Meniscus Implant and Allograft (for Louisiana Only)

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➲ Instructions for Use

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Application

This Medical Policy only applies to the state of Louisiana.

Coverage Rationale

Meniscus Allograft Transplantation (MAT) with human cadaver tissue is proven and medically necessary for replacement of major meniscus loss due to trauma or previous meniscectomy when all of the following criteria are met:

- Individuals who are skeletally mature with documented closure of growth plates
- Disabling knee pain causing Functional Impairment that is refractory to conservative treatment
- Absence of more than half of the meniscus due to surgery or injury or **the presence of a** ~~has a~~ tear that cannot be repaired
- Radiographic criteria established by a standing anteroposterior (AP) view demonstrates all ~~of~~ the following:
  - Normal alignment or correctable varus or valgus deformities
  - No osteophytes or marginal osteophytes
  - No irreparable articular cartilage defects
  - No significant joint space narrowing
- Normal knee biomechanics, or alignment and stability achieved concurrently with meniscal transplantation
- Minimal to absent degenerative changes in surrounding articular cartilage (Outerbridge Grade II or less)
- No evidence of active inflammatory arthritis or systemic arthritis

Collagen Meniscus Implants (CMI) are unproven and not medically necessary for treating ~~or evaluating and managing~~ meniscus injuries or tears due to insufficient evidence of efficacy.

Definitions

Collagen Meniscal Implant (CMI): Resorbable and biocompatible Type I collagen matrix that was developed to restore the segmental loss of meniscal tissue in the knee. It consists of a porous cross-linked matrix scaffold that allows for the ingrowth of the body's own cells **(Warth and Rodkey, 2015).** ~~. (Hayes, 2019)~~

Functional or Physical Impairment: A functional or physical or physiological impairment causes deviation from the normal function of a tissue or organ. This results in a significantly limited, impaired, or delayed capacity to move, coordinate actions, or perform physical activities and is exhibited by difficulties in one or more of the following areas: physical and motor tasks; independent movement; performing basic life functions **(World Health Organization and World Bank (WHO), 2011).** ~~(Who, 2011)~~

Meniscal Allograft Transplantation (MAT): Transplant of the meniscus of the knee, which separates the thigh bone (femur) from the lower leg bone (tibia). The worn or damaged meniscus is removed and is replaced with a new one from a donor. The meniscus to be transplanted is taken from a cadaver, and, as such, is known as an allograft **(AAOS, 2021).** ~~(Hayes, 2017)~~

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 federal, state, or contractual requirements 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 Policies and Guidelines may apply.

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

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

Codes labeled with an asterisk(*) are not on the state of Louisiana Fee Schedule and therefore not covered by the State of Louisiana Medicaid Program.

Description of Services

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. Allografts are grafts of tissues made available from a live person or a human cadaver. Allografts from cadavers avoid morbidity from harvesting tissue from a different site on the person requiring meniscus repair. The goal of meniscal allograft transplantation is to restore knee function and prevent further joint degeneration by replacing the damaged or destroyed meniscus with allograft tissue having similar properties as the damaged tissue.

The Collagen Meniscal Implant (CMI) is an implant derived from bovine collagen used to treat acute or chronic advanced meniscal loss or damage with the intent of relieving symptoms and preventing joint degeneration. The CMI is a flexible, sickle-shaped disc that mimics the shape of the native meniscus and is attached arthroscopically to native tissue with suture. ~~The porous, collagen-glycosaminoglycan matrix of t~~**T**he CMI is meant to serve as a temporary template to support migration of the host's cells to the meniscal deficiency, restoring meniscal volume and function. ~~(Hayes 2019)~~

Clinical Evidence

Collagen Meniscus Implants (CMIs)

There is insufficient evidence to demonstrate the efficacy of collagen meniscus implants for treating meniscus injuries or tears. Robust randomized controlled trial studies are needed along with long-term outcomes to establish the safety and efficacy of this procedure.

