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Clinical Appropriateness Guidelines

Musculoskeletal

Appropriate Use Criteria: Level of Care for Musculoskeletal Surgery

“Site of Care,” “Site of Service” or another term such as “Setting” or “Place of Service” may be terms used in benefit plans, provider contracts, or other materials instead of or in addition to “Level of Care” and, in some plans, these terms may be used interchangeably.

Proprietary

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Description and Application of the Guidelines

The Carelon Clinical Appropriateness Guidelines (hereinafter “the Carelon Clinical Appropriateness Guidelines” or the “Guidelines”) are designed to assist providers in making the most appropriate treatment decision for a specific clinical condition for an individual. The Guidelines establish objective and evidence-based criteria for medical necessity determinations, where possible, that can be used in support of the following:

- To establish criteria for when services are medically necessary
- To assist the practitioner as an educational tool
- To encourage standardization of medical practice patterns
- To curtail the performance of inappropriate and/or duplicate services
- To address patient safety concerns
- To enhance the quality of health care
- To promote the most efficient and cost-effective use of services

The Carelon guideline development process complies with applicable accreditation and legal standards, including the requirement that the Guidelines be developed with involvement from appropriate providers with current clinical expertise relevant to the Guidelines under review and be based on the most up-to-date clinical principles and best practices. Resources reviewed include widely used treatment guidelines, randomized controlled trials or prospective cohort studies, and large systematic reviews or meta-analyses. Carelon reviews all of its Guidelines at least annually.

Carelon makes its Guidelines publicly available on its website. Copies of the Guidelines are also available upon oral or written request. Additional details, such as summaries of evidence, a list of the sources of evidence, and an explanation of the rationale that supports the adoption of the Guidelines, are included in each guideline document.

Although the Guidelines are publicly available, Carelon considers the Guidelines to be important, proprietary information of Carelon, which cannot be sold, assigned, leased, licensed, reproduced or distributed without the written consent of Carelon.

Carelon applies objective and evidence-based criteria, and takes individual circumstances and the local delivery system into account when determining the medical appropriateness of health care services. The Carelon Guidelines are just guidelines for the provision of specialty health services. These criteria are designed to guide both providers and reviewers to the most appropriate services based on a patient’s unique circumstances. In all cases, clinical judgment consistent with the standards of good medical practice should be used when applying the Guidelines. Guideline determinations are made based on the information provided at the time of the request. It is expected that medical necessity decisions may change as new information is provided or based on unique aspects of the patient’s condition. The treating clinician has final authority and responsibility for treatment decisions regarding the care of the patient and for justifying and demonstrating the existence of medical necessity for the requested service. The Guidelines are not a substitute for the experience and judgment of a physician or other health care professionals. Any clinician seeking to apply or consult the Guidelines is expected to use independent medical judgment in the context of individual clinical circumstances to determine any patient’s care or treatment.

The Guidelines do not address coverage, benefit or other plan specific issues. Applicable federal and state coverage mandates take precedence over these clinical guidelines, and in the case of reviews for Medicare Advantage Plans, the Guidelines are only applied where there are not fully established CMS criteria. If requested by a health plan, Carelon will review requests based on health plan medical policy/guidelines in lieu of the Carelon Guidelines. Pharmaceuticals, radiotracers, or medical devices used in any of the diagnostic or therapeutic interventions listed in the Guidelines must be FDA approved or conditionally approved for the intended use. However, use of an FDA approved or conditionally approved product does not constitute medical necessity or guarantee reimbursement by the respective health plan.

The Guidelines may also be used by the health plan or by Carelon for purposes of provider education, or to review the medical necessity of services by any provider who has been notified of the need for medical necessity review, due to billing practices or claims that are not consistent with other providers in terms of frequency or some other manner.

General Clinical Guideline

Clinical Appropriateness Framework

Critical to any finding of clinical appropriateness under the guidelines for a specific diagnostic or therapeutic intervention are the following elements:

- Prior to any intervention, it is essential that the clinician confirm the diagnosis or establish its pretest likelihood based on a complete evaluation of the patient. This includes a history and physical examination and, where applicable, a review of relevant laboratory studies, diagnostic testing, and response to prior therapeutic intervention.
- The anticipated benefit of the recommended intervention is likely to outweigh any potential harms, including from delay or decreased access to services that may result (net benefit).
- Widely used treatment guidelines and/or current clinical literature and/or standards of medical practice should support that the recommended intervention offers the greatest net benefit among competing alternatives.
- There exists a reasonable likelihood that the intervention will change management and/or lead to an improved outcome for the patient.

