This Medical Policy provides assistance in interpreting UnitedHealthcare benefit plans. When deciding coverage, the member specific benefit plan document must be referenced. The terms of the member specific benefit plan document [e.g., Certificate of Coverage (COC), Schedule of Benefits (SOB), and/or Summary Plan Description (SPD)] may differ greatly from the standard benefit plan upon which this Medical Policy is based. In the event of a conflict, the member specific benefit plan document supersedes this Medical Policy. All reviewers must first identify member eligibility, any federal or state regulatory requirements, and the member specific benefit plan coverage prior to use of this Medical Policy. Other Policies and Coverage Determination Guidelines may apply. UnitedHealthcare reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines 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.

**INSTRUCTIONS FOR USE**

**CORE DECOMPRESSION FOR AVASCULAR NECROSIS**

**Policy Number:** 2016T02190

**Effective Date:** October 1, 2016

**Table of Contents**

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>INSTRUCTIONS FOR USE</td>
<td>1</td>
</tr>
<tr>
<td>BENEFIT CONSIDERATIONS</td>
<td>1</td>
</tr>
<tr>
<td>COVERAGE RATIONALE</td>
<td>1</td>
</tr>
<tr>
<td>APPLICABLE CODES</td>
<td>2</td>
</tr>
<tr>
<td>DESCRIPTION OF SERVICES</td>
<td>2</td>
</tr>
<tr>
<td>CLINICAL EVIDENCE</td>
<td>3</td>
</tr>
<tr>
<td>U.S. FOOD AND DRUG ADMINISTRATION</td>
<td>6</td>
</tr>
<tr>
<td>CENTERS FOR MEDICARE AND MEDICAID SERVICES</td>
<td>6</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>6</td>
</tr>
<tr>
<td>POLICY HISTORY/REVISION INFORMATION</td>
<td>7</td>
</tr>
</tbody>
</table>

**BENEFIT CONSIDERATIONS**

Before using this policy, please check the member specific benefit plan document and any federal or state mandates, if applicable.

**Essential Health Benefits for Individual and Small Group**

For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits ("EHBs"). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage for benefits which are deemed EHBs, the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute EHBs is made on a state by state basis. As such, when using this policy, it is important to refer to the member specific benefit plan document to determine benefit coverage.

**COVERAGE RATIONALE**

Core decompression is proven and medically necessary for treating early (pre-collapse stage I and II) avascular necrosis of the femoral head.

Core decompression is unproven and not medically necessary for treating late avascular necrosis of the femoral head or for avascular necrosis elsewhere, including the humeral head, the distal femur, the talus, or the mandibular condyle.
The available evidence for core decompression for these conditions is limited and low quality. Most clinical studies involve a small number of patients and lack proper controls. Therefore, there is insufficient data to allow conclusions regarding the safety and efficacy of core decompression for these indications.

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 Coverage Determination Guidelines may apply.

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<thead>
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<th>Description</th>
</tr>
</thead>
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<tr>
<td>27299</td>
<td>Unlisted procedure, pelvis or hip joint</td>
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<td>Unlisted procedure, femur or knee</td>
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<tr>
<td>27899</td>
<td>Unlisted procedure, leg or ankle</td>
</tr>
</tbody>
</table>

**HCPCS Code**

<table>
<thead>
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<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Hip core decompression</td>
</tr>
</tbody>
</table>

DESCRIPTION OF SERVICES

Avascular necrosis (AVN), also known as osteonecrosis, aseptic necrosis and ischemic bone necrosis, is a relatively common disease characterized by death of cellular elements of bone or marrow.

Avascular necrosis (AVN) occurs when the blood flow to the bone has been interrupted leading to the death of bone. As the bone tissue dies, the bone structure collapses which results in pain and loss of joint function. This condition occurs most often in the femoral head but can affect other bones and joints. There are many risk factors for the disease including hemoglobinopathies, dislocation of the hip, alcoholism, fracture of the femoral neck, use of corticosteroids, as well as collagen vascular disease. AVN is a progressive disorder that often results in the eventual collapse of the bone and the need for joint replacement or other arthroplasty.

Core decompression of the hip is usually employed before collapse and fracture of the femoral head and/or neck to delay or avoid reconstructive surgery of the affected joint. It is generally carried out to preserve the function and the structure of the hip as well as to relieve pain associated with AVN. Core decompression consists of drilling one or more small channels into the dead bone (necrotic lesion). The procedure is designed to decrease pressure within the bone by restoring blood flow to the bone. Bone grafting may or may not be used with core decompression.