Veronesi et al. (2021) conducted a systematic review to collect and evaluate the available evidence on biosynthetic scaffolds for meniscus regeneration both in vivo and in clinical studies. Three databases were searched: A total of 46 in vivo preclinical studies and 30 clinical studies were identified. Sixteen natural, 15 synthetic, and 15 hybrid scaffolds were studied in vivo. Among them, only 2 scaffolds were evaluated in clinical studies: The Collagen Meniscus Implant was evaluated in 11 studies, and the polyurethane-based scaffold Actifit® was evaluated in 19 studies. Although positive outcomes were described in the short- to mid-term, the number of concurrent procedures and the lack of randomized trials are the major limitations of the available clinical literature. According to the authors, current solutions offer a significant but incomplete clinical improvement, and the regeneration potential is still unsatisfactory. Authors Rodkey et al., 2008; Bulgheroni et al., 2015; and Zaffagnini et al., 2011 which were previously cited in this policy are included in the Veronesi et al., 2021 systematic review.

In a follow up study to evaluate the long-term clinical results, reoperations, surgical failure and complications at a minimum of 20 years of follow-up, Lucidi et al. (2021) assessed the outcomes of the first 8 patients who received medial CMIs implanted in a pilot prospective study. The pilot study included 8 men with a final age of 55.2 + 8.9 years; however, one patient was not available for the long-term follow-up so data for the remaining 7 men were included in this study. The average follow-up was 21.5 + 0.5 years with evaluations utilizing the Cincinnati Knee Rating System, the visual analogical scale (VAS) and the Lysholm score. The authors did not perform any statistical analyses due to the small number of patients included in the study. The authors reported one failure with one patient who underwent a total knee arthroplasty after 13 years. Of the six patients who were not considered procedure failures, 3 were rated as "excellent" based on the Lysholm score, 1 as "good" and 2 as "fair" while the Cincinnati score and the VAS for pain were stable with respect to the previous follow-ups. The authors found that the CMI for partial meniscal resection could provide pain relief and good knee function at a

minimum of 20-year follow-up. The authors concluded that CMI is a safe procedure with satisfactory results and a low failure rate at long-term follow-up.
~~In a Hayes technology assessment (2019), the authors reported that studies for collagen meniscus implants commonly incuded small total enrollment, differences in duration of follow-up between groups, lack of blinding/masking, retrospective design; and less frequently included incomplete reporting, and in comparative studies, differences in group characteristics, duration of follow-up, and attrition. The overall quality of the evidence was rated as low to very low, due to poor quality studies, and inconsistent findings.~~

~~In an ECRI custom product brief (2018), the authors reported the following: The evidence review provides too few data to draw conclusions about how well CMI works compared to other meniscus scaffolds or partial meniscectomy. Most of the studies have a high risk of bias because of small sample size and lack of control groups, randomization, and blinding. To assess CMI's comparative safety and effectiveness, RCTs would be needed that compare CMI and meniscectomy or other meniscus scaffolds and report patient-oriented outcomes (e.g., functional status, AEs, quality of life).~~

~~A poor-quality retrospective cohort study compared outcomes after Collagen Meniscus Implant (CMI) during concomitant ACL reconstruction with partial medial meniscectomy. (Bulgheroni et al., 2015) The results suggest that outcomes are not significantly different between CMI and partial medial meniscectomy. Among patients with chronic pattern, patients treated with CMI had significantly lower postoperative pain than patients treated with partial medial meniscectomy; however, no difference was noted in patients with acute pattern or overall. Study limitations include small size, retrospective design with preoperative outcome scores obtained postoperatively, limited number of study centers, possible bias in selection of control group, and lack of blinding.~~