Providers may be required to submit clinical documentation in support of a request for services. Such documentation must a) accurately reflect the clinical situation at the time of the requested service, and b) sufficiently document the ordering provider's clinical intent.

If these elements are not established with respect to a given request, the determination of appropriateness will most likely require a peer-to-peer conversation to understand the individual and unique facts that would justify a finding of clinical appropriateness. During the peer-to-peer conversation, factors such as patient acuity and setting of service may also be taken into account to the extent permitted by law.

Simultaneous Ordering of Multiple Diagnostic or Therapeutic Interventions

Requests for multiple diagnostic or therapeutic interventions at the same time will often require a peer-to-peer conversation to understand the individual circumstances that support the medical necessity of performing all interventions simultaneously. This is based on the fact that appropriateness of additional intervention is often dependent on the outcome of the initial intervention.

Additionally, either of the following may apply:

- Current literature and/or standards of medical practice support that one of the requested diagnostic or therapeutic interventions is more appropriate in the clinical situation presented; or
- One of the diagnostic or therapeutic interventions requested is more likely to improve patient outcomes based on current literature and/or standards of medical practice.

Repeat Diagnostic Intervention

In general, repeated testing of the same anatomic location for the same indication should be limited to evaluation following an intervention, or when there is a change in clinical status such that additional testing is required to determine next steps in management. At times, it may be necessary to repeat a test using different techniques or protocols to clarify a finding or result of the original study.

Repeated testing for the same indication using the same or similar technology may be subject to additional review or require peer-to-peer conversation in the following scenarios:

- Repeated diagnostic testing at the same facility due to technical issues
- Repeated diagnostic testing requested at a different facility due to provider preference or quality concerns

- Repeated diagnostic testing of the same anatomic area based on persistent symptoms with no clinical change, treatment, or intervention since the previous study
- Repeated diagnostic testing of the same anatomic area by different providers for the same member over a short period of time

Repeat Therapeutic Intervention

In general, repeated therapeutic intervention in the same anatomic area is considered appropriate when the prior intervention proved effective or beneficial and the expected duration of relief has lapsed. A repeat intervention requested prior to the expected duration of relief is not appropriate unless it can be confirmed that the prior intervention was never administered. Requests for on-going services may depend on completion of previously authorized services in situations where a patient's response to authorized services is relevant to a determination of clinical appropriateness.

Level of Care Guidelines for Musculoskeletal Surgery and Procedures

“Site of Care,” “Site of Service” or another term such as “Setting” or “Place of Service” may be terms used in benefit plans, provider contracts, or other materials instead of or in addition to “Level of Care” and, in some plans, these terms may be used interchangeably.

Scope

Evidence is growing that supports the safety and effectiveness of the outpatient surgery setting for many orthopedic and spine surgical procedures. Procedures that have historically been performed in the inpatient setting are now being successfully performed in the outpatient surgery setting. Factors that have contributed to this movement include:

- Equal or better outcomes compared to inpatient setting
- Minimal invasive techniques and improved surgical technologies
- Improved anesthesia techniques and more effective postoperative pain management
- Lower costs and operational efficiency

Appropriate patient selection for the outpatient setting is paramount. It may be medically necessary for patients with certain risk factors and undergoing certain procedures to have their procedures performed in the inpatient setting.

The intent of this guideline is to assist in determining the appropriate level of care necessary to perform the intended surgical procedure safely and effectively. Provider should submit the required supporting medical documentation to include but not limited to the following:

- Provider office notes detailing preoperative medical optimization
- List of managed or unmanaged comorbidities and/or other surgical risk factors
- If requested, the specific reason for an inpatient preoperative day
- Copies of medical consultations or clearances
- American Society of Anesthesiologists (ASA) physical status (see [Appendix](#)), Charlson Comorbidity Index score, or other validated surgical risk score, if necessary, to support the requested level of care

This guideline does not address the medical necessity of the procedure itself. The prior authorization process for medical necessity of the surgical procedure is completed separately and precedes the level of care determination. The procedure must meet the respective Carelon musculoskeletal surgery guideline for clinical appropriateness prior to level of care determination.

