HIP RESURFACING AND REPLACEMENT SURGERY  
(ARTHROPLASTY)

Policy Number: 2019T0503Q  
Effective Date: April 1, 2019

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Coverage Rationale

**Hip Replacement Surgery (Arthroplasty)**

Hip replacement surgery (arthroplasty) is proven and medically necessary in certain circumstances. For medical necessity clinical coverage criteria, see the following MCG™ Care Guidelines, 23rd edition, 2019:

- Hip Arthroplasty, S-560 (ISC)
- Hip: Displaced Fracture of Femoral Neck, Hemiarthroplasty, S-600 (ISC)

Click [here](#) to view the MCG™ Care Guidelines.

**Hip Resurfacing Arthroplasty**

Hip resurfacing is proven and medically necessary in certain circumstances. For medical necessity clinical coverage criteria, see MCG™ Care Guidelines, 23rd edition, 2019, Hip Resurfacing, S-565 (ISC).

Click [here](#) to view the MCG™ Care Guidelines.

Documentation Requirements

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 documentation requirements outlined below are used to assess whether the member meets the clinical criteria for coverage but do not guarantee coverage of the service requested.

<table>
<thead>
<tr>
<th>CPT Codes*</th>
<th>Required Clinical Information</th>
</tr>
</thead>
</table>
| 27120, 27122, 27125 | Medical notes documenting all of the following:  
  - Complete report(s) of diagnostic imaging (MRI, CT scan, x-rays and bone scan)  
  - Condition requiring procedure  
  - Severity of pain and details of functional disability(ies) interfering with activities of daily living (preparing meals, dressing, driving, walking)  
  - Physician’s treatment plan including pre-op discussion  
  - Pertinent physical examination of the relevant joint  
  - Co-morbid medical conditions  
  - Therapies tried and failed of the following, including dates:  
    - Orthotics  
    - Medications/injections  
    - Physical therapy  
    - Surgery  
    - Other pain management procedures  
  - If the location is being requested as an inpatient stay, provide medical notes to... |
<table>
<thead>
<tr>
<th>Required Clinical Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>support at least <strong>one</strong> of the following:</td>
</tr>
<tr>
<td>o Surgery is bilateral</td>
</tr>
</tbody>
</table>

**Acetabuloplasty and Displaced Fracture of Femoral Neck, Hemi-Arthroplasty**

<table>
<thead>
<tr>
<th>Required Clinical Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Member has significant co-morbidities; include the list of comorbidities and current treatment</td>
</tr>
<tr>
<td>o Member does not have appropriate resources to support post-operative care after an outpatient procedure; include the barriers to care as an outpatient</td>
</tr>
</tbody>
</table>

**Hip Arthroplasty**

<table>
<thead>
<tr>
<th>Medical notes documenting all of the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Complete report(s) of diagnostic imaging (MRI, CT scan, x-rays and bone scan)</td>
</tr>
<tr>
<td>• Condition requiring procedure</td>
</tr>
<tr>
<td>• Severity of pain and details of functional disability(ies) interfering with activities of daily living (preparing meals, dressing, driving, walking)</td>
</tr>
<tr>
<td>• Physician’s treatment plan, including pre-op discussion</td>
</tr>
<tr>
<td>• Pertinent physical examination of the relevant joint</td>
</tr>
<tr>
<td>• Co-morbid medical conditions (cardiovascular diseases, hypertension, diabetes, cancer, pulmonary diseases, neurodegenerative diseases)</td>
</tr>
<tr>
<td>• Therapies tried and failed of the following including dates:</td>
</tr>
<tr>
<td>o Orthotics</td>
</tr>
<tr>
<td>o Medications/injections</td>
</tr>
<tr>
<td>o Physical therapy</td>
</tr>
<tr>
<td>o Surgical</td>
</tr>
<tr>
<td>o Other pain management procedures</td>
</tr>
<tr>
<td>27130</td>
</tr>
<tr>
<td>27132</td>
</tr>
<tr>
<td>27134</td>
</tr>
<tr>
<td>27137</td>
</tr>
<tr>
<td>27138</td>
</tr>
<tr>
<td>• Documentation that more conservative measures have been considered (e.g., osteotomy, hemiarthroplasty)</td>
</tr>
<tr>
<td>• Documentation that member has failed or is not a candidate for more conservative measure (e.g., osteotomy, hemiarthroplasty)</td>
</tr>
<tr>
<td>• Date of failed previous hip fracture fixation, if applicable</td>
</tr>
<tr>
<td>• If the location is being requested as an inpatient stay, provide medical notes to support at least <strong>one</strong> of the following:</td>
</tr>
<tr>
<td>o Surgery is bilateral</td>
</tr>
<tr>
<td>o Member has significant co-morbidities; include the list of comorbidities and current treatment</td>
</tr>
<tr>
<td>o Member does not have appropriate resources to support post-operative care after an outpatient procedure; include the barriers to care as an outpatient</td>
</tr>
<tr>
<td>• For <strong>revision</strong> surgery, include documentation of the complication and complete (staged) surgical plan</td>
</tr>
</tbody>
</table>

