**Policy Statement**

This policy is designed primarily to address knee arthroscopy with partial meniscectomy and/or chondroplasty as treatment for certain chronic (non-acute) knee conditions. Knee arthroscopy is also employed for diagnostic purposes alone, as well as to enable debridement without chondroplasty/meniscectomy, ligament reconstruction and repair, articular cartilage restoration, synovectomy, loose body removal, lateral release or patellar realignment, manipulation under anesthesia, and lysis of adhesions for arthrofibrosis. Except where noted below as “not medically necessary,” these procedures when performed with knee arthroscopy are not presently addressed in this Blue Shield of California Medical Policy.

Knee arthroscopy with arthroscopic partial meniscectomy/chondroplasty may be considered **medically necessary** when all of the following conditions are met:

- **One** of the following:
  - For persons presenting without osteoarthritis, documentation including physical exam with knee swelling/effusion and painful range of motion, and radiological interpretation and report for bony pathology (e.g., routine radiographs) or soft tissue pathology (e.g. CT scan or MRI) indicating traumatic cartilaginous tears
  - For persons presenting with osteoarthritis, documentation including radiological interpretation and report for bony pathology (e.g., routine radiographs) or soft tissue pathology (e.g., CT scan or MRI) demonstrating no evidence of severe osteoarthritis of the knee as graded III or IV by the Outerbridge scale:
    - Grade 0 – normal cartilage
    - Grade I – cartilage with softening and swelling
    - Grade II – a partial-thickness defect with fissures on the surface that do not reach subchondral bone or exceed 1.5 cm in diameter
    - Grade III – fissuring to the level of subchondral bone in an area with a diameter of more than 1.5 cm
    - Grade IV – exposed subchondral bone head
- Documentation of unsuccessful conservative therapy for a period of at least six weeks (non-surgical medical management, see Policy Guidelines), or documentation of rationale if conservative therapy is considered inappropriate*
- The patient has reviewed, completed, and signed the Knee Arthroscopy Surgery Decision Aid ensuring shared decision making has occurred (see Policy Guidelines)
- The patient has reviewed, completed, and signed the “CollaboRATE” survey

Knee arthroscopy is considered **not medically necessary** for either of the following conditions:

- Arthroscopic lavage and debridement for persons presenting with knee pain only, or severe osteoarthritis classified Grade III or IV by the Outerbridge scale
- Patellofemoral replacement

*Prior conservative treatment for at least six weeks is required for all of the above conditions except for injury caused by acute trauma and infections.

**Policy Guidelines**

**Conservative Treatment**

As medically indicated, members with knee pain should have non-surgical treatment documented in the medical record, including all of the following, unless contraindicated*:

- Anti-inflammatory medications or analgesics
- Activity modification
• Supervised physical therapy which could include an instructed home exercise program, including flexibility and muscle-strengthening exercises. Post-op physical therapy visits will be allowed in addition to the pre-op physical therapy visits.
• Weight reduction counseling as appropriate
• Assistive device use (required for persons with certain relative contraindications** to knee arthroscopy, optional for others)
• Therapeutic injections into the knee as appropriate

For the duration of conservative care, four prospective level 1 evidence studies addressed this issue with specific times included in their studies1-4.

*Prior conservative treatment for at least six weeks is required for all of the above conditions except for injury caused by acute trauma and infections.

**Relative contraindications to knee arthroscopy include the following: morbid obesity (body mass index [BMI] greater than 40), or age less than 50 years unless there are no other treatment options for the patient. Patients with relative contraindications should exhaust all appropriate nonsurgical treatment options prior to surgical consideration.

Knee Arthroscopy Decision Aid
Use of decision aids can promote shared decision making, and may improve patients understanding and enable them to make decisions that are fully informed and consistent with their preferences, values and goals. A decision aid is a tool used to inform patients about available treatments, along with potential benefits, risks and costs, during clinical encounters. The decision aid is intended for use following the patient pre-operative education course. The resulting decision aid is intended to be nondirective, encouraging clinicians to create a conversation with patients using their own communication styles, while simultaneously ensuring that key information is conveyed and that patient preferences are elicited. Blue Shield of California considers the use of decision aids as a higher level of informed consent and requires patients to acknowledge receipt, review, and sign the Enhanced Clinical Programs (ECP) Knee Arthroscopy decision aid as a pre-authorization requirement.

