increase in complication rates for the MIS group when compared to standard TKR and that MIS TKR failed to demonstrate any clinical benefit. Whitehead (2006) reported that recent efforts to shorten the incision in total knee arthroplasty have added significant risk, but little benefit. In a trial comparing the effects of severity of preoperative varus deformity on
radiograph accuracy for subjects who underwent MIS TKR, Niki et al. (2009) reported MIS techniques decreased radiographic accuracy of implant alignment, particularly in patients with severe varus deformity.

Additionally, decreased length of hospitalization stay has been reported for patients who have undergone MIS TKR (Shankar, 2006), while for other similar patient groups there have been reports of minimal differences in length of stay (Kolisek, et al. 2007). Comparison of perioperative outcomes such as shorter incision length, reduced tourniquet time and less intraoperative blood loss has been reported in the literature as well. Radiograph analysis of component positioning has also been performed in some studies with varying results; some suggest MIS TKR results in a high incidence of malpositioning (Huang, et al., 2007; Fisher, et al., 2003) while others report results are comparable to standard approaches with no significant differences in alignment (Bonutti, et al., 2010; Juosponis, et al., 2008; Kashyap and Ommeren, 2008; McAllister, et al., 2008; Chin, et al., 2007; Dalury and Dennis, 2005; Muller, et al., 2004).

Revision rates and implant survival rates vary. Barrack et al. (2009) reported the results of a consecutive series of first-time revision TKRs during a three year period (n=237), 44 subjects had an initial MIS TKR and 193 had a standard TKR. The authors noted the time to revision was significantly shorter for the MIS group compared to the standard TKR group (14.8 versus 80 months) and the authors were concerned regarding the high prevalence of MIS failures in a 24 month period of time. MIS knees were almost twice as likely to have instability or malrotation as a cause of failure.

There are a number of randomized controlled trials (RCTs) evaluating MIS TKR in the published scientific literature (Lai, et al., 2014; Tasker, et al., 2014; Kim, et al., 2011; Varela-Egocheaga, et al., 2010; Wulker, et al., 2010; Pan, et al., 2010; Hernandez-Vaquero, et al., 2010). A majority are limited by small sample populations and short-term outcomes. Lai et al. (2014) reported the results of a prospective RCT comparing clinical and radiographic results of primary TKR (n=33) and mini-subvastus approach (n=35). At an average follow-up of 28 months following surgery there were no significant differences in Knee Society function score, Oxford knee score, and range of motion. In addition the authors noted reduced access and visibility resulted in more technical errors and increased tourniquet time. Tasker et al. (2014) reported the results of a prospective RCT comparing MIS TKR (n=48) with TKR (n=54). The primary measured outcome was length of stay; secondary outcomes included WOMAC, KSS, Oxford scores, and knee ROM. Follow-up occurred at three, 12, and 24 months. The MIS group had a shorter length of stay and fewer surgical complications, there was no significant difference in operative time or alignment, and postoperative functional improvements were not statistically different between groups.

MIS unicompartmental knee replacement (UKR) has also been investigated and some authors have reported encouraging results (O'Donnell, et al., 2010; Pandit, et al., 2010.) Nonetheless, some of the reported outcomes are mixed. Kort et al. (2007) reported the results of a prospective case series involving 154 unicompartmental knee replacements (n=132 patients) using a minimally invasive approach and a phase-3 Oxford mobile bearing device. The authors noted that 11% of the unicompartmental arthroplasties in all patients needed a revision, resulting in a survival rate of 89% during a 2-7 year follow-up interval. Hamilton and colleagues (2006) reported the results of a retrospective cohort of 221 consecutive patients treated with a minimally invasive, medial unicompartmental arthroplasty, compared to patients who underwent a standard arthrotomy and routine patellar eversion. The authors reported a total reoperation rate of 11.3% in the MIS group compared to 8.6% in the standard arthrotomy group. The rate of aseptic loosening in the MIS group was reported to be 3.7% compared to standard group of 1.0%.


Advisory statements regarding minimally invasive and small incision joint replacement surgery by the American Association of Hip and Knee Surgeons (AAHKS, 2004; updated 2008) indicate that same or better long-term outcomes have not been validated with less invasive knee replacement surgery, and there is not a great deal of significant scientific proof to support its use at this time. Scientific evidence and rigorous evaluation of minimally
invasive joint arthroplasty techniques are needed before these techniques are recommended for more widespread clinical practice.

