Department:	Medical Management	**Original Approval:**	11/13/2024
Policy No:	MM202	**Last Approval:**	11/13/2024
Policy Title:	Knee Arthroscopy and Arthroplasty Clinical Coverage Criteria		
Approved By:	UM Criteria Subcommittee		
Applicable Line(s) of Business:	☐ **Washington Apple Health (Medicaid)** ☐ **Behavioral Health Services Only** ☐ **Apple Health Expansion** ☒ **Medicare Advantage/Special Needs Plan** ☒ **Medicare Advantage Only** ☐ **Cascade Select**		

Required Clinical Documentation for Review

Requests for prior authorization for knee arthroscopy and/or arthroplasty must be submitted by an operating orthopedic surgeon and accompanied by clinical documentation that supports the medical necessity for the requested procedures.

Documentation of medical necessity must include all of the following:

1. The primary diagnosis name(s) and the ICD-CM code(s) for the condition requiring arthroscopy;
2. The secondary diagnosis name(s) and ICD-CM code(s) pertinent to any co-morbid conditions, if present;
3. A description of the procedure and appropriate CPT code(s) for the procedure being requested;
4. The most recent medical evaluation, including a summary of the medical history and the most recent physical exam, with emphasis on the orthopedic knee examination and testing specific to the patient's condition;
5. Results of any radiology studies (e.g. routine x-rays, MRI, CT, etc.) and other tests that may have been previously performed and are relevant to the condition for which the procedure is being requested;
6. An official report of all the imaging studies. If the operating surgeon disagrees with the official report, they must document the disagreement. The imaging must have been performed within the last year, or after the onset of the current symptoms or any relevant surgical procedures, whichever comes first.

7. A summary of appropriate, nonsurgical/ conservative treatments that have been tried and have been unsuccessful in managing the patient's condition;
8. Any risk factors and/or co-morbid conditions;
9. Pertinent labs if abnormal

Background

CHPW creates internal coverage criteria for Medicare when the coverage criteria are not fully established in CMS coverage guidelines; National Coverage Determinations (NCDs), or Local Coverage Determinations (LCDs). Criteria may be considered as not fully established when (1) there are no applicable Medicare statutes or regulations, NCD, or applicable LCD setting forth coverage criteria; (2) the NCD or applicable LCD explicitly allow for coverage in circumstances beyond the indications listed in the NCD or LCD; or (3) additional, unspecified criteria are needed to interpret or supplement general Medicare provisions in order to determine medical necessity consistently. The current CMS coverage guidelines can be found on CMS Medicare Coverage Database and in the CMS Online Manual System (IOMs). You can also find new or recently changed policies or procedures in Transmittals. CHPW's internal clinical coverage criteria developed to assist in medical necessity determinations are based on the evidence-based guidelines and clinical studies in the peer-reviewed published medical literature as well as recommended practice guidelines. CHPW establishes internal guidelines to ensure timely decision-making for members and to assure that only services which are proven to be both safe and effective are provided. These services must demonstrate a clear benefit that outweighs any potential risks.

Per CMS, medical necessity is defined as services that are reasonable and necessary for diagnosis or treatment of an illness or injury, or to improve the functioning of a malformed body member and are not excluded under another provision of the Medicare Program. For information on services that are excluded, please review https://med.noridianmedicare.com/web/jfb/topics/non-covered-services.

Per Medicare guidelines, the services should be medically appropriate and necessary to be covered. Investigational and Experimental services will not be covered, as Medicare does not consider them to be medically necessary. Services should be FDA approved when appropriate.

CHPW follows CMS requirements to create Clinical Coverage Policies. All the policies are reviewed and voted on by the CHPW Utilization Management Criteria Committee. Policies are reviewed at least annually to reflect the changes in CMS guidance as well as the emergence of new technologies.