Severity of avascular necrosis is determined by the staging system based on the consensus of the Subcommittee of Nomenclature of the International Association on Bone Circulation and Bone Necrosis (Tofferi, 2008). Staging is as follows:

<table>
<thead>
<tr>
<th>Stage</th>
<th>Clinical Findings</th>
</tr>
</thead>
</table>
| Stage 0 | • Patient is asymptomatic  
• Radiography findings are normal  
• Histology findings demonstrate osteonecrosis |
| Stage I | • Patient may or may not be symptomatic  
• Radiography and CT scan findings are unremarkable  
• AVN is considered likely based on MRI and bone scan results [may be subclassified by extent of involvement (see below)]  
• Histology findings are abnormal |
| Stage II | • Patient is symptomatic  
• Plain radiography findings are abnormal and include osteopenia, osteosclerosis, or cysts  
• Subchondral radiolucency is absent  
• MRI findings are diagnostic |
In 2014, Marti-Carvajal and colleagues conducted a systematic review to compare the effect of surgical treatments with non-surgical treatment of avascular necrosis (AVN) in individuals with sickle cell disease (SCD). Only 1 trial was identified and included 46 participants. Eight patients withdrew after randomization as they declined to participate in the trial. The remaining 38 patients were randomized to receive either hip core decompression and physical therapy or physical therapy alone. After a mean follow-up of 3 years, the surgical group (hip core decompression and physical therapy) showed no clinical improvement compared with the non-surgical group. There were also no significant differences between the study groups in terms of major complications (hip pain; vasocclusions; and acute chest progression and total hip arthroplasty or further surgery suggested a slight superiority of other JPT compared with CD. The authors identified that high heterogeneity of the primary investigations was the main limitation of the study. They concluded that the efficacy and effectiveness of core decompression for ONFH are, at best, no better than other joint preserving strategies. The more recent scientific evidence seems to suggest that such procedure is less successful than other joint preserving strategies. According to the authors further studies are needed to identify the best therapeutic approach to the ONFH.
syndrome). This study did not report patient-relevant outcomes, such as mortality or quality of life (QOL). The author’s conclusion that the addition of core decompression to physical therapy did not improve outcomes for patients with SCD and AVN. Additional studies, preferably RCTs, are necessary to evaluate the role of hip-core depression in patients with SCD.

Shah et al. (2015) undertook a study (n=20) to analyze the clinical, functional and radiological outcome of core decompression and bone grafting in patients with osteonecrosis of the femoral head (ONFH) up to stage IIB. The procedure adopted in 26 hips was core decompression and cancellous bone grafting. Two hips were treated with core decompression and fibular grafting. Functional outcome was assessed by Harris hip score, wherein 19 hips had good or excellent outcome; 1 hip had fair outcome and 8 hips showed poor result. For stage I, 12/13 hips improved, whereas for Stage IIA, 6/11 hips showed improvement and for stage IIB, only 2/4 hips showed improvement. Core decompression procedures showed improvement in patients who had abduction more than 30 degrees and adduction more than 108 degrees. It also showed more improvement for internal rotation in comparison with external rotation. Out of the 28 hips, a majority had pain relief immediately following operation but as time passed deterioration was seen. At 3 months, 22 hips had pain relief but only 19 hips had pain relief at final follow-up. Less than 25% of the hips required a replacement or salvage procedure. The success rate was 92.3% for grade I, 100% for grade IIA and 50% for grade IIB. The authors concluded that core decompression and bone grafting provide satisfactory outcome when patients are carefully selected in early stages of the disease, before the stage of collapse.

Wei et al. (2011) conducted a study on the effect of core decompression combined with an allogeneic, antigen-extracted, autolysed fibular allograft and autologous impacted bone grafting for the treatment of osteonecrosis of the femoral head. The study included 162 patients (223 hips; 61 females, 101 males; mean age 33.5 years, range 19-54 years) with stage II-III avascular necrosis of the femoral head. The outcome was determined by changes in the Harris hip score, by progression in radiographic stages, and by the need for hip replacement. The mean follow-up was 24 months. Excellent and good results were obtained in 93.3% of cases in stage II, and 87% in stages III with a survivorship of 81% in all cases. According to the authors, core decompression combined with an allogeneic, antigen-extracted, autolysed fibular allograft and autologous impacted bone grafting may be the treatment of choice, particularly in the pre-collapse stage.

