



MASSACHUSETTS

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Medical Policy

Autologous Chondrocyte Implantation for Focal Articular Cartilage Lesions

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Policy Number: 374

BCBSA Reference Number: 7.01.48 (For Plan internal use only)

NCD/LCD: N/A

Related Policies

- Autografts and Allografts in the Treatment of Focal Articular Cartilage Lesions, #[111](#)
- Meniscal Allograft Transplantation and Collagen Meniscus Implants, #[110](#)
- Continuous Passive Motion in the Home Setting, #[407](#)
- Orthopedic Applications of Stem Cell Therapy (Including Allograft and Bone Substitute Products Used With Autologous Bone Marrow), #[254](#)

Policy

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

Autologous chondrocyte implantation may be considered **MEDICALLY NECESSARY** for the treatment of disabling full-thickness articular cartilage defects of the knee caused by acute or repetitive trauma, when **all** of the following criteria are met:

- Adolescent patients should be skeletally mature with documented closure of growth plates (eg, ≥ 15 years). Adult patients should be too young to be considered an appropriate candidate for total knee arthroplasty or other reconstructive knee surgery (eg, < 55 years)
- Focal, full-thickness (grade III or IV) unipolar lesions of the weight-bearing surface of the femoral condyles, trochlea, or patella at least 1.5 cm² in size
- Documented minimal to absent degenerative changes in the surrounding articular cartilage (Outerbridge Grade II or less), and normal-appearing hyaline cartilage surrounding the border of the defect
- Normal knee biomechanics or alignment and stability achieved concurrently with autologous chondrocyte implantation.

Autologous chondrocyte implantation for all other joints, including talar, and any indications other than those listed above is **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 and Indemnity	Prior authorization is required .
Medicare HMO Blue SM	Prior authorization is required .
Medicare PPO Blue SM	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, Indemnity, Medicare HMO Blue and Medicare PPO Blue:

CPT Codes

CPT codes:	Code Description
27412	Autologous chondrocyte implantation, knee

ICD-10-PCS Procedure Codes

ICD-10-PCS procedure codes:	Code Description
0SUC07Z	Supplement Right Knee Joint with Autologous Tissue Substitute, Open Approach
0SUC37Z	Supplement Right Knee Joint with Autologous Tissue Substitute, Percutaneous Approach
0SUC47Z	Supplement Right Knee Joint with Autologous Tissue Substitute, Percutaneous Endoscopic Approach

0SUD07Z	Supplement Left Knee Joint with Autologous Tissue Substitute, Open Approach
0SUD37Z	Supplement Left Knee Joint with Autologous Tissue Substitute, Percutaneous Approach
0SUD47Z	Supplement Left Knee Joint with Autologous Tissue Substitute, Percutaneous Endoscopic Approach

Description

Articular Cartilage Lesions

Damaged articular cartilage typically fails to heal on its own and can be associated with pain, loss of function, and disability, and may lead to debilitating osteoarthritis over time.¹ These manifestations can severely impair a patient's activities of daily living and adversely affect quality of life.

Treatment

Conventional treatment options include debridement, subchondral drilling, microfracture, and abrasion arthroplasty.² Debridement involves the removal of synovial membrane, osteophytes, loose articular debris, and diseased cartilage, and it is capable of producing symptomatic relief. Subchondral drilling, microfracture, and abrasion arthroplasty attempt to restore the articular surface by inducing the growth of fibrocartilage into the chondral defect. Compared with the original hyaline cartilage, fibrocartilage has less capability to withstand shock or shearing force and can degenerate over time, often resulting in the return of clinical symptoms. Osteochondral grafts and autologous chondrocyte implantation attempt to regenerate hyaline-like cartilage and thereby restore durable function. Osteochondral grafts for the treatment of articular cartilage defects are discussed in policy #[111](#).

With autologous chondrocyte implantation, a region of healthy articular cartilage is identified and biopsied through arthroscopy. The tissue is sent to a facility licensed by the U.S. Food and Drug Administration (FDA) where it is minced and enzymatically digested, and the chondrocytes are separated by filtration. The isolated chondrocytes are cultured for 11 to 21 days to expand the cell population, tested, and then shipped back for implantation. With the patient under general anesthesia, an arthrotomy is performed, and the chondral lesion is excised up to the normal surrounding cartilage. Methods to improve the first-generation autologous chondrocyte implantation procedure have been developed, including the use of a scaffold or matrix-induced autologous chondrocyte implantation composed of biocompatible carbohydrates, protein polymers, or synthetics. The only FDA approved matrix-induced autologous chondrocyte implantation product to date is supplied in a sheet, which is cut to size and fixed with fibrin glue. This procedure is considered technically easier and less time-consuming than the first-generation technique, which required suturing of a periosteal or collagen patch and injection of chondrocytes under the patch.