Grassi et al. (2021) assessed the clinical outcomes and failures of lateral CMI implantation at a minimum 10-year follow-up. This study included 24 consecutive patients who underwent lateral CMI implantation for partial lateral meniscal defects and who were part of a previous study with a 2-year follow-up (cited as Zaffagnini et al., 2015). Outcome measures at the latest follow-up included the Lysholm score, Knee injury and Osteoarthritis Outcome Score, visual analog scale (VAS) for pain, Tegner activity level, and EuroQol 5-Dimensions score. Data regarding complications and failures were collected, and patients were asked about their satisfaction with the procedure. Included in the final analysis were 19 patients (16 male, 3 female) with a mean age at surgery of 37.1 ± 12.6 years and a mean follow-up of 12.4 ± 1.5 years (range, 10-14 years). Five failures (26%) were reported: 1 CMI removal because of implant breakage and 4 joint replacements (2 unicompartmental knee arthroplasties and 2 total knee arthroplasties). The implant survival rate was 96% at 2 years, 85% at 5 years, 85% at 10 years, 77% at 12 years, and 64% at 14 years. Lysholm scores at the final follow-up were rated as "excellent" in 36% (5 of 14 nonfailures), "good" in 43% (6 of 14), and "fair" in 21% (3 of 14). The VAS score was 3.1 ± 3.1, with only 16% (3 of 19 patients) reporting that they were pain-free; the median Tegner score was 3 (interquartile range, 2-5). All clinical scores decreased from the 2-year follow-up; however, except for the Tegner score, they remained significantly higher compared with the preoperative status. Overall, 79% of patients were willing to undergo the same procedure. The authors concluded that lateral CMI implantation for partial lateral meniscal defects provided good long-term results, with a 10-year survival rate of 85% and a 14-year survival rate of 64%. At the final follow-up, 58% of the patients had "good" or "excellent" Lysholm scores. However, there was a general decrease in outcome scores between the short- and the long-term follow-up.

According to the authors, although this represents the first study to assess the long-term outcome of lateral meniscal replacement using a scaffold, several limitations are present. Four patients were lost to follow-up, thus creating a possible selection bias. Another limitation is the limited number of patients, which did not allow the performance of sophisticated statistical subanalyses to identify outcomes and failure predictors. According to the authors, additional factors such as a surgical learning curve, the time from meniscectomy to scaffold implantation and the cartilage status, and the time of the index surgery could be relevant and should be investigated in studies with a larger sample size.

Grassi et al. (2014) performed a systematic review to summarize and evaluate the clinical outcomes of the collagen meniscus implant (CMI) and its complication and failure rates. These data were then used to evaluate the results of the CMI at different follow-up time periods and investigate possible differences in the behavior of lateral and medial CMI. All studies evaluating medial or lateral CMI using the Lysholm score, visual analogue scale (VAS) for pain, Tegner activity scale and subjective or objective International Knee Documentation Committee (IKDC) scores were included in the systematic review. Eleven studies were included in the systematic review. The pooled number of patients involved in CMI surgery ~~was~~ were 396. The Lysholm score and VAS for pain showed an improvement at six months up to ten years. No noticeable differences were present comparing short-term values of Lysholm score between medial and lateral CMI. The Tegner activity level reached its peak at 12 months after surgery and showed a progressive decrease through five- and ten- years post CMI implantation, however always remaining above the pre-operative level. Only a few knees were rated as "nearly abnormal" or "abnormal" at IKDC grading at all follow-up evaluations. The reviewers concluded the CMI could produce good and stable clinical results, particularly regarding knee function and pain, with low rates of complications and reoperations.

Harston et al. (2012) **conducted a systematic review to examine** ~~examined~~ collagen meniscus implant (CMI) effectiveness for improving patient function, symptoms, and activity level. Study methodologies, rehabilitation, and return to sports guidelines were also reviewed. A total of 11 studies with 520 subjects met inclusion criteria. The authors concluded that knee function, symptoms, and activity level generally improved following CMI use, but poor research report quality was common. They stated that additional well-designed long-term prospective studies are needed to better determine knee osteoarthrosis prevention efficacy and appropriate patient selection.

An assessment by the California Technology Assessment Forum (CTAF), (Tice, 2010) concluded that the collagen meniscus implant does not meet CTAF criteria. The CTAF assessment found that the pivotal randomized clinical trial (citing Rodkey et al, 2008) failed to demonstrate any improvement in pain or symptoms in either arm of the trial and the trial has substantial risk for selection bias, confounding, and reporting bias because of the large number of patients lost to follow-up after randomization and the lack of blinding for subjective outcomes. In addition, no data on osteoarthritis were presented. The CTAF assessment concluded that the trial "presents evidence that the collagen meniscus implant offers no important clinical benefits, requires longer and more intensive post-operative rehabilitation, and some uncertainty remains about the potential for long-term harm from the device."

