

Surgery of the Elbow

Policy Number: CS033.U
Effective Date: January 1, 2026

[Instructions for Use](#)

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| Commercial Policy |
|--|
| <ul style="list-style-type: none"> Surgery of the Elbow |

Application

This Medical Policy does not apply to the states listed below; refer to the state-specific policy/guideline, if noted:

| State | Policy/Guideline |
|----------------|--|
| Idaho | Surgery of the Elbow (for Idaho Only) |
| Indiana | None |
| Kansas | Surgery of the Elbow (for Kansas Only) |
| Kentucky | Surgery of the Elbow (for Kentucky Only) |
| Nebraska | Surgery of the Elbow (for Nebraska Only) |
| New Jersey | Surgery of the Elbow (for New Jersey Only) |
| New Mexico | Surgery of the Elbow (for New Mexico Only) |
| North Carolina | Surgery of the Elbow (for North Carolina Only) |
| Ohio | Surgery of the Elbow (for Ohio Only) |
| Pennsylvania | Surgery of the Elbow (for Pennsylvania Only) |
| Tennessee | Surgery of the Elbow (for Tennessee Only) |

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 service requested; refer to the guidelines titled [Medical Records Documentation Used for Reviews](#).

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 |

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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 |
|------------|---|
| 04/01/2026 | Template Update <ul style="list-style-type: none">Removed content/language pertaining to the state of Louisiana |
| 01/01/2026 | <ul style="list-style-type: none">Routine review; no change to coverage guidelinesArchived previous policy version CS033.T |

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.