Knee Arthroscopy

Prior Authorization Tip Sheet

*This tip sheet is intended to further assist you in the prior authorization process and for clarification of the Evolent Health (formerly Magellan Hawai'i)[1] clinical guidelines. It is for informational purposes only and is **NOT** intended as a substitute for the clinical guidelines that should be reviewed prior to submitting requests for surgical procedures.*

Guideline NIA_CG-316

Office notes should clearly state the surgical plan

Categories for requests:

Knee Ligament Reconstruction/Repair *(includes meniscectomy, lateral release/patellar realignment, articular cartilage restoration)*

Knee Meniscectomy/Meniscal Repair/Meniscal Transplant *(includes synovectomy, loose body removal, chondroplasty/debridement, lateral release/patellar realignment, articular cartilage restoration)*

Knee Surgery – Other *(includes synovectomy, loose body removal, diagnostic knee arthroscopy, debridement with or without chondroplasty, lateral release/patellar realignment, articular cartilage restoration)*

Knee Manipulation under Anesthesia *(includes lysis of adhesions)*

General Comments:

- Office notes for arthroscopic knee surgery requests should document:
    - Symptom onset, duration, and severity;
    - Loss of function and/or limitations;
    - Type and duration of non-operative management modalities (where applicable).
- The required **duration of non-operative treatment** will vary depending on the surgical procedure - (Example: 6 weeks for meniscectomy, 3 months for diagnostic arthroscopy, 6 months for patellofemoral procedures). See NIA guideline 316 for specific requirements.

[1] *Effective 1/20/2023, National Imaging Associates, Inc. is now a subsidiary of Evolent Health. Evolent Health and its affiliates and subsidiaries collectively referred to as "Evolent."*

- Requests for diagnostic knee arthroscopy should have both X-rays *and* an MRI that show indeterminate findings – no arthritis, loose bodies, meniscus tears, etc. The actual MRI report should be provided.

- For all knee arthroscopy requests, **the weight-bearing status of all X-rays** should be documented in the office notes. If an MRI was performed, the actual **MRI report** should be included in the office notes as well.

- **For meniscus surgery requests, if there is evidence of associated arthritis by history, physical examination or MRI, weight-bearing X-rays are required to further establish the degree of articular cartilage loss.** Unless the patient has a locked knee with a displaced bucket-handle tear, weight-bearing X-rays must show **no more than mild arthritis** for approval of meniscus procedures. (No more than K-L 2 changes – see grading appendix*)

- Requests for a MPFL reconstruction can be submitted under “Knee Surgery Other” or Knee Ligament Reconstruction/Repair.

❖ **Knee Ligament Reconstruction/Repair** *(includes meniscectomy, lateral release/patellar realignment, articular cartilage restoration)*

ACL Reconstruction:

ACL reconstruction requests *do not require non-operative treatment* provided the following criteria are met:

- Knee instability (as defined subjectively as "giving way", "giving out", "buckling", two-fist sign) with clinical findings of instability: Lachman’s 1A, 1B, 2A, 2B, 3A, 3B, Anterior Drawer, Pivot Shift test, or instrumented (KT-1000 or KT-2000) laxity of greater than 3 mm side-side difference;
- MRI results confirm complete ACL tear;
- Member has no evidence of severe arthritis (Kellgren-Lawrence** Grade 3 or 4 [see grading appendix]) on weight-bearing x-rays;

  OR

- **At least ONE** of the following criteria are met:
  - MRI results confirm ACL tear associated with other ligamentous instability or repairable meniscus;
  - Acute ACL tear confirmed by MRI in high demand occupation or competitive athlete (any level of participation);

- Member has no evidence of severe arthritis (Kellgren-Lawrence Grade 3 or 4) on weightbearing x-rays

❖ **Knee Meniscectomy/Meniscal Repair/Meniscal Transplant** *(includes synovectomy, loose body removal, chondroplasty/debridement, lateral release/patellar realignment, articular cartilage restoration)*

Non-operative treatment for meniscal tears is not required in the following situations:

- Symptomatic meniscal tear confirmed by MRI results that demonstrate a peripheral tear in the vascular zone, root tear or other tear that the requesting physician considers repairable and is associated with pain localized to the corresponding compartment upon physical examination.

OR

- MRI results demonstrate a meniscus tear in a pediatric or adolescent patient who complains of either pain or mechanical symptoms and has ANY positive meniscal findings on physical examination.