Definitions

Disorders of the knee are evaluated using subjective clinical symptoms such as “locked” or “catching” knee; objective findings on physical examination; radiologic findings; and response to a combination of nonsurgical treatments outlined in Appendix A. Physical examination may include techniques such as the Lachman and drawer tests to assess the integrity of the anterior cruciate ligament; McMurray’s test to assess for meniscal tears; and other tests to help identify the intactness of the major knee structures, such as ligaments and menisci. Magnetic resonance imaging (MRI) can be used to identify tears in knee structures, such as the anterior cruciate ligament, indicating the cause of symptoms and guiding treatment. In some conditions, such as osteoarthritis, the medical necessity of knee arthroscopy may be based on the severity of the condition as measured by grading systems, such as the Kellgren-Lawrence Grading System which appears in Appendix B.

Arthroscopy is a minimally invasive surgical procedure that allows a surgeon to examine and treat a joint's interior. An arthroscope is a small tube that is inserted into the body. It contains a system of lenses, a small video camera, and a light for viewing. The camera is connected to a monitoring system that lets a surgeon view the surgery while it's being done. The arthroscope is often used with other tools that are put through another cut or incision. These tools are used for grasping, cutting, and probing. Depending upon the extent and scope of the injury, your surgeon may be able to repair the problem using small surgical instruments.

Since it is a less invasive procedure compared to the open surgery, the post procedure pain, risk of infection, blood loss during the procedure, surrounding tissue damage, scarring, and the recovery time are significantly reduced. This procedure can be performed in an outpatient (ambulatory) setting.

Needle arthroscopy is a minimally invasive diagnostic and therapeutic arthroscopy system that can be performed using local anesthesia. The patient stays awake during the procedure and can follow instructions during the procedure to better help with the diagnosis. The camera attached to the needle provides real-time images of the joint area, allowing the patient to be directly involved in their care. It can be performed in a physician's office, hospital bedside, surgical suite or treatment room. Needle arthroscopy is a less invasive alternative to traditional arthroscopy and magnetic resonance imaging (MRI). It is a good option when a patient is not able to tolerate MRI or has contraindications to MRI.

CPT codes and descriptions – Knee Arthroscopy
Codes listed here are for informational purposes only.

CPT® Code(s)	Description	Comments
27599	Unlisted procedure, femur or knee	
29850	Arthroscopically aided treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, with or without manipulation; without internal or external fixation (includes arthroscopy)	
29851	Arthroscopically aided treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, with or without manipulation; with internal or external fixation (includes arthroscopy)	
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	
29999	Unlisted procedure, arthroscopy	
HCPCS Code(s)	**Description**	**Comments**
S2112	Arthroscopy, knee, surgical for harvesting of cartilage (chondrocyte cells)	

Indications/Criteria

Indications For Knee Arthroscopy

For clinical coverage criteria for Arthroscopic Lavage and Arthroscopic Debridement for the Osteoarthritic Knee:
Please refer to NCD 150.9 https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=285

For clinical coverage criteria for Total Knee Arthroplasty:
Please refer to LCD - Total Knee Arthroplasty (L36577)

Following guidelines include clinical indications for knee arthroscopy without arthroplasty for following diagnoses:

1) Diagnostic knee arthroscopy
2) Meniscectomy/meniscal repair
3) Baker's or Popliteal Cyst
4) Lateral release/patellar realignment
5) Patellar malalignment and/or patellar instability
6) Collateral ligament reconstruction/repair
7) Anterior cruciate ligament (ACL) reconstruction/repair
8) Posterior cruciate ligament (PCL) reconstruction/repair
9) Loose body removal
10) Synovectomy
11) Lysis of adhesions for arthrofibrosis of the knee secondary to trauma/injury
12) Debridement with or without chondroplasty for mild to moderate cartilage wear
13) Debridement chondroplasty for patellofemoral chondrosis
14) Manipulation under anesthesia (MUA) post total knee replacement

Arthroscopy of the knee is indicated when patient's symptoms persist despite conservative/nonsurgical treatments, with the exception of certain diagnoses. Nonsurgical treatments include rest, physical therapy, and medications or injections to reduce joint inflammation, as stated in Appendix A. This procedure will be considered medically reasonable and necessary when the following indications are met. Approval for coverage of knee arthroscopy is on an individual, case-by-case basis.

