

# Surgery of the Elbow

**Policy Number:** 2025T0551Z

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[Instructions for Use](#)

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## Community Plan Policy

- [Surgery of the Elbow](#)

## Medicare Advantage Policy

- [Joint Procedures](#)

## Application

### UnitedHealthcare Commercial

This Medical Policy applies to UnitedHealthcare Commercial benefit plans.

### UnitedHealthcare Individual Exchange

This Medical Policy applies to Individual Exchange benefit plans.

## Coverage Rationale

**Surgery of the elbow is proven and medically necessary in certain circumstances.** For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures:

- Arthroscopy, Diagnostic, +/- Synovial Biopsy, Elbow
- Arthroscopy, Surgical, Elbow
- Joint Replacement, Elbow
- Removal or Revision, Arthroplasty, Elbow

[Click here to view the InterQual® criteria.](#)

## Medical Records Documentation Used for Reviews

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. Medical records documentation may be required to assess whether the member meets the clinical criteria for coverage but does not guarantee coverage of the service requested; refer to the protocol titled [Medical Records Documentation Used for Reviews](#).

## 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 the member specific benefit plan document 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
<b>Arthroplasty, Joint Replacement, Elbow</b>	
24360	Arthroplasty, elbow; with membrane (e.g., fascial)
24361	Arthroplasty, elbow; with distal humeral prosthetic replacement
24362	Arthroplasty, elbow; with implant and fascia lata ligament reconstruction
24363	Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (e.g., total elbow)
24365	Arthroplasty, radial head
24366	Arthroplasty, radial head; with implant
24370	Revision of total elbow arthroplasty, including allograft when performed; humeral or ulnar component
24371	Revision of total elbow arthroplasty, including allograft when performed; humeral and ulnar component
<b>Arthroscopy, Surgical, Elbow</b>	
29830	Arthroscopy, elbow, diagnostic, with or without synovial biopsy (separate procedure)
29834	Arthroscopy, elbow, surgical; with removal of loose body or foreign body
29835	Arthroscopy, elbow, surgical; synovectomy, partial
29836	Arthroscopy, elbow, surgical; synovectomy, complete
29837	Arthroscopy, elbow, surgical; debridement, limited
29838	Arthroscopy, elbow, surgical; debridement, extensive

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## 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.

Surgeries of the elbow are procedures and, therefore, not regulated by the FDA. However, devices and instruments used during the surgery may require FDA approval. Refer to the following website for additional information:

<http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm>. (Accessed July 19, 2024)

## Policy History/Revision Information

Date	Summary of Changes
05/01/2025	<p><b>Template Update</b></p> <ul style="list-style-type: none"> <li>Created shared policy version to support application to Rocky Mountain Health Plans membership</li> </ul> <p><b>Application</b></p> <p><b>Individual Exchange</b></p> <ul style="list-style-type: none"> <li>Removed language indicating this Medical Policy does not apply to the state of Colorado</li> </ul> <p><b>Supporting Information</b></p> <ul style="list-style-type: none"> <li>Archived previous policy version 2025T0551Y</li> </ul>

## Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, please check the member specific benefit plan document and any applicable federal or state mandates. 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.

This Medical Policy may also be applied to Medicare Advantage plans in certain instances. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance,

CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence ([Medicare IOM Pub. No. 100-16, Ch. 4, §90.5](#)).

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