ELBOW REPLACEMENT SURGERY
(ARTHROPLASTY)

Protocol: ORT014
Effective Date: June 1, 2017

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INSTRUCTIONS FOR USE
This protocol provides assistance in interpreting UnitedHealthcare benefit plans. When deciding
coverage, the enrollee specific document must be referenced. The terms of an enrollee's document
(e.g., Certificate of Coverage (COC) or Evidence of Coverage (EOC)) may differ greatly. In the event
of a conflict, the enrollee's specific benefit document supersedes this protocol. All reviewers must first
identify enrollee eligibility, any federal or state regulatory requirements and the plan benefit coverage
prior to use of this Protocol. Other Protocols, Policies and Coverage Determination Guidelines may
apply. UnitedHealthcare reserves the right, in its sole discretion, to modify its Protocols, Policies and
Guidelines as necessary. This protocol is provided for informational purposes. It does not constitute
medical advice. This policy does not govern Medicare Group Retiree members.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines,
to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in
connection with the independent professional medical judgment of a qualified health care provider and
do not constitute the practice of medicine or medical advice.

COMMERCIAL, MEDICARE, & MEDICAID COVERAGE RATIONALE

For information regarding medical necessity review, when applicable, see MCG™ Care Guidelines,
listed below:

MCG™ Care Guidelines: Elbow Arthroplasty, S-420 (ISC)
Clinical Indications for Procedure

Procedure is indicated for 1 or more of the following:

1. Rheumatoid arthritis treatment indicated by ALL of the following:
   • Failure of alternative treatments (eg, pharmacotherapy, cortisone injections, synovectomy)
   • Pain or loss of function resulting in inability to perform activities of daily living

2. Inability to perform activities of daily living due to 1 or more of the following:
   • Ankylosis of the elbow or other advanced disease causing loss of function
   • Posttraumatic arthrosis causing pain or loss of function
• Supracondylar nonunion causing loss of function
3. Joint instability from tumor resection or other destructive process
4. Hemophilic arthropathy
5. Complex fracture of radial head
6. Elbow dislocation with fracture of the radial head and coronoid process ("terrible triad fracture")
7. Comminuted distal humerus fracture and ALL of the following:
   • Patient older than 65 years of age
   • Patient with osteopenia
8. Displaced intra-articular distal humerus fracture and 1 or more of the following:
   • Osteoporosis
   • Fracture not amenable to internal fixation
9. Nonunion or malunion of intra-articular fracture
10. Revision of failed elbow arthroplasty

*** End of MCG

Medicare does not have a National Coverage Determination (NCD) for elbow replacement surgery. Local Coverage Determinations (LCDs) for Nevada do not exist at this time (Accessed April 2017).

For Medicare and Medicaid Determinations Related to States Outside of Nevada:
Please review Local Coverage Determinations that apply to other states outside of Nevada.
http://www.cms.hhs.gov/mcd/search

Important Note: Please also review local carrier Web sites in addition to the Medicare Coverage database on the Centers for Medicare and Medicaid Services’ Website.

U.S. FOOD AND DRUG ADMINISTRATION (FDA)

Elbow replacement surgery is a procedure and therefore is not regulated by the FDA. However, devices and instruments used during the surgery require FDA approval. See the following website for additional information (product codes JDC and KW1):

FDA-approved total or partial elbow replacement surgery devices are generally approved for the same indications, including any or all of the following:
• Non-inflammatory degenerative joint disease such as osteoarthritis
• Rheumatoid arthritis
• Post-traumatic arthritis, tumor or bone loss causing elbow instability
• Complex fracture(s) of elbow components
• Ankylosis
• Revision of failed elbow replacement surgery
• Correction of functional deformity
APPLICABLE CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other protocols may apply.

<table>
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<th>CPT® Codes</th>
<th>Description</th>
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<tr>
<td>24360</td>
<td>Arthroplasty, elbow; with membrane (e.g., fascial)</td>
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<td>24361</td>
<td>Arthroplasty, elbow; with distal humeral prosthetic replacement</td>
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<tr>
<td>24362</td>
<td>Arthroplasty, elbow; with implant and fascia lata ligament reconstruction</td>
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<tr>
<td>24363</td>
<td>Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (e.g., total elbow)</td>
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<td>24370</td>
<td>Revision of total elbow arthroplasty, including allograft when performed; humeral or ulnar component</td>
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<tr>
<td>24371</td>
<td>Revision of total elbow arthroplasty, including allograft when performed; humeral and ulnar component</td>
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*CPT® is a registered trademark of the American Medical Association*

PROTOCOL HISTORY/REVISION INFORMATION

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The foregoing Health Plan of Nevada/Sierra Health & Life Health Operations protocol has been adopted from an existing UnitedHealthcare coverage determination guideline that was researched, developed and approved by the UnitedHealthcare Coverage Determination Committee.