Definitions

Outpatient Surgical Setting

An outpatient surgical procedure is defined as one where a patient arrives and is registered at a setting other than the acute inpatient hospital setting, undergoes the procedure, and is discharged the same day or within the timeframe for observation defined by patient’s health plan contract and/or local government regulatory agency. Such settings may include Observation Care, Hospital Outpatient Department (on or off campus), Ambulatory Surgical Center, or Physician Office. For the purposes of this guideline, procedures performed in a Physician Office are out of scope.

Observation Surgical Setting

Observation is a special form of hospital outpatient care that provides interim services in place of an inpatient admission to allow for a reasonable period of time to evaluate and determine the need for further treatment or for

inpatient admission. There is evidence that the characteristics of observation care in clinical practice differ from the Centers for Medicare & Medicaid Services definition and that use of observation care is growing with short inpatient stays being the third most common reason to admit for observation. Individual cases admitted to Observation Care may undergo concurrent clinical review to assess the need for transfer to acute inpatient setting. Maximum length of stay in Observation Care is governed by the patient's health plan contract and/or local government regulatory agency.

Surgeons who request inpatient admission for an outpatient musculoskeletal procedure and who decline Observation Care will need to provide clinical documentation to support the need for direct admission to an acute inpatient setting.

Inpatient Surgical Setting

The inpatient surgical setting, rather than the outpatient setting, is required only if the patient's safety or health would be significantly and directly threatened if care were provided in a less intensive setting. The selection of surgical setting is not justified when it is solely for the convenience of the patient, the patient's family, or the provider.

Guidelines

Acute Inpatient Surgical Setting

The acute inpatient surgical setting may be considered medically necessary when at least **ONE** of the following requirements are met:

- Current postoperative care requirements are of such intensity and/or duration that they cannot be met in an observation or outpatient surgical setting.
- Anticipated postoperative care requirements cannot be met, even initially, in an observational surgical setting due to the complexity, duration, or extent of the planned procedure and/or substantial preoperative patient risk.

Observation Outpatient Surgical Setting

The observation surgical setting may be considered medically necessary in patients with **ONE** or more preprocedural clinical risk factors that increase the likelihood of inpatient admission.

Note: The presence of medical and/or psychiatric comorbidities alone may not always justify an observation surgical setting, but consideration should be given if poorly controlled, unstable, untreated, or anticipated to require treatment postoperatively.

Demographic/constitutional

- Age 65 years or older
- BMI greater than 40 kg/m²
- Pregnancy

Medical risk factors

- Charlson Comorbidity Index score greater than 2, ASA class greater than 2, or other attestation of comorbid status
- Recent venous thromboembolic event
- Severe or uncontrolled diabetes
- Severe anemia (e.g., hemoglobin \leq 10)
- Coagulopathy

- Recent unexplained weight loss
- Malnutrition
- Chronic pulmonary disease
 - COPD, severe and/or oxygen dependent
 - Respiratory distress
- Obstructive sleep apnea
- Liver disease including but not limited to cirrhosis
- Vascular
 - Cardiovascular disease
 - Myocardial infarction within 6 months of intended surgery
 - Angina pectoris with severe functional limitation
 - Cardiac arrhythmia
 - Implantable cardiac device (defibrillator, pacemaker)
 - Congestive heart failure
 - Cerebrovascular disease
 - Recent stroke or transient ischemic attack
 - Uncontrolled preoperative pain
 - Prior complication of anesthesia
 - Prior postoperative complication
 - Ileus
 - Urinary retention

Psychiatric/cognitive

- Ongoing substance abuse
- Cognitive impairment

Functional status

- Patient unable to care for individual needs
- Functional impairment likely to necessitate inpatient rehabilitation after surgery (example: moderate to severe myelopathy)
- Patient is at high risk for falls

Outpatient Surgical Setting (excluding Observation)

The non-observation surgical setting includes Ambulatory Surgery Center or Hospital-based Outpatient Department and may be considered medically necessary for elective spine and joint surgery in low-risk patients and procedures as follows:

Note: These requirements do not prohibit providers from performing these procedures in Ambulatory Surgery Center for carefully selected higher risk patients (e.g., physiologic age < biological age, medically optimized, uneventful prior procedure) according to their professional medical judgement.