Yu et al. (2015) conducted a study to review the outcomes of using synthetic bone graft substitute (calcium sulfate and calcium phosphate) for the treatment of late-stage osteonecrosis of the femoral head. The study consisted of 19 hips in 18 patients with osteonecrosis of the femoral head [6 hips in Association Research Circulation Osseous (ARCO) stage IIC and 13 hips in stage IIIA] who were treated with core decompression combined with PRO-DENSE™ (Injectable Regenerative Graft). The clinical failure was defined as conversion to total hip arthroplasty or progression in head collapse. At the conclusion of the study, 3 in the 6 stage IIC hips and 8 in the 13 stage IIIA hips were converted to total hip arthroplasty postoperatively. Advanced collapse of the femoral head waiting for total hip arthroplasty was observed in the other six hips. Of the 19 hips, only 2 hips survived without further collapse in the 5-year follow-up. This resulted in 89.5% failure rate. The authors concluded that core decompression combined with an injectable (PRO-DENSE) were associated with high failure rates in the early postoperative period. It is not recommended for the treatment of ARCO stage IIC and IIIA osteonecrosis of the femoral head.

Von Stechow and Drees (2007) stated that untreated osteonecrosis will eventually destroy the affected femoral head. Depending on the location and the extent of the osteonecrosis, several surgical options are available. For early small and medium-sized pre-collapse lesions, core decompression is the treatment of choice.

**Core Decompression in the Shoulder, Knee, and Ankle**

While available evidence indicates that core decompression is effective in treating early stages of AVN of the hip, there is currently insufficient evidence that this procedure is effective in treating AVN of the shoulder, knee or ankle. The majority of studies involved a small number of patients and lacked appropriate control groups. Furthermore, several of the studies were published by the same group of investigators. Prospective, well-designed, randomized, controlled trials are needed to ascertain the clinical value of core decompression for joints other than the hip.

**Humeral Head (Shoulder)**

Franceschi et al. (2016) performed a systematic review to identify published studies and analyze clinical evidence available related to the surgical management of osteonecrosis of the humeral head. A search was performed using the PubMed (MEDLINE), EMBASE and Cochrane Library databases. Twelve studies were included: five prospective case series and seven retrospective case series. A total of 309 patients, comprising 382 shoulders, were included. Three main surgical procedures were evaluated: core decompression, hemi-arthroplasty and total shoulder arthroplasty. The authors concluded that based on the current available data, core decompression is a safe and effective option for treating low-grade osteonecrosis of the humeral head, while hemi-arthroplasty and total shoulder arthroplasty should be considered for high-grade osteonecrosis. According to the authors more studies and better-designed trials are needed and the level of evidence had poor reference standard; analyses with no sensitivity analyses.
Kennon and colleagues (2016) evaluated radiographic and functional outcomes after procedures for humeral head atraumatic avascular necrosis (HAAVN), decompression efficacy in chronic steroid-induced (CSI) and sickle cell disease (SCD) populations. Twenty-five shoulders were treated surgically for HAAVN. Stage I/II disease received core decompression and ultrasound bone stimulation. Stage III received surface replacement or hemiarthroplasty, and arthroplasty was performed for stage IV/V. Radiographs and clinical scores were recorded preoperatively and postoperatively. Eleven shoulders (stage I/II disease) underwent core decompression. Seven of 8 shoulders (88%) progressed to stage III/IV after decompression. All SCD patients progressed to collapse. The procedure in 19 shoulders was surface replacement, hemiarthroplasty, or total shoulder arthroplasty (TSA). Constant, American Shoulder and Elbow Surgeons, Simple Shoulder Test-12, and University of California Los Angeles Shoulder scores were significantly higher at 1- and 2-year follow-up with arthroplasty; 13 of 16 arthroplasty patients (81%) had satisfactory to excellent results. One surface replacement was revised to reverse TSA. The authors concluded that the results suggest core decompression for AVN in SCD patients does not alter osteonecrosis progression and humeral head collapse. They suggest that resurfacing and hemiarthroplasty are viable treatment options for stage III, whereas shoulder replacement for stage IV/V disease appears to offer better functional results.

Harreld et al. (2009) conducted a small study to evaluate humeral head core decompression involving percutaneous perforations. During this study, shoulder arthroplasty was avoided in all 15 patients (26 shoulders) for a mean follow-up of 32 months. Of the 26 shoulders, 25 had successful clinical and functional outcomes, and 1 showed radiographic progression of the disease but has not needed further operative treatment. Decompression results were compared with those of a nonoperative historical control group, identified through a literature search. There was a 48% (143/299) rate of progression to arthroplasty in the control group at a follow-up ranging from 2 to 4.5 years. According to the authors, percutaneous decompression appears to be a low-morbidity method for relieving symptoms and deferring shoulder arthroplasty in patients with symptomatic osteonecrosis of the humeral head. This study is limited by lack of randomization, and small sample size.

