Preauthorization is not required.

The following Protocol contains medical necessity criteria that apply for this service. The criteria are also applicable to services provided in the local Medicare Advantage operating area for those members, unless separate Medicare Advantage criteria are indicated. If the criteria are not met, reimbursement will be denied and the patient cannot be billed. Please note that payment for covered services is subject to eligibility and the limitations noted in the patient’s contract at the time the services are rendered.

Description

Meniscal allografts and other meniscal implants (e.g., collagen or polyurethane) are intended to improve symptoms and reduce joint degeneration in patients who have had a total or partial resection of the meniscus.

Summary of Evidence

Meniscal allograft transplantation, performed in combination with other surgical interventions, appears to improve symptoms in some patients with a prior meniscectomy who are considered too young to undergo total knee replacement. Evidence consisting primarily of retrospective case series indicates that this procedure may produce short- to intermediate-term pain relief in selected patients. Although short- to intermediate-term results are promising, the literature does not permit conclusions concerning the effect of meniscal transplantation on the long-term progression of degenerative changes and joint space narrowing.

Meniscal allograft transplantation is associated with a high number of complications, including tears of the transplanted meniscus, displacement, or arthrofibrosis. Careful selection of patients and surgical technique appear to be critical for success of this procedure.\textsuperscript{1,2} These major interventions are considered salvage procedures and are not recommended to be performed casually or by surgeons without extensive experience and expertise in complex knee reconstruction. Therefore, meniscal allograft transplant may be considered medically necessary for patients with prior meniscectomy who have disabling knee pain, and who are too young to be considered for total knee arthroscopy.

Similar types of evidence are available for meniscal allograft transplantation in combination with treatment of focal articular lesions, with case series reporting short- to intermediate-term improvement in pain and functioning. Based on the available evidence and clinical input, meniscal allograft transplantation may be considered medically necessary when performed in combination with treatment of focal articular cartilage lesions in patients younger than 55 years with disabling knee pain that has not shown an adequate response to physical therapy and analgesic medications.

The collagen meniscus implant and polyurethane meniscus implant do not have U.S. Food and Drug Administration (FDA) approval. Current controlled trials do not report improvements in outcomes for most pain and functional status measures. In addition to FDA approval, mid-to long-term follow-up from controlled studies
with a larger number of subjects is needed to determine whether implantation of a polyurethane or collagen scaffold is able to slow joint degeneration, reduce pain, or otherwise improve the net health outcome.

There are no randomized controlled trials for the polyurethane meniscal scaffold, and this product is not approved for marketing in the United States at this time. Therefore, synthetic meniscal implants are considered investigational.

**Policy**

Meniscal allograft transplantation may be considered medically necessary in patients who have had a prior meniscectomy and have symptoms related to the affected side, when all of the following criteria are met:

- Adult patients should be too young to be considered an appropriate candidate for total knee arthroplasty or other reconstructive knee surgery (e.g., younger than 55 years)
- Disabling knee pain with activity that is refractory to conservative treatment
- Absence or near absence (more than 50%) of the meniscus, established by imaging or prior surgery
- Documented minimal to absent diffuse degenerative changes in the surrounding articular cartilage (e.g., Outerbridge Grade II or less, less than 50% joint space narrowing)
- Normal knee biomechanics, or alignment and stability achieved concurrently with meniscal transplantation.

Meniscal allograft transplantation may be considered medically necessary when performed in combination, either concurrently or sequentially, with treatment of focal articular cartilage lesions using any of the following procedures:

- autologous chondrocyte implantation, or
- osteochondral allografting, or
- osteochondral autografting.

Use of other meniscal implants incorporating materials such as collagen and polyurethane are considered investigational.

**Policy Guidelines**

Patients should exhibit symptoms of persistent disabling knee pain that has not shown an adequate response to physical therapy and analgesic medications. Uncorrected misalignment and instability of the joint are contraindications. Therefore additional procedures, such as repair of ligaments or tendons or creation of an osteotomy for realignment of the joint, may be performed at the same time.

Severe obesity, e.g., body mass index greater than 35 kg/m², may affect outcomes due to the increased stress on weight bearing surfaces of the joint. Meniscal allograft transplantation is typically recommended for young active patients who are too young for total knee arthroplasty.

**Background**

Historically, the role of normal meniscal cartilage was greatly underappreciated, and until some 30 years ago, torn and damaged menisci were routinely excised. However, it is now known that the menisci are an integral structural component of the human knee, functioning to absorb shocks and providing load sharing, joint stability, congruity, proprioception, and lubrication and nutrition of the cartilage surfaces.
Total and partial meniscectomy frequently result in degenerative osteoarthritis (OA). The integrity of the menisci is particularly important in knees in which the anterior cruciate ligament (ACL) has been damaged. In these situations, the menisci act as secondary stabilizers of anteroposterior and varus-valgus translation. With this greater understanding, the surgical principles of treating torn or damaged menisci evolved to favor repair and preservation whenever possible.