Hospital-based outpatient department

Patient meets **ALL** of the following:

- Age 64 years or younger
- BMI less than or equal to 40 kg/m²
- Low medical comorbidity risk
- Safe post-surgical disposition

All necessary staff, equipment, and resources are available to perform the requested procedure safely and effectively in an ambulatory surgical center.

- Cervical
 - One- or two-level anterior cervical discectomy and fusion (ACDF) between C3 and C7
 - One- or two-level cervical disc arthroplasty between C3 and C7
 - One- or two-level foraminotomy
 - Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural
- Thoracic
 - Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural
- Lumbar
 - One- or two-level discectomy and/or decompression (laminectomy, laminotomy, or foraminotomy)
 - One- or two-level posterior or posterolateral with posterior interbody fusion
 - Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural
- Sacral
 - Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural
- Vertebroplasty
- Kyphoplasty
- Joint
 - Total or partial primary hip arthroplasty for unilateral osteoarthritis
 - Total or partial primary knee arthroplasty for unilateral osteoarthritis

Ambulatory surgery center with 23-hour observation

Patient meets **ALL** of the following:

- Age 64 years or younger
- BMI less than or equal to 40 kg/m²
- Low medical comorbidity risk
- Safe post-surgical disposition

All necessary staff, equipment, and resources are available to perform the requested procedure safely and effectively in the ambulatory surgical center.

- Cervical
 - One- or two-level anterior cervical discectomy and fusion (ACDF) between C3 and C7
 - One- or two-level cervical disc arthroplasty between C3 and C7
 - One- or two-level foraminotomy
 - Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural
- Thoracic

- Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural
- Lumbar
 - One- or two-level discectomy and/or decompression (laminectomy, laminotomy, or foraminotomy)
 - One- or two-level posterior or posterolateral with posterior interbody fusion
 - Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural
- Sacral
 - Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural
- Vertebroplasty
- Kyphoplasty
- Joint
 - Total or partial primary shoulder arthroplasty
 - Total or partial primary hip arthroplasty for unilateral osteoarthritis
 - Total or partial primary knee arthroplasty for unilateral osteoarthritis

Facility has the capability for minimum of 23-hour observation.

Ambulatory surgery center with or without 23-hour observation

The following procedure can be safely performed in the Ambulatory Surgical Center with or without 23 hours of observation.

- Arthroscopy

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Joint Surgery

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Codes

The following code list is not meant to be all-inclusive. Authorization requirements will vary by health plan. Please consult the applicable health plan for guidance on specific procedure codes.

Medical necessity reviews are initiated by submitting the correct AMA CPT codes. Specific CPT codes for services should be used when available. The submitted codes must accurately identify the service or procedure to be performed. If no such code exists, contact the health plan directly and report the service or procedure using the appropriate unlisted procedure or Not Otherwise Classified (NOC) code (which often ends in 99). Do not submit a code that is “close to” the procedure performed in lieu of an unlisted code. Correct coding demands that the code reported is appropriate for the service provided (i.e., a code that most accurately represents the service provided), and not a code that is similar but represents another service. (*CPT® Assistant*, December 2010) Nonspecific or NOC codes may be subject to additional documentation requirements and review.

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CPT codes for Joint Surgery

Note: Codes listed are in scope for joint surgery.

Shoulder Arthroplasty (Total/Partial/Revision Shoulder Replacement)

23470	Arthroplasty, glenohumeral joint; hemiarthroplasty
23472	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))

Shoulder Arthroscopy and Open Procedures

23105	Arthrotomy; glenohumeral joint, with synovectomy, with or without biopsy
23107	Arthrotomy, glenohumeral joint, with joint exploration, with or without removal of loose or foreign body
23120	Claviculectomy; partial
23130	Acromioplasty or acromionectomy, partial, with or without coracoacromial ligament release
23410	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute
23412	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; chronic
23415	Coracoacromial ligament release, with or without acromioplasty
23420	Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)