Use Outside of the US: The National Institute for Health and Care Excellence (NICE) issued a procedural guidance regarding mini-incision surgery for total knee replacement (March, 2010). The Institute concluded that current evidence on the safety and efficacy of mini-incision surgery for total knee replacement is adequate to support the use of this procedure provided that normal arrangements are in place for clinical governance, consent and audit.

Focal Knee Joint Resurfacing
Focal resurfacing of a knee joint defect is a surgical procedure in which a limited amount of bone is removed from the surface of the joint and then replaced with a metal or metal/plastic implant. It has been proposed as an alternative to unicompartmental or total knee replacement, involving less removal of the patient’s bone and theoretically allowing more normal joint function. Candidates for resurfacing are usually younger in age, physically active, and have focal articular defects (i.e., early stage OA changes that are isolated).

U.S. Food and Drug Administration (FDA): Two FDA approved knee resurfacing prosthesis include the HemiCAP™ Femoral Condyle System (Arthrosurface, Inc., Franklin, MA) and the UniCAP™ Unicompartmental Knee Resurfacing Implant (Arthrosurface, Inc., Franklin, MA). These devices are approved through the FDA 510(k) approval process as Class II devices and are intended to be used with bone cement.

Literature Review: Evidence in the peer-reviewed published scientific literature evaluating safety and efficacy of focal knee joint resurfacing using these or other similar devices is limited. Becher et al. (2011) published the results of a case series involving 21 patients who received a HemiCap device with average follow-up of 5.3 years. Boller et al. reported the results of a case series involving 19 subjects treated with a HemiCap device with an average follow-up of 34 months. Although there was improvement in pain and function scores, the studies were limited by small populations, lack of a control group and short to mid-term outcomes. Published data regarding the safety, efficacy and improved health outcomes with the use of this technology as an alternative to TKR or UKR is insufficient and precludes the ability to draw conclusions as this time.

Miscellaneous Knee Procedures Coding and Billing Information

The American Board of Internal Medicine’s (ABIM) Foundation Choosing Wisely® Initiative: No relevant statements.

Appendix 1 – Procedure to Coding Crosswalk

<table>
<thead>
<tr>
<th>Musculoskeletal Procedure/Orthobiologic</th>
<th>Intended Use (this list may not be all inclusive)</th>
<th>Application CPT/HCPCS Codes</th>
<th>Product HCPCS Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autologous platelet-derived growth factors (e.g., platelet rich plasma)</td>
<td>Knee ligament or meniscus reconstruction, regeneration, transplantation</td>
<td>29999: 0232T</td>
<td>P9020 S9055</td>
</tr>
<tr>
<td>Bioreabsorbable porous polyurethane (bioactive/tissue engineered scaffold)</td>
<td>Meniscal regeneration/transplantation</td>
<td>29999</td>
<td>L8699</td>
</tr>
<tr>
<td>Collagen meniscal implant (bioactive/tissue engineered scaffold)</td>
<td>Meniscal regeneration/transplantation</td>
<td>29999 G0428</td>
<td>L8699</td>
</tr>
<tr>
<td>Meniscal prosthesis/total meniscus replacement</td>
<td>Meniscal regeneration/transplantation</td>
<td>29999</td>
<td>L8699</td>
</tr>
<tr>
<td>Xenograft</td>
<td>Meniscal regeneration/transplantation</td>
<td>29999</td>
<td>L8699</td>
</tr>
<tr>
<td>Healing Response Technique</td>
<td>Knee ligament repair</td>
<td>29999</td>
<td>L8699</td>
</tr>
<tr>
<td>-----------------------------</td>
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</tbody>
</table>
| Juvenile cartilage allograft:  
  - DeNovo® NT Natural Tissue Graft Graft  
  - DeNovo® ET™ Engineered Tissue Graft Graft  
  - BioCartilage | Treatment of articular cartilage defects | 23929, 24999, 27299, 27599, 28899, 29999 | L8699 |
| Matrix-induced autologous chondrocyte implantation:  
  - MACI® (Vericel Corporation, Cambridge, MA) | Treatment of articular cartilage defects, other than knee | 27599, 23929, 24999, 27299, 27899, 29999 | J7330 L8699 |
| Autologous chondrocyte transplantation (e.g., Carticel®, MACI®) for lesions other than the femoral condyle | Treatment of lesions in any joint other than the femoral condyle of the knee, (e.g., tibia/patella, ankle, hip, shoulder) | 23929, 24999, 27299, 27899, 29999 | J7330 L8699 |
| Autologous chondrocyte transplantation (e.g., Carticel®, MACI®) | Treatment of cartilage damage associated with generalized osteoarthritis | 23929, 24999, 27299, 27899 | J7330 L8699 |
| Osteochondral autograft transplantation | Treatment of articular cartilage defects involving joint surfaces other than the femoral condyle (e.g., patella) | 20962, 23929, 24999, 27299, 27899, 28103, 28446, 29999 | L8699 |
| Osteochondral allograft transplantation | Treatment of articular cartilage defects involving joint surfaces other than the femoral condyle (e.g., patella) | 20962, 23929, 24999, 27299, 27899, 28103, 28446, 29999 | L8699 |
| Osteochondral allograft using decellularized cartilage (e.g., Chondrofix) | Treatment of articular cartilage defects using allograft | | L8699 |
| Osteochondral synthetic resorbable polymers:  
  - TruFit® cylindrical plug  
  - TruGraft™ granules | Treatment of osteochondral articular cartilage defects | 23929, 24999, 27299, 27599, 27899, 29999 | L8699 |
| Customized knee replacement procedures/implants:  
  - pre-operative imaging studies (e.g., CT scans, MRI) associated with the customization and/or | Knee replacement (i.e., total, partial) | 73700-73702, 73721-73722, 27599 | L8699 |
utilized as part of intraoperative navigation (e.g., MAKOplasty)
• customized templates, and/or instrumentation
• customized knee implant
• gender specific implant

