



MASSACHUSETTS

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Medical Policy

Meniscal Allografts and Other Meniscal Implants

Table of Contents

- [Policy: Commercial](#)
- [Policy: Medicare](#)
- [Authorization Information](#)
- [Coding Information](#)
- [Description](#)
- [Policy History](#)
- [Information Pertaining to All Policies](#)
- [References](#)

Policy Number: 110

BCBSA Reference Number: 7.01.15 (For Plan internal use only)

Related Policies

- Osteochondral Allograft Transplantation and Osteochondral Autograft Transplantation, #[111](#)
- Autologous Chondrocyte Implantation, #[374](#)

Policy

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

Meniscal allograft transplantation may be considered **MEDICALLY NECESSARY** in individuals who have had a prior meniscectomy and have symptoms related to the affected side, when **ALL** of the following criteria are met:

- Adult individuals should be too young to be considered an appropriate candidate for total knee arthroplasty or other reconstructive knee surgery (eg, <55 years)
- Disabling knee pain with activity that is refractory to conservative treatment
- Absence or near absence (>50%) of the meniscus, established by imaging or prior surgery
- Documented minimal to absent diffuse degenerative changes in the surrounding articular cartilage (eg, Outerbridge grade II or less, < 50% joint space narrowing)
- Normal knee biomechanics, or alignment and stability achieved concurrently with meniscal transplantation.

Meniscal allograft transplantation may be considered **MEDICALLY NECESSARY** when performed in combination, either concurrently or sequentially, with treatment of focal articular cartilage lesions using any of the following procedures:

- Autologous chondrocyte implantation, **OR**
- Osteochondral allografting, **OR**
- Osteochondral autografting.

Use of other meniscal implants incorporating materials such as collagen are **INVESTIGATIONAL**.

Prior Authorization Information

Inpatient

- For services described in this policy, precertification/preauthorization **IS REQUIRED** for all products if the procedure is performed **inpatient**.

Outpatient

- For services described in this policy, see below for products where prior authorization **might be required** if the procedure is performed **outpatient**.

	Outpatient
Commercial Managed Care (HMO and POS)	Prior authorization is required .
Commercial PPO	Prior authorization is required .

Requesting Prior Authorization Using Authorization Manager

Providers will need to use [Authorization Manager](#) to submit initial authorization requests for services. Authorization Manager, available 24/7, is the quickest way to review authorization requirements, request authorizations, submit clinical documentation, check existing case status, and view/print the decision letter. For commercial members, the requests must meet medical policy guidelines.

To ensure the service request is processed accurately and quickly:

- Enter the facility’s NPI or provider ID for where services are being performed.
- Enter the appropriate surgeon’s NPI or provider ID as the servicing provider, *not* the billing group.

Authorization Manager Resources

Refer to our [Authorization Manager](#) page for tips, guides, and video demonstrations.

CPT Codes / HCPCS Codes / ICD Codes

Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member’s contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

The following codes are included below for informational purposes only; this is not an all-inclusive list.

The above medical necessity criteria MUST be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity:

CPT Codes

CPT codes:	Code Description
29868	Arthroscopy, knee, surgical; meniscal transplplantation (includes arthrotomy for meniscal insertion), medial or lateral

ICD-10-PCS Procedure Codes

ICD-10-PCS procedure codes:	Code Description
0SQC0ZZ	Repair Right Knee Joint, Open Approach
0SQC4ZZ	Repair Right Knee Joint, Percutaneous Endoscopic Approach
0SQD0ZZ	Repair Left Knee Joint, Open Approach
0SQD4ZZ	Repair Left Knee Joint, Percutaneous Endoscopic Approach

The following HCPCS code is considered investigational for Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity:

HCPCS Codes

HCPCS codes:	Code Description
G0428	Collagen meniscus implant procedure for filling meniscal defects (e.g., CMI, collagen scaffold, Menaflex)

Description

Meniscal Cartilage Damage

Meniscal cartilage is an integral structural component of the human knee, functioning to absorb shocks and providing load sharing, joint stability, congruity, proprioception, and lubrication and nutrition of the cartilage surfaces. Total and partial meniscectomy frequently result in degenerative osteoarthritis. The integrity of the menisci is particularly important in knees in which the anterior cruciate ligament has been damaged. In these situations, the menisci act as secondary stabilizers of anteroposterior and varus-valgus translation.

