

Surgery of the Elbow (for Nebraska Only)

Policy Number: CS033NE.V
Effective Date: January 1, 2026

[Instructions for Use](#)

Table of Contents	Page
Application	1
Coverage Rationale	1
Medical Records Documentation Used for Reviews	1
Applicable Codes	1
U.S. Food and Drug Administration	2
Policy History/Revision Information	2
Instructions for Use	2

Related Policies
None

Application

This Medical Policy only applies to the State of Nebraska.

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 federal, state, or contractual requirements, 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 services requested.

The patient's medical record must contain documentation that fully supports the medical necessity for the requested services. This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures. Documentation supporting the medical necessity should be legible, maintained in the patient's medical record, and must be made available upon request.

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 federal, state, or contractual requirements 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
Arthroplasty, Joint Replacement, Elbow	
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
Arthroscopy, Surgical, Elbow	
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

CPT® is a registered trademark of the American Medical Association

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 September 29, 2025)

Policy History/Revision Information

Date	Summary of Changes
01/01/2026	<ul style="list-style-type: none"> Routine review; no change to coverage guidelines Archived previous policy version CS033NE.U

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, check the federal, state or contractual requirements for benefit plan coverage. 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.

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