Arthroscopy knee (surgical), for chondroplasty

We provide coverage for this procedure for adult members who meet medical necessity criteria.

- **For dates of service on or after July 1, 2020**, submit authorization requests to TurningPoint Healthcare Solutions, LLC. You can submit authorization requests to TurningPoint starting on June 1, 2020. See the [BCN Musculoskeletal Services](#) page for more information.

- **For dates of service before July 1, 2020**, submit authorization requests through the e-referral system. The submitter will receive a prompt to complete a questionnaire to determine the appropriateness of the requested service. The questions are listed below. If all questions are answered, e-referral will either approve or pend the case. If the case pends and we cannot authorize it, we will contact the provider for additional clinical information.

Authorization is not a guarantee of payment. Payment is based on established claim edits. We will retrospectively monitor compliance with this authorization requirement.

Applicable procedure codes: *29877, *29879, G0289

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See below for the questions you'll encounter in the e-referral system.

**Q** Does the patient have knee pain OR knee giving way during activities that involve knee rotation?

**A** Possible answers: □ Yes □ No

**Q** Does the patient have at least ONE of the following findings (A-C)? A. Limited range of motion. B. Joint swelling/effusion. C. Crepitus (crackling/popping sounds or grating sensation).

**A** Possible answers: □ Yes □ No
### Preview questionnaire

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For BCN HMO℠ (commercial) and BCN Advantage℠ members

**Effective Dec. 8, 2019**

<table>
<thead>
<tr>
<th>Question</th>
<th>Possible answers</th>
</tr>
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<tbody>
<tr>
<td>Does the patient have severe osteoarthritis (severe degenerative changes in bone or cartilage) identified by imaging?</td>
<td>□ Yes □ No □ No imaging performed</td>
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<tr>
<td>Does the patient have continued symptoms or findings after treatment within the last year with NSAID (nonsteroidal anti-inflammatory drugs) for at least 3 weeks (unless contraindicated or not tolerated)?</td>
<td>□ Yes □ No</td>
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<tr>
<td>Does the patient have continued symptoms or findings after treatment within the last year with physician directed home exercise program OR physical therapy for at least 6 weeks?</td>
<td>□ Yes □ No</td>
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<tr>
<td>Does the patient have continued symptoms or findings after treatment within the last year with activity modification for at least 6 weeks?</td>
<td>□ Yes □ No</td>
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