**Femoral Condyle or Distal Femur (Knee)**

The knee is the second most common location for osteonecrosis with about a 10% incidence of the disease in the hip.

One retrospective, uncontrolled study (n=248 knees), provided weak but positive evidence of the long-term effectiveness of core decompression in delaying secondary surgery in the early stages of AVN of the femoral condyle. A second core decompression procedure was performed in 16% of patients; the criteria for repeat core decompression were not reported. Only 7 knees were at stage III at the time of diagnosis. The overall survival rate for knees included in the 2000 report (stages I through III) was 79%, based on a mean of 7 years of follow-up (minimum of 2 years) (Mont et al., 2000).

Comparability of these results (Mont et al., 2000) with those of future studies may be limited. First, patients were selected for core decompression only after 3 months of conservative treatment failed to relieve symptoms. This is a reasonable selection process but not one reported by other authors. Results from core decompression might have been more favorable in patients whose symptoms had not already been shown to be unresponsive to conservative treatment. Secondly, 16% of patients had two, rather than one, core decompression procedures for AVN in the knee, which may have inflated results.

**Talus (Ankle)**

Gross and colleagues (2014) conducted a systematic review evaluating various interventions for talar avascular necrosis, including hind foot fusion, conservation treatment approaches, bone grafts, core decompression, and talar replacement. A total of 19 studies (321 ankles) were included for detailed review. All individual studies were considered poor quality, and the overall body of evidence was considered very low quality due to study limitations, such as imprecise and sparse data and possible reporting bias. Study author concluded that additional randomized studies are needed to inform and guide specific treatments for avascular necrosis of the talus.

Marulanda et al (2010) conducted a non-randomized study to examine the results of percutaneous drilling to treat osteonecrosis of the ankle in 31 patients (44 ankles). At a mean follow-up duration of 45 +/- 12 months, 40 (91%) ankles had achieved a successful clinical outcome. There were no perioperative complications, although 3 ankles subsequently collapsed and required arthrodesis. According to the authors, the percutaneous drilling technique appears to be a useful method for the relief of symptomatic ankle osteonecrosis. This study is limited by lack of randomization, control and small sample size.

**Mandibular Condyle**

Osteonecrosis of the mandibular condyle has only recently been reported, and there is limited information on the efficacy of core decompression. In 8 of 9 patients (16 joints) with histologically confirmed osteonecrosis of the mandible, core decompression resulted in substantial pain reduction over a mean follow-up period of 34 months. (Chuong et al., 1995) In a second group of 8 patients (15 joints) with more severe lesions, core decompression with bone grafting resulted in significant clinical improvement in 11 joints during the follow-up period (mean 28 months).
**Summary**

Although the majority of the studies have a weak study design with no controlled comparisons and small sample sizes, results were consistent and support the conclusions of preliminary research that core decompression is safe, and may result in prevention or deferral of partial or complete arthroplasty, if performed in hips with AVN at stage I or II, with a substantially higher likelihood of success at stage I. Joint survival rates for hips at stage I were quite high (92% to 100%). In all studies, joint survival declined with increasing baseline disease stage.

However, the available evidence for core decompression for other conditions, such as late avascular necrosis of the femoral head, or avascular necrosis of the humeral head, distal femur, talus, or mandibular condyle is limited and low quality. Most clinical studies involve a small number of patients and lack proper controls. Hence, definitive conclusions regarding the safety and efficacy of these other indications cannot be drawn.

**U.S. FOOD AND DRUG ADMINISTRATION (FDA)**

Core decompression is a surgical procedure and is not regulated by FDA. The procedure is performed with ordinary surgical instruments. The FDA has not approved any devices specifically for core decompression. Approval has been granted to numerous bone graft substitutes (product code LYC), some of which may be used in conjunction with core decompression. Available at: [http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmncfm.](http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmncfm.)

(Accessed July 13, 2016)

**CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)**

Medicare does not have a National Coverage Determination (NCD) for core decompression for the treatment of avascular necrosis of the femoral head, humeral head, distal femur, mandibular condyle or the talus. Local Coverage Determinations (LCDs) do not exist at this time.

(Accessed July 15, 2016)

**REFERENCES**


### POLICY HISTORY/REVISION INFORMATION

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</tr>
</tbody>
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