Determination of medical necessity for knee arthroscopy is based on clinical data including, but not limited to, indicators that would affect the relative risks and benefits of the knee arthroscopy. These criteria include, but are not limited to, the following.

1. Diagnostic knee arthroscopy may be medically necessary when ALL of the following criteria (a through d) are met:

   a. At least 12 weeks of knee pain accompanied by documented functional limitations, which may include difficulty with weight-bearing, joint instability, or reduced range of motion (e.g., greater than 10 degrees of flexion contracture or less than 90 degrees of flexion, or both). These issues must significantly affect the individual's ability to perform daily activities (ADLs), engage in recreational pursuits, or maintain employment due to pain or injury.
   b. Failure of 12 weeks of nonsurgical treatments to improve symptoms.;

   c. Clinical documentation detailing the signs and symptoms both prior to and following the nonsurgical treatments.
   d. Indeterminate radiographic and MRI findings.

   2. Meniscectomy or repair of torn meniscus may be medically necessary when ALL of the following criteria (a through c) are met:

   a. ONE of the following criteria (i or ii) is met:

      i. Symptomatic meniscal tear confirmed by MRI results that show a peripheral longitudinal tear in a vascular zone, associated with pain and mechanical symptoms upon physical exam;

      ii. At least three of the following five criteria are met:
      a. History of “catching” or “locking” as reported by the patient;
      b. Knee joint-line pain with forced hyperextension on physical exam;
      c. Knee joint-line pain with maximum flexion on physical exam;
      d. Knee pain or an audible click with McMurray’s maneuver on physical exam;
      e. Joint-line tenderness to palpation on physical exam;

   b. At least six weeks of nonoperative care has failed to improve symptoms;

   c. One of the following findings (i, ii, or iii) exists:
      i. Radiographs without moderate or severe osteoarthritic changes;

ii. MRI results confirm meniscal tear in patients < 30 years of age;
iii. MRI results confirm displaced tear (any age).

3. Excision of a popliteal/Baker's cyst or exploration of causative pathology may be medically necessary after a failed trial of nonsurgical therapy.

4. Lateral release/patellar realignment may be medically necessary when ALL of the following criteria (a through f) are met:

   a. Evidence of lateral patellar tilt from one of the following radiologic images (patellofemoral view);
      i. Mercer-Merchant (45-60 degrees flexion);
      ii. skyline (60-90 degrees flexion);
      iii. sunrise (60-90 degrees flexion).

   b. Associated lateral patella facet K-L changes, grade I, II, or III;

   c. Reproducible isolated lateral patellofemoral pain with patellar tilt test;

   d. At least six months of non-operative care has failed to improve symptoms, including appropriate hamstring/IT band stretching and patellar mobilization techniques;

   e. No evidence of patellar dislocation without documented patellar tilt; and

   f. No evidence of medial patellofemoral changes (Kellgren-Lawrence Grades II, III, or IV osteoarthritis).

5. Patellar malalignment and/or patellar instability repair may be medically necessary when ALL of the following criteria (a through d) are met:

   a. ONE of the following criteria (i, ii, or iii) is present:

      i. Acute traumatic patellar dislocation is associated with an osteochondral fracture, loose body, vastus medialus obliquus/Medial patellofemoral ligament muscle avulsion, or other intra-articular injury that requires urgent operative management;
      ii. Repeat (more than two) patellar dislocations or subluxations have occurred despite six months of nonoperative care with radiologic confirmation of MPFL (medial patellofemoral ligament) deficiency;

iii. Physical exam has patellofemoral tenderness and abnormal articulation of the patella in the femoral trochlear groove (patellar apprehension with positive-J sign);

b. Radiologic images rule out fracture or loose body, and show abnormal articulation, trochlear dysplasia, or other abnormality related to malalignment;
c. CT scan or MRI rules out other abnormality to malalignment (tibial tubercle trochlear groove (TT-TG) distance > 20 millimeters);
d. At least six months of nonoperative care has failed to improve symptoms.