<table>
<thead>
<tr>
<th>Minimally Invasive Knee Replacement</th>
<th>Knee replacement (i.e., total, partial)</th>
<th>27599</th>
<th>N/A</th>
</tr>
</thead>
</table>
| Focal resurfacing of a single knee joint:
  • HemiCAP™
  • UniCAP™ | Knee arthroscopy | 27438, 27440, 27442 | C1776, L8699 |

**Coding/Billing Information**

**Note:**
1) This list of codes may not be all-inclusive.
2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

**Considered Medically Necessary when criteria in the applicable policy statements listed above are met:**

**Articular Cartilage Repair**

Experimental/Investigational/Unproven when autologous chondrocyte (e.g., Carticel®, MACI®), osteochondral autograft or allograft transplant is used for the treatment of articular cartilage defects in locations other than the distal femur within the knee:

<table>
<thead>
<tr>
<th>CPT* Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>20962</td>
<td>Bone graft with microvascular anastomosis; other than fibula, iliac crest, or metatarsal</td>
</tr>
<tr>
<td>23929</td>
<td>Unlisted procedure, shoulder</td>
</tr>
<tr>
<td>24999</td>
<td>Unlisted procedure, humerus or elbow</td>
</tr>
<tr>
<td>27299</td>
<td>Unlisted procedure, pelvis or hip joint</td>
</tr>
<tr>
<td>27899</td>
<td>Unlisted procedure, leg or ankle</td>
</tr>
<tr>
<td>28103</td>
<td>Excision or curettage of bone cyst or benign tumor, talus or calcaneus; with allograft</td>
</tr>
<tr>
<td>28446</td>
<td>Open osteochondral autograft, talus (includes obtaining graft[s])</td>
</tr>
<tr>
<td>29999</td>
<td>Unlisted procedure, arthroscopy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J7330</td>
<td>Autologous cultured chondrocytes, implant</td>
</tr>
<tr>
<td>L8699</td>
<td>Prosthetic implant, not otherwise specified</td>
</tr>
</tbody>
</table>