23430	Tenodesis of long tendon of biceps
23440	Resection or transplantation of long tendon of biceps
23450	Capsulorrhaphy, anterior; Putti-Platt procedure or Magnuson type operation
23455	Capsulorrhaphy, anterior; with labral repair (eg, Bankart procedure)
23460	Capsulorrhaphy, anterior, any type; with bone block
23462	Capsulorrhaphy, anterior, any type; with coracoid process transfer
23465	Capsulorrhaphy, glenohumeral joint, posterior, with or without bone block
23466	Capsulorrhaphy, glenohumeral joint, any type multidirectional instability
29805	Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure)
29806	Arthroscopy, shoulder, surgical; capsulorrhaphy
29807	Arthroscopy, shoulder, surgical; repair of SLAP lesion
29819	Arthroscopy, shoulder, surgical; with removal of loose body or foreign body
29820	Arthroscopy, shoulder, surgical; synovectomy, partial
29821	Arthroscopy, shoulder, surgical; synovectomy, complete
29822	Arthroscopy, shoulder, surgical; debridement, limited, 1 or 2 discrete structures (eg, humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies])
29823	Arthroscopy, shoulder, surgical; debridement, extensive, 3 or more discrete structures (eg, humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies])
29824	Arthroscopy, shoulder, surgical; distal claviclectomy including distal articular surface (Mumford procedure)
29825	Arthroscopy, shoulder, surgical; with lysis and resection of adhesions, with or without manipulation
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure)
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
29828	Arthroscopy, shoulder, surgical; biceps tenodesis

Hip Arthroplasty (Total/Partial/Revision Hip Replacement)

27125	Hemiarthroplasty, hip, partial (eg, femoral stem prosthesis, bipolar arthroplasty)
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft

Hip Arthroscopy

29860	Arthroscopy, hip, diagnostic with or without synovial biopsy (separate procedure)
29861	Arthroscopy, hip, surgical; with removal of loose body or foreign body
29862	Arthroscopy, hip, surgical; with debridement/shaving of articular cartilage (chondroplasty), abrasion arthroplasty, and/or resection of labrum
29863	Arthroscopy, hip, surgical; with synovectomy
29914	Arthroscopy, hip, surgical; with femoroplasty (ie, treatment of cam lesion)
29915	Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion)
29916	Arthroscopy, hip, surgical; with labral repair

Knee Arthroplasty (Total/Partial/Revision Knee Replacement)

27437	Arthroplasty, patella; without prosthesis
27438	Arthroplasty, patella; with prosthesis
27440	Arthroplasty, knee, tibial plateau

27441	Arthroplasty, knee, tibial plateau; with debridement and partial synovectomy
27442	Arthroplasty, femoral condyles or tibial plateau(s), knee
27443	Arthroplasty, femoral condyles or tibial plateau(s), knee; with debridement and partial synovectomy
27446	Arthroplasty, knee, condyle and plateau; medial OR lateral compartment
27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)

Knee Arthroscopy and Open Procedures

27331	Arthrotomy, knee; including joint exploration, biopsy, or removal of loose or foreign bodies
27332	Arthrotomy, with excision of semilunar cartilage (meniscectomy) knee; medial OR lateral
27333	Arthrotomy, with excision of semilunar cartilage (meniscectomy) knee; medial AND lateral
27334	Arthrotomy, with synovectomy, knee; anterior OR posterior
27335	Arthrotomy, with synovectomy, knee; anterior AND posterior including popliteal area
27403	Arthrotomy with meniscus repair, knee
27405	Repair, primary, torn ligament and/or capsule, knee; collateral
27407	Repair, primary, torn ligament and/or capsule, knee; cruciate
27409	Repair, primary, torn ligament and/or capsule, knee; collateral and cruciate ligaments
27427	Ligamentous reconstruction (augmentation), knee; extra-articular
27428	Ligamentous reconstruction (augmentation), knee; intra-articular (open)
27429	Ligamentous reconstruction (augmentation), knee; intra-articular (open) and extra-articular
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)
29877	Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty)
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)
29883	Arthroscopy, knee, surgical; with meniscus repair (medial AND lateral)
29884	Arthroscopy, knee, surgical; with lysis of adhesions, with or without manipulation (separate procedure)
29885	Arthroscopy, knee, surgical; drilling for osteochondritis dissecans with bone grafting, with or without internal fixation (including debridement of base of lesion)
29886	Arthroscopy, knee, surgical; drilling for intact osteochondritis dissecans lesion
29887	Arthroscopy, knee, surgical; drilling for intact osteochondritis dissecans lesion with internal fixation
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
29889	Arthroscopically aided posterior cruciate ligament repair/augmentation or reconstruction