Meniscal allograft transplantation has been investigated in patients with a previous meniscectomy, or in patients who require a total or near total meniscectomy for irreparable tears. There are three general groups of patients who have been treated with meniscal allograft transplantation:

- young patients with a history of meniscectomy who have symptoms of pain and discomfort associated with early OA that is localized to the meniscus-deficient compartment
- patients undergoing ACL reconstruction in whom a concomitant meniscal transplant is intended to provide increased stability
- young athletes with few symptoms in whom the allograft transplantation is intended to deter the development of osteoarthritis. Due to the risks associated with this surgical procedure, prophylactic treatment for this purpose is not frequently recommended

Issues under study include techniques for processing and storing the grafts, proper sizing of the grafts, and the most appropriate surgical techniques (e.g., suturing or anchored with bone plugs). Four primary ways of processing and storing allografts (fresh, fresh frozen, cryopreserved, lyophilized) have been reported. Fresh implants, harvested under sterile conditions, are less frequently used because the grafts must be used within a couple of days to maintain viability. Alternatively, the harvested meniscus can be fresh frozen for storage until needed. Another commonly used method, cryopreservation, freezes the graft in glycerol, which aids in preserving the cell membrane integrity and donor fibrochondrocyte viability. Cryolife (Marietta, GA) is a commercial supplier of such grafts. In addition to freezing, donor tissue may be dehydrated (freeze-dried or lyophilized), permitting storage at room temperature. Lyophilized grafts have been shown to be prone to reduced tensile strength, graft shrinkage, poor rehydration, posttransplantation joint effusion, and synovitis and are no longer used in the clinical setting. Several secondary sterilization techniques may be used, with gamma irradiation the most common. The dose of radiation considered effective has been shown to change the mechanical structure of the allograft; therefore, nonirradiated grafts from screened donors are most frequently used.

Tissue engineering that grows new replacement host tissue for individual patients is also being investigated. For example, the ReGen Collagen Scaffold (Ivy Sports Medicine, formerly ReGen Biologics), which may also be referred to as the Menaflex™ collagen meniscus implant or CMI™, is a resorbable collagen matrix composed primarily of type I collagen from bovine Achilles tendons. The implant is provided in a semilunar shape and trimmed to size for suturing to the remaining meniscal rim. The implant provides an absorbable collagen scaffold that is replaced by the patient’s own soft tissue; it is not intended to replace normal body structure. In addition, because it requires a meniscal rim for attachment, it is intended to fill meniscus defects after a partial meniscectomy. Other scaffold materials and cell-seeding techniques are being investigated. For example, Actifit® (Orteq) is a biodegradable polyurethane scaffold that is currently being studied in Europe. Nonabsorbable and nonporous synthetic implants for total meniscus replacement are in development. One total meniscus replacement that is in early phase clinical testing is NUsurface® (Active Implants), which is composed of a polyethylene reinforced polycarbonate urethane.

**Regulatory Status**

The ReGen Collagen Scaffold (CS) received 510(k) marketing clearance from FDA in 2008. The marketing clearance was based on the decision that this collagen scaffold was substantially equivalent to existing predicate absorbable surgical mesh devices. The ReGen Collagen Scaffold (also known as MenaflexTM CMI) was the only
CMI with FDA clearance at that time. Amid controversy about the 510(k) clearance for the ReGen Collagen Scaffold, FDA initiated a review of the clearance process for this device. In September 2009, FDA issued a preliminary report on the review of the ReGen Menaflex®: Departure from Processes, Procedures, and Practices Leave the Basis for a Review Decision in Question. This preliminary report documents findings and recommendations concerning FDA’s review and clearance of the ReGen Biologics, CS device for meniscal repair, marketed as Menaflex™. In October 2010, FDA announced that the device should not have been cleared for marketing, as the Menaflex™ device is intended to be used for different purposes and is technologically dissimilar from devices already on the market (predicate devices).

No partial or total meniscal implant is approved or cleared for marketing in the United States.

Related Protocols
Autografts and Allografts in the Treatment of Focal Articular Cartilage Lesions
Autologous Chondrocyte Implantation for Focal Articular Cartilage Lesions

Services that are the subject of a clinical trial do not meet our Technology Assessment Protocol criteria and are considered investigational. For explanation of experimental and investigational, please refer to the Technology Assessment Protocol.

It is expected that only appropriate and medically necessary services will be rendered. We reserve the right to conduct prepayment and postpayment reviews to assess the medical appropriateness of the above-referenced procedures. Some of this Protocol may not pertain to the patients you provide care to, as it may relate to products that are not available in your geographic area.

References
We are not responsible for the continuing viability of web site addresses that may be listed in any references below.