Shared Decision Making
Shared Decision Making (SDM) is a process in which patients openly explore with their physicians’ assistance both the available evidence supporting each therapeutic intervention, and also determine what matters most to the patient. This allows both the physician and the patient to reach agreed-upon treatment decisions reflecting mutual goals and expected outcomes. The completion of the CollaboRATE survey and signing of the Knee Arthroscopy surgery decision aid by the member helps to assure the member’s personal preferences have been considered.

CollaboRATE
Patient-centered health care is a central component of current health policy agendas. CollaboRATE is a 3-Item questionnaire that measures the level of shared decision making in the clinical encounter from the patient’s perspective. In the questionnaire, the patient rates, on a scale of 1 to 9, the provider’s efforts to understand the surgical plan of care from the patient’s perspective. The CollaboRATE SDM tool has demonstrated discriminative validity, concurrent validity, intra-rater reliability, and sensitivity to change.

To access further information, please visit the following websites: http://www.jmir.org/2014/1/e2/; http://www.collaboratescore.org/.

Description
This medical policy is designed to enhance the long-term outcome of the arthroscopic treatment of partial meniscectomy of the knee by ensuring that conservative therapies are initiated before the surgical procedure, and that every patient who undergoes this treatment
knows exactly what to expect from the procedure chosen. A decision aid and shared decision making tool have been incorporated to improve patient knowledge, adjust unrealistic expectations, and elicits values about the benefit desired and the degree of acceptable risks for the patient contemplating this procedure.

Determining how to help physicians better incorporate clinical guidelines and evidence-based medicine into this decision-making has important implications for patient outcomes after an arthroscopic partial meniscectomy of the knee. Therefore, reducing the incidence of “inappropriate” knee arthroscopy procedures and eliminating overuse helps to ensure that the most appropriate care to Blue Shield members is being delivered.

### Related Policies

- Partial Thickness Rotator Cuff Tears

### Benefit Application

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal mandates [e.g., Federal Employee Program (FEP)] prohibits plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

### Regulatory Status

Arthroscopy of the knee is a surgical procedure and therefore is not regulated by the U.S. Food and Drug Administration (FDA).

### Rationale

**Background**

Arthroscopy is a surgical procedure in which the inside of the knee can be visualized and treated through the use of an arthroscope (a fiber-optic instrument with a camera attached to the end) that is inserted through a small incision in the knee. Looking at the interior of the joint on a monitor, the surgeon can then determine the amount or type of injury and, if necessary, take a biopsy specimen or repair or correct the problem. These images allow the surgeon to view in detail the inside of the knee and its structures. Arthroscopy can be used to diagnose and treat specific knee problems such as repairing cartilage or removing damaged tissue.

Arthroscopic meniscectomy is a procedure involving the removal of all or part of a torn meniscus from the knee. The meniscus is a half-moon-shaped piece of shock-absorbing cartilage between the femur and the tibia in the knee. This procedure is performed when a meniscal tear is too large to be corrected by surgical repair of the meniscus.

According to the American Medical Society for Sports Medicine (AMSSM), arthroscopic partial meniscectomy of the knee is the most commonly performed orthopedic surgery in the United States, with about 700,000 procedures performed annually.

**Osteoarthritis**

Osteoarthritis (OA) affects about 21 million people in the United States. By age 65, the
majority of the population has radiographic evidence of OA and 11 percent have symptomatic OA of the knee.\textsuperscript{6} OA (of any joint) was the primary diagnosis that led to 11.3 million ambulatory care visits in 2009. It was estimated that 9.9 million adults had symptomatic OA of the knee in 2010.\textsuperscript{7}

OA is defined as a slowly progressive joint disease that affects middle aged to elderly people. In osteoarthritis, the cartilage between the bones in the joint breaks down, which can cause the affected bones to slowly get bigger. The joint cartilage often breaks down because of mechanical stress or biochemical changes within the body, causing the bone underneath to fail. Symptoms of OA include but are not limited to joint pain and stiffness, knobby swelling at the joint, cracking or grinding noise and movement, and decreased function of the joint.\textsuperscript{8}

Genetics, large body mass, certain occupations, repetitive knee bending or heavy lifting, and hereditary vulnerability are other factors that increase a patient’s risk of developing OA.\textsuperscript{7}

The American College of Rheumatology (ACR) proposed an algorithm of diagnosis criteria for OA of the knee.\textsuperscript{9} The diagnosis of OA is established using a combination of clinical information from patient history, physical examination, radiologic imaging, and laboratory evaluation. The diagnosis of OA is defined as presenting with pain and meeting at least five of the following criteria:

- Age > 50 years
- Less than 30 minutes of morning stiffness
- Crepitus (noisy, grating sounds) on active motion
- Bony tenderness
- Bony enlargement
- Lack of palpable synovial warmth
- Erythrocyte sedimentation rate (ESR) < 40 mm/hour
- Rheumatoid factor < 1:40
- Synovial fluid signs of OA (clear, viscous, and/or white blood cell count < 2,000 cells/mm\textsuperscript{3})

**Arthroscopic Debridement**

Arthroscopic debridement is a procedure which involves the removal of cartilage or meniscal fragments, with the intention to improve symptoms and joint function in patients with mechanical symptoms such as locking or catching of the knee. Its effectiveness declines in arthritic joints, and it may be completely ineffective as a treatment option in knees with considerable osteoarthritis.

**Literature Review**

**Arthroscopic Meniscectomy**

In 2013, Herrlin, et al reported on a prospective randomized intervention study (N=96) which evaluated the outcome at a 2 and 5 year follow-up (from their 2007 study\textsuperscript{3}) on whether combined arthroscopic surgery followed by exercise therapy was superior to the same exercise therapy alone when treating non-traumatic, degenerative medial meniscal tears.\textsuperscript{10} Radiographic examination was done at the start of the study and after 5 years, while questionnaires (KOOS, Lysholm Knee Scoring Scale, and Tegner Activity Scale) and pain ratings (Visual Analogue Scale, VAS) were conducted at the start of the study and then at 2 and 5 year follow-up. Both groups showed highly significant clinical improvements from baseline to the follow-ups at 2 and 5 years on the subscales of KOOS, Lysholm Knee Scoring Scale, and VAS (p<0.0001). The authors reported that the findings indicate that arthroscopic surgery followed by exercise therapy was not superior to the same exercise therapy alone for this type of patients. Consequently, exercise therapy can be recommended as initial treatment. However, one third of the patients from the exercise group still had disabling knee symptoms after exercise therapy but improved to the same level as the rest of the patients after arthroscopic surgery with partial meniscectomy.
In 2013, Yim et al reported on a randomized controlled trial (N=102) on whether the clinical outcomes of arthroscopic meniscectomy would be better than those of nonoperative treatment for a degenerative horizontal tear of the medial meniscus. Fifty patients underwent arthroscopic meniscectomy, and 52 patients underwent nonoperative treatment with strengthening exercises. Functional outcomes were compared using a visual analog scale (VAS) for pain, Lysholm knee score, Tegner activity scale, and patient subjective knee pain and satisfaction. Radiological evaluations were performed using the Kellgren-Lawrence classification to evaluate osteoarthritic changes. In terms of clinical outcomes, meniscectomy did not provide better functional improvement than nonoperative treatment. The authors reported there were no significant differences between arthroscopic meniscectomy and nonoperative management with strengthening exercises in terms of relief in knee pain, improved knee function, or increased satisfaction in patients after 2 years of follow-up.

Katz et al reported on a multicenter, randomized, controlled trial (N=351) done to determine whether arthroscopic partial meniscectomy for symptomatic patients with a meniscal tear and knee osteoarthritis resulted in better functional outcomes than nonoperative therapy. The patients were randomly assigned to surgery and postoperative physical therapy or to a standardized physical-therapy regimen (with the option to crossover to surgery at the discretion of the patient and surgeon). The patients were evaluated at 6 and 12 months. The primary outcome was the difference between the groups with respect to the change in the Western Ontario and McMaster Universities Osteoarthritis Index (WOMAC) physical-function score (ranging from 0 to 100, with higher scores indicating more severe symptoms) 6 months after randomization. In the intention-to-treat analysis, the mean improvement in the WOMAC score after 6 months was 20.9 points (95% confidence interval [CI], 17.9 to 23.9) in the surgical group and 18.5 (95% CI, 15.6 to 21.5) in the physical-therapy group (mean difference, 2.4 points; 95% CI, −1.8 to 6.5). The results at 12 months were similar to those at 6 months. In the intention-to-treat analysis, the authors did not find significant differences between the study groups in functional improvement 6 months after randomization; however, 30% of the patients who were assigned to physical therapy alone underwent surgery within 6 months.