Meniscal Allograft Transplantation of the Knee

29868	Arthroscopy, knee, surgical; meniscal transplantation (includes arthrotomy for meniscal insertion), medial or lateral
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Osteochondral Grafts

27412	Autologous chondrocyte implantation, knee
27415	Osteochondral allograft, knee, open
27416	Osteochondral autograft(s), knee, open (eg, mosaicplasty) (includes harvesting of autograft[s])
29866	Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the autograft[s])
29867	Arthroscopy, knee, surgical; osteochondral allograft (eg, mosaicplasty)
29892	Arthroscopically aided repair of large osteochondritis dissecans lesion, talar dome fracture, or tibial plafond fracture, with or without internal fixation (includes arthroscopy)

CPT codes for Small Joint Surgery

27702	Arthroplasty, ankle; with implant (total ankle)
27703	Arthroplasty, ankle; revision, total ankle
27704	Removal of ankle implant
27870	Arthrodesis, ankle, open
28110	Osteotomy, partial excision, fifth metatarsal head (bunionette) (separate procedure)
28285	Correction, hammertoe (eg, interphalangeal fusion, partial or total phalangectomy)
28286	Correction, cock-up fifth toe, with plastic skin closure (eg, Ruiz-Mora type procedure)
28289	Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; without implant
28291	Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; with implant
28292	Correction, hallux valgus with bunionectomy, with sesamoidectomy when performed; with resection of proximal phalanx base, when performed, any method
28295	Correction, hallux valgus with bunionectomy, with sesamoidectomy when performed; with proximal metatarsal osteotomy, any method
28296	Correction, hallux valgus with bunionectomy, with sesamoidectomy when performed; with distal metatarsal osteotomy, any method
28297	Correction, hallux valgus with bunionectomy, with sesamoidectomy when performed; with first metatarsal and medial cuneiform joint arthrodesis, any method
28298	Correction, hallux valgus with bunionectomy, with sesamoidectomy when performed; with proximal phalanx osteotomy, any method
28299	Correction, hallux valgus with bunionectomy, with sesamoidectomy when performed; with double osteotomy, any method
28306	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal
28307	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal with autograft (other than first toe)
28308	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; other than first metatarsal, each
28310	Osteotomy, shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)
28312	Osteotomy, shortening, angular or rotational correction; other phalanges, any toe
28315	Sesamoidectomy, first toe (separate procedure)
28750	Arthrodesis, great toe; metatarsophalangeal joint

CPT codes for Spine Surgery

Note: Codes listed are in scope for spine surgery.

Anterior Cervical Discectomy Fusion (ACDF) or Artificial Cervical Disc Arthroplasty

22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophyctomy and decompression of spinal cord and/or nerve roots; cervical below C2
22552	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophyctomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for separate procedure)
22554	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2
22585	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)
22634	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; each additional interspace (List separately in addition to code for primary procedure)
22845	Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure)
22853	Insertion of interbody biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace (List separately in addition to code for primary procedure)
22856	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophyctomy for nerve root or spinal cord decompression and microdissection); single interspace, cervical
22858	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophyctomy for nerve root or spinal cord decompression and microdissection); second level, cervical (List separately in addition to code for primary procedure)

Cervical Laminotomy/Laminectomy

63020	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical
63035	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)
63040	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; cervical
63043	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional cervical interspace (List separately in addition to code for primary procedure)
63048	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional vertebral segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)
63075	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophyctomy; cervical, single interspace
63076	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophyctomy; cervical, each additional interspace (List separately in addition to code for primary procedure)
63265	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; cervical

Lumbar Discectomy/Laminectomy

63005	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; lumbar, except for spondylolisthesis
63012	Laminectomy with removal of abnormal facets and/or pars inter-articularis with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar (Gill type procedure)
63017	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), more than 2 vertebral segments; lumbar
63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar

