Cohere Medicare Advantage Policy - Knee Open or Arthroscopic Bursectomy

Clinical Guidelines for Medical Necessity Review

Version: 1
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Important Notices

Notices & Disclaimers:

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Other Notices:

Guideline Information:

Specialty Area: Disorders of the Musculoskeletal System
Guideline Name: Cohere Medicare Advantage Policy - Knee Open or Arthroscopic Bursectomy

Date of last literature review: 3/18/2025
Document last updated: 3/19/2025
Type: [**X**] Adult (18+ yo) | [**X**] Pediatric (0-17 yo)

Table of Contents

Medical Necessity Criteria

***Service*: Knee Open or Arthroscopic Bursectomy**

Benefit Category

Not applicable.

Please Note: This may not be an exhaustive list of all applicable Medicare benefit categories for this item or service.

Related CMS Documents

There are no applicable NCDs and/or LCDs for knee open or arthroscopic bursectomy. Please refer to the CMS Medicare Coverage Database for the most current applicable CMS National Coverage.

Recommended Clinical Approach

Prepatellar bursitis, the inflammation of the bursa in front of the kneecap, may result from repetitive injury, acute trauma, or inflammatory conditions, including gout, syphilis, tuberculosis, or rheumatoid arthritis.[1] Often, prepatellar bursitis can be treated with aspiration, immobilization, and antibiotic therapy–in the case of septic bursitis–or with non-steroidal anti-inflammatory drugs for non-septic bursitis.[1,2] An open or endoscopic knee bursectomy may be necessary when conservative treatment fails. An endoscopic bursectomy is a minimally invasive surgery, typically performed as an outpatient procedure, in which a small incision is made to remove the bursa, resulting in restored or improved function and pain relief. After surgery, patients should forego vigorous physical exertion for 2 weeks.[3]

Evaluation of Clinical Harms and Benefits

Cohere Health uses the criteria below to ensure consistency in reviewing the conditions to be met for coverage of knee open or arthroscopic bursectomy. This process helps to prevent both incorrect denials and inappropriate approvals of medically necessary services. Specifically, limiting incorrect approvals reduces the risks associated with unnecessary procedures, such as complications from surgery, infections, and prolonged recovery times.

The potential clinical harms of using these criteria may include:

- A retrospective analysis of 536 patients treated for traumatic lesions of the olecranon and prepatellar bursa found a 6.3% and 6.7% rate of infections and wound healing disturbances, respectively. Other, less common complications included keloid scar formation, hematoma, seroma, recurrent bursitis, and swelling.[4]
- Other studies have found that patients undergoing a knee bursectomy are at risk of surgical site morbidities, including sub-optimal healing of the incision, decreased sensation, atrophic skin changes, and tenderness or pain around the scarring.[3,5-7]
- Increased healthcare costs and complications from the inappropriate use of emergency services and additional treatments.

The clinical benefits of using these criteria include:

- A systematic review conducted by Brown et al. (2021) to establish the optimal management for prepatellar bursitis found that endoscopic knee bursectomy was associated with improved patient morbidity, restored range of motion, and reduced pain.[7]
- Enhanced overall patient satisfaction and healthcare experience.

This policy includes provisions for expedited reviews and flexibility in urgent cases to mitigate risks of delayed access. Evidence-based criteria are employed to prevent inappropriate denials, ensuring that patients receive medically necessary care. The criteria aim to balance the need for effective treatment with the minimization of potential harms, providing numerous clinical benefits in helping avoid unnecessary complications from inappropriate care.

In addition, the use of these criteria is likely to decrease inappropriate denials by creating a consistent set of review criteria, thereby supporting optimal patient outcomes and efficient healthcare utilization.

Medical Necessity Criteria

Indications

- ➔ A **knee open or arthroscopic bursectomy** is considered appropriate if **ANY** of the following is **TRUE**[1-8]:
  - ◆ Failure of conservative management (e.g., rest, analgesics, physical therapy, oral or injectable corticosteroids) must be documented for a period of greater than 3 months. Documentation should include detailed evidence of the measures taken, rather than solely a physician's statement; **OR**
  - ◆ Suspected septic prepatellar knee bursitis/infection when symptoms have not improved significantly within 36-48 hours after initiation of antibiotic treatment.[9]

Non-Indications

- ➔ A **knee open or arthroscopic bursectomy** is not considered appropriate if **ANY** of the following is **TRUE**:
  - ◆ There are no published contraindications.

Level of Care Criteria

Inpatient or Outpatient

Procedure Codes (CPT/HCPCS)

CPT/HCPCS Code	Code Description
27340	Excision, prepatellar bursa

Disclaimer: G, S, I, and N Codes are non-covered per CMS guidelines due to their experimental or investigational nature.

Medical Evidence

Brown et al (2022) performed a systematic review to determine the optimal treatment for prepatellar bursitis. It included 10 studies (702 patients) comparing endoscopic and open bursectomy and assessing the duration of antibiotics. The primary outcome was recurrence after 1 year. Results showed no significant difference in recurrence between endoscopic and open bursectomy or surgical complications. Endoscopic bursectomy offered shorter hospital stays and lower postoperative pain risk. Antibiotic treatment for less than 8 days did not significantly increase recurrence compared to longer treatment. The study suggests endoscopic bursectomy as a viable option for septic and aseptic prepatellar bursitis. There is no significant improvement in recurrence or hospital stay with antibiotic treatment exceeding 7 days for septic bursitis.[7]

Uçkay et al (2017) conducted a randomized trial to analyze the optimal surgical approach for patients with septic bursitis. A total of 164 patients were randomized to receive either 1-stage or 2-stage bursectomy, along with 7 days of oral antibiotic therapy post-surgery. Of these patients, 130 had elbow bursitis, and 34 had patellar bursitis. The results showed 22 treatment failures overall, with a slightly lower rate in the 1-stage group (10%) than in the 2-stage group (16%), though this difference was not statistically significant. Recurrent infections were observed in a small percentage of patients, some caused by the same pathogen and others by a different pathogen. However, outcomes favored the 1-stage approach in terms of lower rates of wound dehiscence for elbow bursitis (1 out of 66 vs 9 out of 64), shorter median hospital stay (4.5 vs 6.0 days), reduced nurses' workload, and lower total costs. The conclusion drawn was that for adults with moderate to severe septic bursitis requiring hospitalization, bursectomy with primary closure and 7 days of antibiotic therapy was safe, effective, and cost-saving. Additionally, the study suggested that using a 2-stage approach may be associated with a higher risk of wound dehiscence for olecranon bursitis than the 1-stage approach.[8]

Baumbach et al (2015) reported on a study to develop a treatment algorithm for olecranon and prepatellar bursitis, which are common conditions predominantly affecting middle-aged male patients. About one-third of cases were septic, while two-thirds were non-septic, with treatment approaches varying internationally. A literature review identified 52 relevant papers. Differentiation between septic and non-septic bursitis relied on clinical presentation, bursal aspirate, and blood sampling analysis. Bursal aspirate criteria included purulence, glucose ratio, white cell count, cell type, Gram staining, and culture - general treatment for both types involved bursal aspiration, NSAIDs, and PRICE. In non-septic cases with high demands,

intrabursal steroid injection might be considered. Septic bursitis requires antibiotic therapy. Surgical intervention like incision, drainage, or bursectomy were reserved for severe, refractory, or chronic/recurrent cases. The authors concluded that immediate bursectomy lacked sufficient evidence support and suggested a conservative approach based on bursal aspirate differentiation between septic and non-septic bursitis.[9]

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Clinical Guideline Revision History/Information

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