In a systematic review by Azam and Shenoy in 2016, the authors reviewed the role of arthroscopic meniscectomy in patients with degenerative meniscus tears and suggested recommendations for clinical practice. The majority of randomized control trials suggested that arthroscopic partial meniscectomy is not superior to conservative measures such as exercise programs. Furthermore, one randomized control trial found that arthroscopic partial meniscectomy was not even superior to sham surgery. The authors found that there is significant overtreatment of knee pain with arthroscopic partial meniscectomy when alternative, less invasive, and less expensive treatment options are equally effective. First-line treatment of degenerative meniscus tears should be non-operative therapy focused on analgesia and physical therapy to provide pain relief as well as improve mechanical function of the knee joint. Arthroscopic partial meniscectomy should be considered as a last resort when extensive exercise programs and physiotherapy have been tried and failed.

After a systematic review of the literature, Siemieniuk et al (2017) put forth a guideline whereby the panel made a strong recommendation against the use of arthroscopy in nearly all patients with degenerative knee disease. It was found that among patients with a degenerative medial meniscus tear, knee arthroscopy was no better than exercise therapy.

Thorlund et al conducted a systematic review and meta-analysis of nine trials (N=1,270) in 2015. The objective was to determine benefits and harms of arthroscopic knee surgery involving partial meniscectomy, debridement, or both for middle aged or older patients with knee pain and degenerative knee disease. After analysis, the authors found that the small inconsequential benefit seen from interventions that include arthroscopy for the degenerative knee is limited in time and absent at one to two years after surgery. Knee arthroscopy is associated with harms such as deep venous thrombosis, pulmonary embolism, and infection. Taken together, these
findings do not support the practice of arthroscopic surgery for middle aged or older patients with knee pain with or without signs of osteoarthritis.

In 2014, Hwang and Kwoh conducted a multi-center randomized controlled trial (the Meniscal Repair in Osteoarthritis Research [METEOR] trial; N=351) that aimed to compare the short-term (6-month) and long-term (12-month) efficacy of arthroscopic partial meniscectomy and physical therapy in patients with symptomatic meniscal tear and osteoarthritis of the knee. The METEOR trial concluded that physical therapy is acceptable at first, and that surgery is not routinely needed. In patients assigned to physical therapy who eventually needed surgery, the delay resulting from a trial of conservative management did not impair outcomes at 12 months from the initial presentation.

Similar findings were found in two other studies suggesting that knee arthroscopy with partial meniscectomy as first line treatment for knee pain with or without OA is no more beneficial than the use of conservative measures on future health outcomes. In a 2014 systematic review by Mezhov et al, the authors concluded there is no convincing evidence that operative approaches are superior to conservative measures as the first-line treatment of older people with knee pain and meniscal tears. From the available data, a first-line trial of conservative therapy, which includes weight loss, is recommended for the treatment of degenerative meniscal tears in older adults. The exception to this may be when mechanical symptoms, such as knee locking, predominate.

As part of the Choosing Wisely campaign, an initiative of the American Board of Internal Medicine (ABIM) Foundation in partnership with Consumer Reports that seeks to advance a national dialogue on avoiding wasteful or unnecessary medical tests, treatments and procedures, the AMSSM recommended to “Avoid recommending knee arthroscopy as initial management for patients with degenerative meniscal tears and no mechanical symptoms.”

Arthroscopic Debridement
Although arthroscopic debridement and partial meniscectomy can provide relief to highly selected patients suffering knee pain due to OA, there is increasing medical evidence that knee arthroscopy is of questionable efficacy as a modality in the treatment of knee pathology in patients affected by knee OA.

In 2010, Reichenbach et al conducted a systematic review of 7 trials (N=567) to compare joint lavage with sham intervention, placebo, or non-intervention control in terms of effects on pain, function and safety outcomes in patients with knee osteoarthritis. The authors concluded that joint lavage did not result in a relevant benefit for patients with knee osteoarthritis in terms of pain relief or improvement of function.