~~Zaffagnini et al. (2011) conducted a cohort study that included 33 nonconsecutive patients (men; mean age, 40 years) with meniscal injuries. Study participants received medial collagen meniscus implant (MCMI) or served as a control patient treated with partial medial meniscectomy (PMM). The choice of treatment was decided by the patient. All patients were clinically evaluated at time 0 and at 5 years and a minimum of 10 years~~

~~after surgery by Lysholm, visual analog scale (VAS) for pain, objective International Knee Documentation Committee (IKDC) knee form, and Tegner activity level scores. The MCMI group, compared with the PMM one, showed significantly lower VAS for pain and higher objective IKDC, Teger index, and SF-36 for Physical Health Index scores. Radiographic evaluation showed significantly less medial joint space narrowing in the MCMI group than in the PMM group. The MRI evaluation of the MCMI patients revealed 11 cases of myxoid degeneration signal: 4 had a normal signal with reduced size, and 2 had no recognizable implant. The investigators concluded that pain, activity level, and radiological outcomes are significantly improved with use of the MCMI at a minimum 10-year follow-up compared with PMM alone. According to the investigators, randomized controlled trials on a larger population are necessary to confirm MCMI benefits at long term.~~

~~An assessment by the California Technology Assessment Forum (CTAF), (Tice, 2010) concluded that the collagen meniscus implant does not meet CTAF criteria. The CTAF assessment found that the pivotal randomized clinical trial (citing Rodkey et al, 2008) failed to demonstrate any improvement in pain or symptoms in either arm of the trial and the trial has substantial risk for selection bias, confounding, and reporting bias because of the large number of patients lost to follow-up after randomization and the lack of blinding for subjective outcomes. In addition, no data on osteoarthritis were presented. The CTAF assessment concluded that the trial "presents evidence that the collagen meniscus implant offers no important clinical benefits, requires longer and more intensive post-operative rehabilitation, and some uncertainty remains about the potential for long-term harm from the device."~~

~~Bulgheroni et al. (2010) investigated the clinical outcomes and any progression of knee osteoarthritis in 34 patients who underwent arthroscopic placement of a collagen meniscus implant. Lysholm and Tegner activity scores at 2 and 5 years after surgery improved significantly compared to the preoperative score. These patients showed good to excellent clinical results after 5 years from a CMI placement. In most of cases, the CMI-new tissue complex had a slight reduction in size, compared to a normal medial meniscus, but the new tissue had no apparent negative effects. According to the investigators, 5 years after the implant, the regenerated tissue still was not completely similar to a normal meniscus. This study is limited by a small sample size and lack of a control group.~~

~~A technology assessment conducted by Blue Cross and Blue Shield Association Technology Evaluation Center (TEC). (2010) concluded that the collagen meniscal implant for irreparable medical meniscus injury did not meet technology assessment criteria. The published evidence did not support improvement in health outcomes or that clinical improvement was attainable outside of the investigational setting. Although promising, long-term data supporting safety, efficacy and improved clinical outcomes, including prevention of osteoarthritis, are not yet available to support widespread use of this bioactive scaffold for meniscal regeneration.~~

~~Rodkey et al. (2008) conducted a randomized controlled trial that included 311 patients with an irreparable injury of the medial meniscus or a previous partial medial meniscectomy. There were two study arms, one consisting of 157 patients who had had no prior surgery on the involved meniscus (the acute arm of the study) and one consisting of 154 patients who had had one, two, or three prior meniscal surgical procedures (the chronic arm). Patients were randomized either to receive the collagen meniscus implant (CMI) or to serve as a control subject treated with a partial meniscectomy only. Patients underwent frequent clinical follow-up examinations over two years and completed validated outcomes questionnaires over seven years. Patients who received the collagen meniscus implant followed a different post-op protocol, receiving a specific rehabilitation~~