OR

- History of acute injury/onset of symptoms with a locked knee and/or mechanical symptoms of locking; Physical examination demonstrates ANY positive meniscal findings on examination or demonstrates evidence of a locked knee (loss of terminal extension); MRI demonstrates a bucket-handle tear of the meniscus. (Does not include an extruded meniscus or flap tears)

Most meniscal tears WILL require documentation of non-operative treatment as follows:

- Failure of at least 6 weeks of non-operative treatment, including **at least two** of the following:
  - Rest or activity modifications/limitations
  - Ice/heat
  - Protected weight bearing
  - Pharmacologic treatment: oral/topical NSAIDS, acetaminophen, analgesics, tramadol
  - Brace/orthosis
  - Physical therapy modalities
  - Supervised home exercise
  - Weight optimization
  - Corticosteroid injection

❖ **Loose body removal**

Non-operative treatment is not required if the following criteria are met:

- Documentation of mechanical symptoms the cause limitation or loss of function
- X-ray or MRI documentation of a loose body

❖ **Patellar Malalignment and/or Patellar Instability:**

Surgical intervention for the treatment of patellar malalignment and/or patellar instability is indicated when **ALL** of the following criteria in any of the following subsections are met:

- 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.

  OR

- Repeat (2 or more) patellar dislocations or subluxations have occurred despite 6 months of non-operative treatment with radiologic confirmation of MPFL (medial patellofemoral ligament) deficiency (including evidence of acute or remote injury, scarring, incomplete healing, etc.) **OR** physical examination demonstrates evidence of patellar instability (positive apprehension test).

  OR

- When all the following criteria have been met:
  - Physical exam has patellofemoral tenderness and abnormal articulation of the patella in the femoral trochlear groove (patellar apprehension or positive J sign);
  - Radiologic and/or advanced images (CT or MRI) rule out fracture or loose body, and show abnormal articulation, trochlear dysplasia, abnormal TT-TG distance (tibial tubercle-trochlear groove)* or other abnormality related to malalignment.
  - Failure of at least 6 months of non-operative treatment, including at least 3 months of physical therapy, and **ONE** of the following:
    - Rest or activity modifications/limitations
    - Ice/heat
    - Protected weight bearing
    - Pharmacologic treatment: oral/topical NSAIDS, acetaminophen, analgesics, tramadol
    - Brace/orthosis
    - Supervised home exercise
    - Weight optimization
    - Corticosteroid injection

*The tibial tubercle-trochlear groove (TT-TG) distance is normally @5-10mm. Some authors use 13mm as a cut-off and most agree that a TT-TG of 15 or over is abnormal. TT-TG values over 17 indicate other possible bony abnormalities.

The following is a summary of non-operative treatment required for some of the other more *common* arthroscopic knee procedures. The guidelines should be reviewed for additional requirements including duration of symptoms, physical examination, and radiographic criteria and for the complete listing of other procedures not included below. (NIA Guideline 316)

❖ Lateral Release

- Failure of **at least 6 months** of non-operative treatment, including quadriceps strengthening and appropriate hamstring/IT band stretching and patellar mobilization techniques, and **at least one** of the following:
    - Rest or activity modifications/limitations
    - Ice/heat
    - Protected weight bearing
    - Pharmacologic treatment: oral/topical NSAIDS, acetaminophen, analgesics, tramadol
    - Brace/orthosis
    - Physical therapy modalities
    - Supervised home exercise
    - Weight optimization
    - Corticosteroid injection

❖ Debridement chondroplasty for patellofemoral chondrosis

- Failure of **at least 12 weeks** of non-operative treatment, including **at least two** of the following:
    - Rest or activity modifications/limitations
    - Ice/heat
    - Protected weight bearing
    - Pharmacologic treatment: oral/topical NSAIDS, acetaminophen, analgesics, tramadol
    - Brace/orthosis
    - Physical therapy modalities
    - Supervised home exercise
    - Weight optimization
    - Corticosteroid injection

❖ Diagnostic Knee Arthroscopy

- Failure of at least 12 weeks of non-operative treatment, including at least **two** of the following:
    - Rest or activity modifications/limitations
    - Ice/heat
    - Protected weight bearing
    - Pharmacologic treatment: oral/topical NSAIDS, acetaminophen, analgesics, tramadol

- Brace/orthosis
- Physical therapy modalities
- Supervised home exercise
- Weight optimization
- Corticosteroid injection

*** Kellgren-Lawrence Grading System (Standing/weight-bearing X-rays):**
MRI should not be the primary tool used to determine the presence or severity of arthritic changes in the joint.

Grade	Description
0	No radiographic features of osteoarthritis
1	Possible joint space narrowing and osteophyte formation
2	Definite osteophyte formation with possible joint space narrowing
3	Moderate multiple osteophytes, definite narrowing of joint space, some sclerosis and possible deformity of bone contour
4	Large osteophytes, marked narrowing of joint space, severe sclerosis and definite deformity of bone contour