6. Collateral ligament repair or reconstruction: Collateral ligament repair or reconstruction should rarely occur independent of additional repair or reconstruction surgery. All nontraumatic collateral ligament repair/reconstruction requests will be reviewed for medical necessity on a case-by-case basis.

7. Anterior cruciate ligament (ACL) reconstruction or repair may be medically necessary when ALL of the following criteria (a and b) are met:

a. ONE of the following two criteria (i or ii) is met:

i. All of the following ((a) through (c)) are met:
a) Knee instability (as defined subjectively as “giving way”, “giving out”, “buckling”, or two-fist sign) with clinical findings of instability: Lachman’s 1A, 1B, 2A, 2B, 3A, 3B, Anterior Drawer, or Pivot Shift, instrumented (KT-1000 or KT-2000) laxity of greater than three mm side-side difference;
b) MRI results confirm complete ACL tear;
c) Patient has no evidence of severe arthritis (Kellgren-Lawrence Grade III or IV);

ii. ONE of the following criteria ((a), (b), or (c)) is met:
(a) MRI results confirm ACL tear associated with other ligamentous instability or repairable meniscus;
(b) MRI results confirm partial or complete ACL tear AND patient has persistent symptoms despite at least 12 weeks of nonoperative care;
(c) Acute ACL tear confirmed by MRI in high-demand occupation or competitive athlete (as quantified by Marx activity score for athletics (any score greater than four) and Tegner activity score for athletics and/or occupation (score greater than two);

b. Patient has no evidence of severe arthritis (Kellgren-Lawrence Grade III or IV).

c. NB. Tears in patients less than age 13 will be reviewed on a case-by-case basis to determine if (ACL) reconstruction or repair is medically necessary.

8. Posterior Cruciate Ligament reconstruction or repair may be medically necessity when ALL of the following criteria (a through d) are met:
    a. Knee instability (defined subjectively as “giving way”, “giving out”, “buckling”, or two-fist sign) with clinical findings of a positive posterior drawer test, posterior sag test, quadriceps active test, dial test at 90 degrees knee flexion, or reverse pivot shift test;
    b. MRI results confirm complete PCL tear;
    c. Failed nonoperative care (including bracing in full extension for acute PCL tears);
    d. Absence of medial and patellofemoral Kellgren-Lawrence grade III-to-IV changes in chronic tears.

    The following clinical scenarios will be reviewed on a case-by-case basis to determine if posterior cruciate ligament reconstruction or repair is medically necessary:
        i. Symptomatic partial tears with persistent instability despite nonoperative care;
        ii. Incidental Kellgren-Lawrence grade II-to III-osteoarthritis in acute or subacute tears with unstable joint;
        iii. Tears in patients less than age 13.

9. Loose body or foreign object that causes documented functional limitations, which may include difficulty with weight-bearing, joint instability, or reduced range of motion (e.g., greater than 10 degrees of flexion contracture or less than 90 degrees of flexion, or both). These issues must significantly affect the individual's ability to perform daily activities (ADLs), engage in recreational pursuits, or maintain employment due to pain or injury.

10. Synovectomy (major = 2+ compartments; minor = 1 compartment) as defined by the medial compartment (inside the knee joint), the lateral compartment (outside the knee joint), and the patellofemoral compartment (front of the knee joint between the patella and the femur) may be medically necessary when ONE of the following criteria (a, b, c, or d) is met:

    a. Proliferative rheumatoid synovium (in patients with established rheumatoid arthritis according to the American College of Rheumatology Guidelines) that is not responsive to disease modifying antirheumatic drug (DMARD) therapy for at least six months, and at least six weeks of nonoperative care that has failed to

improve symptoms, and at least one instance of aspiration of joint effusion and cortisone injection (if no evidence of infection);