~~protocol and the requirement of a second-look arthroscopy with biopsy one year after implant placement. In the acute group, seventy-five patients received a collagen meniscus implant and eighty-two were controls. In the chronic group, eighty-five patients received the implant and sixty-nine were controls. The mean duration of follow-up was fifty-nine months. The 141 repeat arthroscopies done at one year showed that the collagen meniscus implants had resulted in significantly increased meniscal tissue compared with that seen after the original index partial meniscectomy. The implant supported meniscus-like matrix production and integration as it was assimilated and resorbed. In the chronic group, the patients who had received an implant regained significantly more of their lost activity than did the controls and they underwent significantly fewer non-protocol re-operations. No differences were detected between the two treatment groups in the acute arm of the study. The investigators concluded that new biomechanically competent meniscus-like tissue forms after placement of a collagen meniscus implant and use of the implant appears safe. The collagen meniscus implant supports new tissue ingrowth that appears to be adequate to enhance meniscal function as evidenced by improved clinical outcomes in patients with a chronic meniscal injury. According to the investigators, the implant was not found to have any benefit for patients with an acute injury.~~

~~The data from the Rodkey study was used by the U.S. Food and Drug Administration (FDA) in the 510(k)-application process for the Menaflex collagen meniscus implant. An FDA executive summary of the Rodkey data indicated that patients who received the collagen meniscus implant followed a different post-op protocol than the control group and control patients were not required to undergo a planned second-look arthroscopy since it was assumed that there was no tissue regrowth in these patients. The FDA also indicated that more meniscal tissue was removed from the collagen meniscus implant patients than in the control patients. The FDA noted that the re-look arthroscopy results for collagen meniscus implant group showed that 16% of evaluated devices were not firmly attached to the host rim and 18% of knee compartments were determined to be worse than during the operative procedure at the time of the re-look arthroscopic procedure. According to the FDA summary, the Tegner Index is meant to complement other functional scores (Lysholm knee score) for patients with ligamentous injuries, however, the investigators reported the Tegner Index in isolation and there was no pre-specified hypothesis for its use in the study design, thus, it is unclear how this endpoint should be interpreted given that there is no defined clinical significance for the Tegner Score when used in isolation. In addition, the FDA executive summary stated that at the 3 to 7 year annual follow-up time points, there is approximately 50% of the data available. It is not clear how the missing data has impacted the presentation of the safety and effectiveness endpoints at time-points later than 24 months. The primary endpoint was a 24-month endpoint.~~

Meniscus Allograft Transplantation (MAT)

In a systematic review, Waugh et al. (2019) assessed the clinical effectiveness of MAT after meniscal injury and subsequent meniscectomy. Thirty-seven papers from 19 studies of MAT were included in the review. Cohort size in the included studies ranged from 30 to 313, with a total of 1731 people undergoing at least one MAT. There was considerable evidence from observational studies, of improvement in symptoms after meniscal allograft transplantation, but the authors found only one small pilot trial with a randomized comparison with a control group that received non-surgical care. MAT has not yet been proven to be chondroprotective. The authors concluded that the benefits of MAT include symptomatic relief and restoration of at least some previous activities, which will be reflected in utility values and hence in quality-adjusted life years, and in the longer term, prevention or delay of osteoarthritis, and avoidance or postponement of some knee replacements.

Elattar et al. (2011) conducted a meta-analysis of published trials reporting outcomes of meniscal allograft transplantation to establish its safety and reproducibility. The outcomes of 678 medial and 458 lateral grafts in 613 male, 265 female and 190 non-defined patients with a mean age of 34.8 years were included in the meta-analysis. According to the authors, all studies reported a continuously satisfactory outcome with restoration of working capacity in these active patients. The authors stated that meniscal allograft transplantation can be considered as safe and reliable for the treatment of refractory post-meniscectomy symptoms in selected patients.