**Bone Filler Materials**

Experimental/Investigational/Unproven when synthetic resorbable polymers (e.g., PolyGraft™ BGS, TruFit® [cylindrical plug], TruGraft® [granules]); juvenile cartilage allograft tissue implantation (e.g., DeNovo® NT Natural Tissue Graft, DeNovo® ET™ Engineered Tissue Graft); or decellularized osteochondral allograft implant (e.g., Chondrofix Osteochondral Allograft) are used to report the treatment of articular cartilage defects:
<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>23929</td>
<td>Unlisted procedure, shoulder</td>
</tr>
<tr>
<td>24999</td>
<td>Unlisted procedure, humerus or elbow</td>
</tr>
<tr>
<td>27299</td>
<td>Unlisted procedure, pelvis or hip joint</td>
</tr>
<tr>
<td>27599</td>
<td>Unlisted procedure, femur or knee</td>
</tr>
<tr>
<td>27899</td>
<td>Unlisted procedure, leg or ankle</td>
</tr>
<tr>
<td>28899</td>
<td>Unlisted procedure, foot or toes</td>
</tr>
<tr>
<td>29999</td>
<td>Unlisted procedure, arthroscopy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>L8699</td>
<td>Prosthetic implant, not otherwise specified</td>
</tr>
</tbody>
</table>

**Ligament/Meniscus Reconstruction**

Experimental/Investigational/Unproven when used to report autologous platelet-derived growth factors, bioactive scaffolds (e.g., collagen meniscal implants), bioresorbable porous polyurethane, healing response technique, meniscal prosthesis, tissue engineered menisci, or xenograft:

<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>29999</td>
<td>Unlisted procedure, arthroscopy</td>
</tr>
<tr>
<td>0232T</td>
<td>Injection(s), platelet rich plasma, any site, including image guidance, harvesting and preparation when performed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0428</td>
<td>Collagen meniscus implant procedure for filling meniscal defects (e.g., CMI, collagen scaffold, menaflex)</td>
</tr>
<tr>
<td>L8699</td>
<td>Prosthetic implant, not otherwise specified</td>
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<tr>
<td>P9020</td>
<td>Platelet rich plasma, each unit</td>
</tr>
<tr>
<td>S9055</td>
<td>Procuren or other growth factor preparation to promote wound healing</td>
</tr>
</tbody>
</table>

**Miscellaneous Knee Procedures**

Experimental, investigational, unproven when used to report focal resurfacing of a single knee joint defect and the associated implant:

<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>Description</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>27438</td>
<td>Arthroplasty, patella; with prosthesis</td>
<td></td>
</tr>
<tr>
<td>27440</td>
<td>Arthroplasty, knee, tibial plateau</td>
<td></td>
</tr>
<tr>
<td>27442</td>
<td>Arthroplasty, femoral condyles or tibial plateau(s), knee;</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1776</td>
<td>Joint device (implantable)</td>
</tr>
<tr>
<td>L8699</td>
<td>Prosthetic implant, not otherwise specified</td>
</tr>
</tbody>
</table>

Experimental, investigational, unproven when used to report a minimally invasive knee arthroplasty, or customized knee procedures, or patient-specific templates/instrumentation:
<table>
<thead>
<tr>
<th>CPT* Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>27599</td>
<td>Unlisted procedure, femur or knee</td>
</tr>
</tbody>
</table>

Experimental, investigational, unproven when used to report pre-operative imaging studies (e.g., CT scans, MRI) utilized as part of customized knee replacement:

<table>
<thead>
<tr>
<th>CPT* Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>73700</td>
<td>Computed tomography, lower extremity; without contrast material</td>
</tr>
<tr>
<td>73701</td>
<td>Computed tomography, lower extremity; with contrast material(s)</td>
</tr>
<tr>
<td>73702</td>
<td>Computed tomography, lower extremity; without contrast material, followed by contrast material(s) and further sections</td>
</tr>
<tr>
<td>73721</td>
<td>Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material</td>
</tr>
<tr>
<td>73722</td>
<td>Magnetic resonance (eg, proton) imaging, any joint of lower extremity; with contrast material(s)</td>
</tr>
<tr>
<td>73723</td>
<td>Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material(s), followed by contrast material(s) and further sequences</td>
</tr>
</tbody>
</table>

Not medically necessary when used to report pre-operative imaging studies (e.g., CT scans, MRI) utilized as part of intraoperative navigation (e.g., MAKOplasty):

<table>
<thead>
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</thead>
<tbody>
<tr>
<td>73700</td>
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</tr>
</tbody>
</table>

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References


120. Hettrich, CM, Crawford, D, and Rodeo, SA. Cartilage repair: third-generation cell-based technologies--