Treatment

Meniscal allograft transplantation (MAT) is considered a salvage procedure, reserved for patients with disabling knee pain following meniscectomy who are considered too young to undergo total knee arthroplasty or in patients who require a total or near total meniscectomy for irreparable tears. As a result, the population intended to receive these transplants is relatively limited. Using a large database of privately insured non-Medicare patients, Cvetanovich et al (2015) estimated an annual incidence of MAT in the U.S. of 0.24 per 100,000.¹ It is not expected that clinical trials will be conducted to compare meniscal allografts with other orthopedic procedures, although trials comparing allograft transplant with medical therapy are possible.

There are 3 general groups of patients who have been treated with MAT:

- young patients with a history of meniscectomy who have symptoms of pain and discomfort associated with early osteoarthritis that is localized to the meniscus-deficient compartment.
- patients undergoing anterior cruciate ligament reconstruction in whom a concomitant meniscal transplant is intended to provide increased stability.
- young athletes with few symptoms in whom the allograft transplantation is intended to deter the development of osteoarthritis. Due to the risks associated with this surgical procedure, prophylactic treatment for this purpose is not frequently recommended.

Issues under study include techniques for processing and storing the grafts, proper sizing of the grafts, and appropriate surgical techniques. The 4 primary ways of processing and storing allografts are fresh viable, fresh frozen, cryopreserved, and lyophilized. Fresh viable implants, harvested under sterile conditions, are less frequently used because the grafts must be used within a couple of days to maintain viability. Alternatively, the harvested meniscus can be fresh frozen for storage until needed. Cryopreservation freezes the graft in glycerol, which aids in preserving the cell membrane integrity and donor fibrochondrocyte viability. CryoLife is a commercial supplier of such grafts. Donor tissues may also be dehydrated (freeze-dried or lyophilized), permitting storage at room temperature. Lyophilized grafts are prone to reduced tensile strength, shrinkage, poor rehydration, posttransplantation joint effusion, and synovitis; these are no longer used in the clinical setting. Several secondary sterilization techniques may be used, with gamma irradiation the most common. The dose of radiation considered effective has been shown to change the mechanical structure of the allograft; therefore, nonirradiated grafts from screened donors are most frequently used. In a survey conducted by the International Meniscus Reconstruction Experts Forum, when surgeons were asked about allograft preference, 68% preferred fresh frozen nonirradiated allografts, with 14% responding fresh viable allografts.²

There are several techniques for MAT; most are arthroscopically assisted or all-arthroscopic. Broadly, the techniques are either all-suture fixation or bone fixation. Within the bone fixation category, the surgeon may use either bone plugs or a bone bridge. Types of bone bridges include keyhole, trough, dove-tail, and bridge-in-slot. The technique used depends on laterality and the need for concomitant procedures. Patients

with malalignment, focal chondral defects, and/or ligamentous insufficiency may need concomitant procedures (osteotomy, cartilage restoration, and/or ligament reconstruction, respectively).³

Tissue engineering that grows new replacement host tissue is also being investigated. For example, the Collagen Meniscus Implant (CMI®) (by Stryker, formerly the ReGen Collagen Scaffold® by ReGen Biologics), is a resorbable collagen matrix composed primarily of type I collagen from bovine Achilles tendons. The implant is provided in a semilunar shape and trimmed to size for suturing to the remaining meniscal rim. The implant provides an absorbable collagen scaffold that is replaced by the patient's soft tissue; it is not intended to replace normal body structure. Because it requires a meniscal rim for attachment, it is intended to fill meniscus defects after a partial meniscectomy. Other scaffold materials and cell-seeding techniques are being investigated. Nonabsorbable and nonporous synthetic implants for total meniscus replacement are in development. One total meniscus replacement that is in early phase clinical testing is NUsurface® (Active Implants); it is composed of a polyethylene reinforced polycarbonate urethane.