Hergan et al. (2011) performed a systematic review evaluating ~~meniscal allograft transplantation (~~MAT~~)~~. Included in the review were 14 studies with at least 2 years' follow-up, studies with validated outcome measures, and studies in which the allograft meniscal horns were secured with bony fixation. Thirteen of the articles provided Level IV evidence, and one article ~~(Stollsteimer et al. 2000)~~ provided Level III evidence. The authors concluded that good early and midterm results of cryopreserved or fresh-frozen, nonirradiated MAT can be achieved in a relatively young patient with only mild chondromalacia (lower than Outerbridge grade 3) who is not overweight and has a stable, mechanically aligned lower extremity, if the allograft is sized radiographically by use of anteroposterior and lateral films and the allograft meniscal horns have bony attachments and are fixed by bony techniques. Similar results can be expected if the transplant is performed alone or with a concomitant cartilage repair procedure; however, significant cartilage defects (Outerbridge grade 2 or greater) on both the femoral and tibial sides in the same compartment requiring autologous cartilage implantation result in a high failure rate. Good outcomes of MAT can be expected when performing a concomitant ligament reconstruction or malalignment procedure on the knee, unless greater than 3 concomitant procedures are performed. There is no significant difference in outcome between medial and lateral MAT. According to the authors, despite a growing body of knowledge on the topic, there remains a lack of consensus regarding optimal allograft sizing technique, allograft fixation techniques, tissue processing, indications, and long-term efficacy. The authors stated that a prospective, randomized trial comparing MAT in a meniscectomized knee with a control group is needed to determine the best technique and patient selection criteria.

Clinical Practice Guidelines

~~Professional Societies~~

American Academy of Orthopedic Surgeons (AAOS)

The AAOS published an information statement regarding the use of musculoskeletal tissue allografts (AAOS, 2011). ~~The American Academy of Orthopedic Surgeons published an information statement regarding the use of musculoskeletal tissue allografts (AAOS, 2011).~~ The AAOS supports the following:

- The use of musculoskeletal allograft as a therapeutic alternative to autograft use for appropriate patients. Allograft tissues should be acquired from facilities that demonstrate compliance, use well-accepted banking methodology and good tissue practices. The AAOS urges all tissue banks to follow rigorous national guidelines and standards.
- The AAOS strongly favors on-site inspection and recommends the use of tissue banks by the American Association of Tissue Banks (AATB).
- The AAOS supports informed consent, for both the donor family and the recipient of human tissue, in accordance with local, state and federal laws and regulations.

U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

Transplantation of meniscal allografts is a surgical procedure and, as such, is not subject to regulation by the FDA. However, the FDA does regulate certain aspects of tissue banking, and tissues are subject to FDA registration and requirements for good tissue practices and infectious disease screening and testing, as well as to the good manufacturing practice requirements applicable to drugs and devices. According to current rules, FDA premarket review or marketing approval is not required for minimally processed tissues transplanted from one person to another for their normal structural functions; these criteria apply to meniscal allografts. See the following website for more information: http://www.fda.gov/BiologicsBloodVaccines/TissueTissueProducts/default.htm. (Accessed **May 16, 2022**~~June 4, 2020~~)

Collagen meniscus implants, also known as collagen scaffold~~, or Menaflex,~~ are bioresorbable, primarily bovine type 1 collagen **products that**~~. This product was~~ **are** designed as a tissue-engineered scaffold to support the generation of new meniscus-like tissue. ~~The Collagen Meniscal Implant (CMI), the ReGen Collagen Scaffold (CS), and the Menaflex device are different names for the same device. https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm?ID=K170364~~ **For information on collagen meniscus implants, see the following FDA website for Premarket Approvals (use product code OLC): https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm (Accessed May 16, 2022)**

~~Stryker® acquired Ivy Sport Medicine (developer of the Menaflex collagen meniscus implant) in 2016.~~

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Policy History/Revision Information

Date	Summary of Changes
TBD	**Coverage Rationale** • Replaced language indicating "Collagen Meniscus Implants (CMI) are unproven and not medically necessary for treating *or evaluating and managing* meniscus injuries or tears" with "Collagen Meniscus Implants (CMI) are unproven and not medically necessary for treating meniscus injuries or tears" **Applicable Codes** • Added notation to indicate HCPCS code G0428 is not on the State of Louisiana Fee Schedule and therefore is not covered by the State of Louisiana Medicaid Program **Supporting Information** • Updated *Description of Services, Clinical Evidence, FDA,* and *References* sections to reflect the most current information • Archived previous policy version CS078LA.J

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The UnitedHealthcare Medical Policies 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.