b. Hemarthrosis from injury, coagulopathy, or bleeding disorder confirmed by physical exam, joint aspiration, or MRI, and ONE of the following criteria (i or ii) is met:
   i. At least six weeks of nonoperative care that has failed to improve symptoms and at least one instance of aspiration of joint effusion and injection of cortisone (if no evidence of infection);
   ii. Detection of painful plica confirmed by physical exam and MRI findings, with at least 12 weeks of nonoperative care that has failed to improve symptoms and at least one instance of aspiration of joint effusion OR single injection of cortisone (effusion may not be present with symptomatic plica);
c. Proliferative pigmented villonodular synovitis, synovial chondromatosis, sarcoid synovitis, or similar proliferative synovial disease, traumatic hypertrophic synovitis confirmed by history, MRI, or biopsy when the following criteria (i and ii) are met;
   i. At least six weeks of nonoperative care that has failed to improve symptoms; and
   ii. At least one instance of aspiration of joint effusion and injection of cortisone (if no evidence of infection);
d. Detection of painful plica confirmed by physical exam and MRI findings when the following criteria (i and ii) are met;
   i. At least 12 weeks of nonoperative care that has failed to improve symptoms; and
   ii. At least one instance of aspiration of joint effusion OR single injection of cortisone (effusion may not be present with symptomatic plica).

11. Arthroscopically assisted lysis of adhesions for arthrofibrosis of the knee: Surgical indications are based on relevant clinical symptoms, physical exam and radiologic findings, time from primary knee surgery, and response to medically appropriate nonsurgical management. Improvement in range of motion may be accomplished through arthroscopically assisted lysis of adhesions. Arthroscopically assisted lysis of adhesions may be medically necessary when ONE of the following criteria (a or b) is met:
    a. ALL of the following criteria (i, ii, and iii) are met:
       i. Physical exam findings demonstrate inadequate range of motion of the knee, defined as less than 105 degrees of flexion;

ii. Range of motion of the knee has failed to improve despite six weeks (12 visits) of documented physical therapy;
iii. The member is more than 12 weeks after ligamentous or joint reconstruction, or resolved infection;

b. ALL of the following criteria (i, ii, and iii) are met:
i. The member is more than 12 weeks after trauma, or resolved infection;
ii. The member has a native knee;
iii. Manipulation under anesthesia is also performed.

12. Debridement with or without chondroplasty for mild-to-moderate cartilage wear may be medically necessary when ONE of the following criteria (a or b) is met:
a. ALL of the following criteria (I through IV) are met:
I. At least 12 weeks of knee pain with documented functional limitations, which may include difficulty with weight-bearing, joint instability, or reduced range of motion (e.g., greater than 10 degrees of flexion contracture or less than 90 degrees of flexion, or both). These issues must significantly affect the individual's ability to perform daily activities (ADLs), engage in recreational pursuits, or maintain employment due to pain or injury.
II. At least 12 weeks of nonoperative care that has failed to improve symptoms;
III. MRI results showing evidence of unstable chondral flap;
IV. Recurrent (more than two) or persistent effusion(s);

b. Arthrofibrosis as evidenced by physical exam findings of painful stiffness and loss of motion due to proliferation of scar tissue in and around the joint, and at least six weeks of supervised or self-directed physical therapy that has failed to improve symptoms. Imaging may be used to determine the diagnosis but is not necessary.

13. Debridement chondroplasty for patellofemoral chondrosis may be medically necessary when ALL of the following criteria (a through f) are met:
a. At least 12 weeks of knee pain accompanied by documented functional limitations, which may include difficulty with weight-bearing, joint instability, or reduced range of motion (e.g., greater than 10 degrees of flexion contracture or less than 90 degrees of flexion, or both). These issues must significantly affect the individual's ability to perform daily activities (ADLs), engage in recreational pursuits, or maintain employment due to pain or injury.

b. Other extra-articular or intra-articular sources of pain or dysfunction, such as referred pain, radicular pain, tendinitis, bursitis, or neuroma, have been excluded;
c. Tenderness localized to the patellofemoral joint on physical exam with pain aggravated by activities that load the joint, including performing a single leg squat; ascending is more difficult than descending stairs; and being in a seated position for extended periods of time with knee flexed;
d. Imaging to measure tibial tubercle–trochlear groove distance (radiographs, MRI, or CT);
e. At least 12 weeks of nonoperative care have failed to improve symptoms;
f. No evidence of Kellgren-Lawrence Grade III-IV osteoarthritis evidenced on standing or weight-bearing radiographs and patellofemoral views.

