

## Acellular Dermal Matrix Grafts

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<b>Approved By:</b>	Highmark Health Options – Market Leadership
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<b>Products:</b>	Medicaid
<b>Application:</b>	All participating hospitals and providers
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### Disclaimer

Highmark Health Options medical policy is intended to serve only as a general reference resource regarding coverage for the services described. This policy does not constitute medical advice and is not intended to govern or otherwise influence medical decisions.

### POLICY STATEMENT

Highmark Health Options may provide coverage under medical surgical benefits of the Company's Medicaid products for medically necessary Arthrex bovine collagen.

This policy is designed to address medical necessity guidelines that are appropriate for the majority of individuals with a particular disease, illness or condition. Each person's unique clinical circumstances warrant individual consideration, based upon review of applicable medical records.

The qualifications of the policy will meet the standards of the National Committee for Quality Assurance (NCQA) and the Delaware Department of Health and Social Services (DHSS) and all applicable state and federal regulations.

### DEFINITIONS

**Highmark Health Options (HHO)** – Managed care organization serving vulnerable populations that have complex needs and qualify for Medicaid. Highmark Health Options members include individuals and families with low income, expecting mothers, children, and people with disabilities. Members pay nothing to very little for their health coverage. Highmark Health Options currently services Delaware Medicaid: Delaware Healthy Children (DHCP) and Diamond State Health Plan Plus members.

**Acellular dermal matrix grafts** – Are used to reinforce or reconstruct areas where weakness exists. Acellular dermal matrix grafts may be used as reinforcement of the rotator cuff in superior capsular reconstruction surgery.

### PROCEDURES

A prior authorization is not required.

Acellular dermal matrix grafts may be considered medically necessary for superior capsular reconstruction when ALL of the following criteria are met:

- Massive, irreparable rotator cuff tear; and

- There is minimal or no evidence of arthritis; and
- Pain unrelieved through non-surgical treatment; and
- Decreased mobility; and
- Planned procedure includes one of the following:
  - o Latissimus dorsi tendon transfer; or
  - o Lower trapezius tendon transfer.

Acellular dermal matrix grafts not meeting the criteria as indicated in this policy are considered experimental/investigational and therefore non-covered because the safety and effectiveness cannot be established by review of the available published peer-reviewed literature.

**POST-PAYMENT AUDIT STATEMENT**

The medical record must include documentation that reflects the medical necessity criteria and is subject to audit by Highmark Health Options at any time pursuant to the terms of your provider agreement.

**PLACE OF SERVICE: INPATIENT/OUTPATIENT**

Experimental/INVESTIGATIONAL (E/I) services are not covered regardless of place of service.

Arthrex bovine collagen is typically an outpatient procedure which is only eligible for coverage as an inpatient procedure in special circumstances, including, but not limited to, the presence of a co-morbid condition that would require monitoring in a more controlled environment such as the inpatient setting.

**CODING REQUIREMENTS**

CPT code	Description
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair

**REIMBURSEMENT**

Participating facilities will be reimbursed per their Highmark Health Options contract.

**Reference**

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Jackson GR, Bedi A, Denard PJ. Graft augmentation of repairable rotator cuff tears: An algorithmic approach based on healing rates. *Arthroscopy.* 2021: S0749-8063(21)00963-4.

**POLICY UPDATE HISTORY**

12/21/2021	Approved in Medical Policy Committee
01/2022	Approved in QI/UM
12/28/2022	Annual review; approved in Medical Policy Committee
01/03/2023	Approved in QI/UM