Desired features of articular cartilage repair procedures are the ability (1) to be implanted easily, (2) to reduce surgical morbidity, (3) not to require harvesting of other tissues, (4) to enhance cell proliferation and maturation, (5) to maintain the phenotype, and (6) to integrate with the surrounding articular tissue. In addition to the potential to improve the formation and distribution of hyaline cartilage, use of a scaffold with matrix-induced autologous chondrocyte implantation eliminates the need for harvesting and suture of a periosteal or collagen patch. A scaffold without cells may also support chondrocyte growth.

Summary

A variety of procedures are being developed to resurface articular cartilage defects. Autologous chondrocyte implantation involves harvesting chondrocytes from healthy tissue, expanding the cells in vitro, and implanting the expanded cells into the chondral defect. Second- and third-generation techniques include combinations of autologous chondrocytes, scaffolds, and growth factors.

For individuals who have focal articular cartilage lesion(s) of the weight-bearing surface of the femoral condyles, trochlea, or patella who receive autologous chondrocyte implantation, the evidence includes systematic reviews, randomized controlled trials (RCTs), and observational studies. Relevant outcomes are symptoms, change in disease status, morbid events, functional outcomes, and quality of life. There is

a large body of evidence on autologous chondrocyte implantation for the treatment of focal articular cartilage lesions of the knee. For large lesions, autologous chondrocyte implantation results in better outcomes than microfracture, particularly in the long term. In addition, there is a limit to the size of lesions that can be treated with osteochondral autograft transfer, due to a limit on the number of osteochondral cores that can be safely harvested. As a result, autologous chondrocyte implantation has become the established treatment for large articular cartilage lesions in the knee. In 2017, first-generation autologous chondrocyte implantation with a collagen cover was phased out and replaced with an autologous chondrocyte implantation preparation that seeds the chondrocytes onto a bioresorbable collagen sponge. Although the implantation procedure for this second-generation autologous chondrocyte implantation is less technically demanding, studies to date have not shown improved outcomes compared with first-generation autologous chondrocyte implantation. Some evidence has suggested an increase in hypertrophy (overgrowth) of the new implant that may exceed that of the collagen membrane-covered implant. Long-term studies with a larger number of patients will be needed to determine whether this hypertrophy impacts graft survival. Based on mid-term outcomes that approximate those of first-generation autologous chondrocyte implantation and the lack of alternatives, second-generation autologous chondrocyte implantation may be considered an option for large disabling full-thickness cartilage lesions of the knee. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have focal articular cartilage lesions of joints other than the knee who receive autologous chondrocyte implantation, the evidence includes case series, systematic reviews of case series, and a network meta-analysis of prospective (none of which evaluated autologous chondrocyte implantation) and retrospective studies. Relevant outcomes are symptoms, change in disease status, morbid events, functional outcomes, and quality of life. The greatest amount of literature is for autologous chondrocyte implantation of the talus. Comparative trials are needed to determine whether autologous chondrocyte implantation improves outcomes for lesions in joints other than the knee. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Policy History

Date	Action
9/2023	Policy clarified to include prior authorization requests using Authorization Manager.
6/2023	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
6/2022	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
11/2021	Clarified coding information
5/2021	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
6/2020	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
5/2019	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
5/2018	Annual policy review. New references added. Summary clarified.
2/2018	Annual policy review. New references added.
6/2017	Annual policy review. Policy statements on matrix-induced autologous chondrocyte implantation removed. 6/1/2017.
4/2017	Policy statements clarified to include matrix-induced autologous chondrocyte implantation (MACI). 4/1/2017
1/2017	Annual policy review. New references added.
3/2016	Annual policy review. Autologous chondrocyte implantation of the patella considered medically necessary; need for a prior surgical procedure removed from policy statement. Clarified coding information. Effective 3/1/2016.
8/2015	Annual policy review. New references added.

9/2014	Annual policy review. New references added.
7/2014	Updated Coding section with ICD10 procedure and diagnosis codes, effective 10/2015.
12/2013	Annual policy review. Statements on minced cartilage moved to policy No. 111, Autografts and Allografts in the Treatment of Focal Articular Cartilage Lesions. Effective 12/1/2013.
11/2011-4/2012	Medical policy ICD 10 remediation: Formatting, editing and coding updates. No changes to policy statements.
6/2011	Reviewed - Medical Policy Group - Orthopedics, Rehabilitation and Rheumatology. No changes to policy statements.
11/1/2010	Annual policy review. Changes to policy statements.
7/2010	Reviewed - Medical Policy Group - Orthopedics, Rehabilitation and Rheumatology. No changes to policy statements.
7/1/2010	Annual policy review. Changes to policy statements.
1/2010	Annual policy review.
8/2009	Changes to policy statements.
8/1/2009	New policy, effective 08/01/2009, describing covered and non-covered indication.
7/2009	Reviewed - Medical Policy Group - Orthopedics, Rehabilitation and Rheumatology. No changes to policy statements.
7/2008	Reviewed - Medical Policy Group - Orthopedics, Rehabilitation and Rheumatology. No changes to policy statements.
4/2008	Annual policy review. Changes to policy statements.
7/2007	Reviewed - Medical Policy Group - Orthopedics, Rehabilitation and Rheumatology. No 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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