14. Manipulation under anesthesia (MUA) may be medically necessary when ALL of the following criteria (a through c) are met:
    a. Physical exam findings demonstrate inadequate range of motion of the knee defined as less than 105 degrees of flexion;
    b. Six weeks (minimum of 12 visits) of physical therapy fails to show improved range of motion of the knee;
    c. Patient is less than 12 weeks after ligamentous or joint reconstruction.

Special Considerations

Failure of nonsurgical treatments is not required in the following situations:

1. when documented contraindications to particular nonsurgical treatments are present.
2. In the presence of knee infection.
3. Acute trauma resulting in functional impairment, signs and symptoms of traumatic injury supported by radiological findings.

Limitations/Exclusions

Arthroscopy of knee arthroscopy will not be considered to be medically necessary under certain circumstances. Examples of such circumstances include, but are not limited to, the following:

1. Osteoarthritis of the knee when this is the sole diagnosis
2. Meniscal tear in chronic degenerative knee joint disease in the absence of mechanical symptoms such as locking or catching knee or the absence of a loose body or meniscal tear
3. Meniscal tear in the presence of Kellgren-Lawrence Grade IV osteoarthritis

4. Presence of isolated medial or collateral ligament tears
5. Procedures utilizing computer-navigated or patient-specific or gender-specific instrumentation
6. Bicompartmental arthroplasty that is considered investigational
7. Robot-assisted TKA (Makoplasty)

Line of Business	Link to Member Coverage Documents
Medicare Advantage Plans (Including D-SNP)	https://medicare.chpw.org/ Select the appropriate plan from the "Plans" drop down on the top navigation bar.
Apple Health	
Cascade Select	

List of Appendices

A. Appendix A: Nonsurgical /Conservative treatments for knee conditions
B. Appendix B: Kellgren-Lawrence (KL) Grading System
C. Appendix C: List of Sources

Citations & References

CFR	42 CFR 422.101(b)(6)	
WAC		
RCW		
LOB & Contract Citation	☐ **WAHIMC**	
	☐ **BHSO**	
	☐ **Wraparound**	
	☐ **SMAC**	
	☐ **HH**	
	☐ **AHE**	
	☒ **MA/DSNP**	MMCM Ch 4, Sec. 10.16: Medical Necessity and Sec. 90: National and Local Coverage Determinations
	☐ **CS**	
Other Requirements		
NCQA Elements		

References	

Revision History

Revision Date	Revision Description	Revision Made By
11/07/2024	Policy created	Aparna Gadekar, MD
11/13/2024	Approval	UM Criteria Subcommittee

Appendix A: Nonsurgical /Conservative treatments for knee conditions

1. Modifications in activity including
    a. Rest or activity modification or limitation
    b. Bracing/orthosis or walking aids
    c. Protected weight bearing
    d. Weight optimization

2. Physical therapy modalities
    a. Ice/heat
    b. Exercises to strengthen and improve mobility in formal physical therapy sessions
    c. Supervised home exercise to strengthen and improve mobility

3. Medications
    a. Oral/topical NSAIDS or other analgesics
    b. Injections such as cortisone

*Physical therapy needs to be confirmed either by the actual PT notes, or by documentation in the member records.

*Conservative treatments must be within 1 year of requested procedure.

*Intra-articular steroid injections should be avoided 1 month prior to planned interventions on the same joint.

Appendix B: Kellgren-Lawrence (KL) Grading System

Grade 0: No radiographic features of osteoarthritis
Grade I: Possible joint space narrowing and osteophyte formation
Grade II: Definite osteophyte formation with possible joint space narrowing
Grade III: Moderate multiple osteophytes, definite narrowing of joint space, some sclerosis and possible deformity of bone contour
Grade IV: Large osteophytes, marked narrowing of joint space, severe sclerosis and definite deformity of bone contour

Appendix C: List of Sources

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