Outcome Measures

The outcomes of this treatment (ie, pain, functional status) are subjective, patient-reported outcomes that are prone to placebo effects. On the other hand, the natural history of a severely damaged meniscus is predictable, with progressive joint damage, pain, and loss of function.

Summary

Description

Meniscal allografts and other meniscal implants (eg, collagen) are intended to improve symptoms and reduce joint degeneration in patients who have had a total or partial meniscus resection.

Summary of Evidence

For individuals who are undergoing partial meniscectomy who receive meniscal allograft transplantation (MAT), the evidence includes systematic reviews of mostly case series and a randomized controlled trial (RCT). Relevant outcomes are symptoms, functional outcomes, and quality of life. The systematic reviews concluded that most studies have shown statistically significant improvements in pain and function following the procedure. The benefits have also been shown to have a long-term effect (>10 years). Reviews have also reported acceptable complication and failure rates. There remains no evidence that MAT can delay or prevent the development of knee osteoarthritis. A limitation of the evidence is its reliance primarily on case series. Because the results of the single RCT, which enrolled a very small number of patients, pooled data from randomized and nonrandomized groups, results cannot be interpreted in a meaningful way. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who are undergoing partial meniscectomy and concomitant repair of malalignment, focal chondral defects, and/or ligamentous insufficiency who receive MAT, the evidence includes a systematic review of case series as well as case series published after the systematic review. Relevant outcomes are symptoms, functional outcomes, and quality of life. The systematic review concluded that pain and function improved following the procedure. One of the series published after the review showed that patients with more severe cartilage damage experienced favorable outcomes similar to patients with less cartilage damage. Another series published subsequently reported an overall 9.7-year survival of the implant. A limitation of the evidence is its reliance primarily on case series. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who are undergoing partial meniscectomy who receive collagen meniscal implants (CMIs), the evidence includes 2 systematic reviews primarily of case series. Relevant outcomes are symptoms, functional outcomes, and quality of life. The reviews reported overall positive results with the CMI, but the quality of the selected studies (RCTs, observational studies) was low. Radiologic evaluations have shown reductions in the size of the implant in a large portion of patients. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Policy History

Date	Action
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9/2023	Policy clarified to include prior authorization requests using Authorization Manager.
6/2023	Annual policy review. Minor editorial refinements to policy statements; intent unchanged.
6/2022	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
6/2022	Prior authorization information clarified for PPO plans. Effective 6/1/2022.
5/2021	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
1/2021	Medicare information removed. See MP #132 Medicare Advantage Management for local coverage determination and national coverage determination reference.
9/2019	Annual policy review. Description, summary and references updated. Policy statements unchanged.
6/2018	Annual policy review. Polyurethane removed from the policy; statements otherwise unchanged.
1/2018	Clarified coding information.
5/2017	Annual policy review. New references added.
9/2015	Clarified coding language.
5/2015	Annual policy review. New references added.
6/2014	Updated Coding section with ICD10 procedure and diagnosis codes. Effective 10/2015.
5/2014	Annual policy review. New references added.
9/2013	Annual policy review. Title and investigational statement changed from "collagen" to other."
11/2011-4/2012	Medical policy ICD 10 remediation: Formatting, editing and coding updates. No changes to policy statements.
12/1/2011	Annual policy review. Changes to policy statements.
6/2011	Reviewed - Medical Policy Group - Orthopedics, Rehabilitation Medicine, and Rheumatology. No changes to policy statements.
9/2010	Annual policy review. Changes to policy statements.
7/2010	Reviewed - Medical Policy Group - Orthopedics, Rehabilitation Medicine, and Rheumatology. No changes to policy statements.
6/1/2010	Annual policy review. Changes to policy statements.
7/2009	Reviewed - Medical Policy Group - Orthopedics, Rehabilitation Medicine, and Rheumatology. No changes to policy statements.
7/1/2009	Annual policy review. Changes to policy statements.

Information Pertaining to All Blue Cross Blue Shield Medical Policies

Click on any of the following terms to access the relevant information:

[Medical Policy Terms of Use](#)

[Managed Care Guidelines](#)

[Indemnity/PPO Guidelines](#)

[Clinical Exception Process](#)

[Medical Technology Assessment Guidelines](#)

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