In 2014, Khan et al conducted a systematic review of 7 randomized controlled trials (N=805) to evaluate the efficacy of arthroscopic meniscal debridement in patients with knee pain in the setting of mild or no concurrent osteoarthritis of the knee in comparison with nonoperative or sham treatments. The pooled treatment effect of arthroscopic surgery did not show a significant or minimally important difference (MID) between treatment arms for long-term functional outcomes (standardized mean difference [SMD] 0.07, 95% confidence interval [CI]: –0.10 to 0.23). Short-term functional outcomes between groups were significant but did not exceed the threshold for MID (SMD 0.25, 95% CI: 0.02 to 0.48). Arthroscopic surgery did not result in a significant improvement in pain scores in the short term (mean difference [MD]: 0.20, 95% CI: –0.67 to 0.26) or in the long term (MD: –0.06, 95% CI: –0.28 to 0.15). The authors concluded there is moderate evidence to suggest that there is no benefit to arthroscopic meniscal debridement for degenerative meniscal tears in comparison with nonoperative or sham treatments in middle-aged patients with mild or no concomitant osteoarthritis. A trial of nonoperative management should be the first-line treatment for such patients.
Kirkley et al conducted a single-center randomized controlled trial (N=92) of arthroscopic surgery in patients with moderate-to-severe osteoarthritis of the knee. Patients were randomly assigned to surgical lavage and arthroscopic debridement together with optimized physical and medical therapy or to treatment with physical and medical therapy alone. Of the 92 patients assigned to surgery, 6 did not undergo surgery. Of the 86 patients assigned to control treatment, all received only physical and medical therapy. After 2 years, the mean (±SD) Western Ontario and McMaster Universities Osteoarthritis Index (WOMAC) score for the surgery group was 874±624, as compared with 897±583 for the control group (absolute difference [surgery-group score minus control-group score], −23±605; 95% CI: −208 to 161; P=0.22 after adjustment for baseline score and grade of severity). The Short Form-36 (SF-36) Physical Component Summary scores were 37.0±11.4 and 37.2±10.6, respectively (absolute difference, −0.2±11.1; 95% CI: −3.6 to 3.2; P=0.93). Analyses of WOMAC scores at interim visits and other secondary outcomes also failed to show superiority of surgery. The authors concluded that arthroscopic surgery for osteoarthritis of the knee provides no additional benefit to optimized physical and medical therapy.

Supplemental Information
Practice Guidelines and Position Statements

American Academy of Orthopaedic Surgeons (AAOS)
According to the AAOS 2013 evidence based guideline for the treatment of osteoarthritis of the knee, the following surgical treatment recommendations address arthroscopy with lavage and/or debridement and arthroscopic partial meniscectomy:

- **Recommendation 12**: “We cannot recommend performing arthroscopy with lavage and/or debridement in patients with a primary diagnosis of symptomatic osteoarthritis of the knee. (Strength of Recommendation: Strong)”
- **Recommendation 13**: “We are unable to recommend for or against arthroscopic partial meniscectomy in patients with osteoarthritis of the knee with a torn meniscus. (Strength of Recommendation: Inconclusive)”

References


**Documentation for Clinical Review**

**Please provide the following documentation (if/when requested):**
- History and physical and/or consultation notes including:
  - Type of procedure
  - Reason for procedure
  - Clinical records indicating pain and functional disability that interferes with ADLs
  - Treatment plan
- Radiology reports (e.g., routine radiographs, CT, MRI) used to make surgical decision
- Outerbridge scale Grade, as applicable
- Prior conservative treatments, duration, and response or reason conservative treatment is inappropriate
- Past and present diagnostic testing and results
- Pertinent past procedural and surgical history
- Completed and signed Knee Arthroscopy Surgery Decision Aid by the physician and patient
- Completed and signed CollaboRATE survey by the patient

**Post Service**
- Procedure report(s)
Coding

This Policy relates only to the services or supplies described herein. Benefits may vary according to product design; therefore, contract language should be reviewed before applying the terms of the Policy. Inclusion or exclusion of codes does not constitute or imply member coverage or provider reimbursement.

MN/NMN

The following services may be considered medically necessary when policy criteria are met.

Services may be considered not medically necessary when policy criteria are not met.

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Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

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<td>Medical Policy Committee</td>
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Definitions of Decision Determinations

Medically Necessary: A treatment, procedure, or drug is medically necessary only when it has been established as safe and effective for the particular symptoms or diagnosis, is not investigational or experimental, is not being provided primarily for the convenience of the patient or the provider, and is provided at the most appropriate level to treat the condition.

Investigational/Experimental: A treatment, procedure, or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance
with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

**Split Evaluation:** Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a split evaluation, where a treatment, procedure, or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

### Prior Authorization Requirements (as applicable to your plan)

Within five days before the actual date of service, the provider must confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department. Please call (800) 541-6652 or visit the provider portal at www.blueshieldca.com/provider.

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.