63042	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar
63044	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional lumbar interspace (List separately in addition to code for primary procedure)
63047	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar
63048	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional vertebral segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)
63056	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; lumbar (including transfacet, or lateral extraforaminal approach) (eg, far lateral herniated intervertebral disc)
63057	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; each additional segment, thoracic or lumbar (List separately in addition to code for primary procedure)
63267	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; lumbar

Lumbar Fusion and Treatment of Spinal Deformity (including Scoliosis and Kyphosis)

22633	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace, lumbar
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Vertebroplasty/Kyphoplasty

22510	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic
22511	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral
22512	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; each additional cervicothoracic or lumbosacral vertebral body (List separately in addition to code for primary procedure)
22513	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance
22514	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance
22515	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance

Appendix

ASA Physical Status Classification System

Classification	Definition	Adult examples, including, but not limited to:
ASA I	A normal healthy patient	Healthy, non-smoking, no or minimal alcohol use
ASA II	A patient with mild systemic disease	Mild diseases only without substantive functional limitations. Current smoker, social alcohol drinker, pregnancy, obesity (30 < BMI < 40), well-controlled DM/HTN, mild lung disease
ASA III	A patient with severe systemic disease	Substantive functional limitations; One or more moderate to severe diseases. Poorly controlled DM or HTN, COPD, morbid obesity (BMI ≥ 40), active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of ejection fraction, ESRD undergoing regularly scheduled dialysis, premature infant PCA < 60 weeks, history (> 3 months) of MI, CVA, TIA, or CAD/stents.
ASA IV	A patient with severe systemic disease that is a constant threat to life	Recent (< 3 months) MI, CVA, TIA, or CAD/stents, ongoing cardiac ischemia or severe valve dysfunction, severe reduction of ejection fraction, sepsis, DIC, ARD or ESRD not undergoing regularly scheduled dialysis
ASA V	A moribund patient who is not expected to survive without the operation	Ruptured abdominal/thoracic aneurysm, massive trauma, intracranial bleed with mass effect, ischemic bowel in the face of significant cardiac pathology or multiple organ/system dysfunction
ASA VI	A declared brain-dead patient whose organs are being removed for donor purposes	–

*The addition of "E" denotes Emergency surgery: (An emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part)

Source: 2014 [ASA Physical Status Classification System](#) (Amended December 13, 2020) available at the American Society of Anesthesiologists website; Accessed March 3, 2022.

History

Status	Review Date	Effective Date	Action
Reaffirmed	04/15/2024	Unchanged	Independent Multispecialty Physician Panel (IMPP) review. Guideline reaffirmed. Removed “and Procedures” from the title. Added references.
Updated	n/a	01/01/2024	Annual CPT code update. Description changes for 28292, 28295, 28296, 28297, 28298, 28299. Added guidance for correct coding to code section.
Revised	04/12/2023	11/05/2023 for commercial, Medicare and Medicaid except IA and LA; 04/14/2024 for IA Medicaid	IMPP review. Added Total or partial primary shoulder arthroplasty for Ambulatory surgery center with 23-hour observation. Added Shoulder arthroplasty CPT codes: 23470 and 23472. Updated references. Added required language to General Clinical Guideline per new Medicare regulations.
Updated	–	01/01/2023	2023 Annual CPT code update: description change for 22633.
Updated	–	01/01/2022	2022 Annual CPT code update: description changes for 22633, 22634, 63048. Updated access date to ASA physical status chart.
Reaffirmed	11/11/2021	Unchanged	IMPP review. Guideline reaffirmed.
Updated	–	01/01/2021	2021 Annual CPT code update: description changes for 23466, 29822, 29823.
Revised	02/03/2020	11/01/2020	IMPP review. Added clarifications for thoracic and sacral spine. Added CPT codes for joint surgery: 27702, 27703, 27704, 27870, 28110, 28285, 28286, 28289, 28291, 28292, 28295, 28296, 28297, 28298, 28299, 28306, 28307, 28308, 28310, 28312, 28315, 28750, 29871, 29892. Added CPT codes for spine surgery: 22633, 22634, 63265, 63267.
Revised	07/11/2018	03/09/2019	IMPP review. Added the General Clinical Guideline.
Revised	07/11/2018	01/28/2019	IMPP review. Added observation surgical setting.
Created	12/12/2017	03/01/2018	IMPP review. Original effective date.