**Additional Clinical Information**

**Note:** Device information is not utilized in prior authorization determinations.

Provide the following details on the device you intend to use during the procedure:

- Specify which implant brand or manufacturer to be used:
  - o Arthrex
  - o BioMet
  - o Conformis
  - o Consensus
  - o DePuy Synthes
  - o DJO Surgical
  - o MicroPort
  - o Smith & Nephew
  - o Stryker
  - o Zimmer
  - o Other (include name and reason for this selection)

- Provide the fixation type from the following:
  - o Cemented
  - o Cemented with antibiotic impregnated
  - o Non-cemented
  - o Other (if another fixation type, then explain)
  - o Cannot identify fixation prior to procedure

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*For code descriptions, see the [Applicable Codes](#) section.*

**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.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>27120</td>
<td>Acetabuloplasty (e.g., Whitman, Colonna, Haygroves, or cup type)</td>
</tr>
<tr>
<td>27122</td>
<td>Acetabuloplasty; resection, femoral head (e.g., Girdlestone procedure)</td>
</tr>
<tr>
<td>27125</td>
<td>Hemiarthroplasty, hip, partial (e.g., femoral stem prosthesis, bipolar arthroplasty)</td>
</tr>
<tr>
<td>27130</td>
<td>Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft</td>
</tr>
<tr>
<td>27132</td>
<td>Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft</td>
</tr>
<tr>
<td>27134</td>
<td>Revision of total hip arthroplasty; both components, with or without autograft or allograft</td>
</tr>
<tr>
<td>27137</td>
<td>Revision of total hip arthroplasty; acetabular component only, with or without autograft or allograft</td>
</tr>
<tr>
<td>27138</td>
<td>Revision of total hip arthroplasty; femoral component only, with or without allograft</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S2118</td>
<td>Metal-on-metal total hip resurfacing, including acetabular and femoral components</td>
</tr>
</tbody>
</table>

**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.

Hip replacement surgery is a procedure and therefore is not regulated by the FDA. However, devices and instruments used during the surgery require FDA approval. Several devices have FDA approval. Additional information (product code MEH, JDI, JDG, LWJ, LPH, LZO, KWY, KWA) is available at: [https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm](https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm). (Accessed January 2, 2019)

Total hip resurfacing systems are approved by the FDA Premarket Approval (PMA) process. Additional information (product code NXT) is available at: [https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMA/pma.cfm](https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMA/pma.cfm). (Accessed January 2, 2019)

In January 2013, the FDA issued a safety communication regarding the ongoing concern related to adverse events associated with increased blood levels of cobalt and chromium following implant of MoM systems. The communication acknowledged reports in the medical literature of the potential for systemic effects of elevated metal ion levels resulting from device wear in MoM hip. At this time, however, the current body of evidence is insufficient to identify any specific metal ion levels that would cause adverse effects (FDA, 2013).

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

Medicare does not have a National Coverage Determination (NCD) for hip replacement surgery or hip resurfacing arthroplasty. Local Coverage Determinations (LCDs) exist; see the LCDs for Lower Extremity Major Joint Replacement (Hip and Knee), Major Joint Replacement (Hip and Knee), Total Hip Arthroplasty and Total Joint Arthroplasty. (Accessed January 11, 2019)

**POLICY HISTORY/REVISION INFORMATION**

<table>
<thead>
<tr>
<th>Date</th>
<th>Action/Description</th>
</tr>
</thead>
</table>
| 12/04/2019 | Coverage Rationale
  - Added reference link to MCG™ Care Guidelines |
| 09/23/2019 | Documentation Requirements
  - Updated and reformatted documentation requirements |
| 07/01/2019 | Template Update
  - Added Documentation Requirements section |
| 04/01/2019 | Revised coverage rationale:
  - Replaced references to "MCG™ Care Guidelines, 22nd edition, 2018" with "MCG™ Care Guidelines, 23rd edition, 2019"; refer to 23rd edition for |
<table>
<thead>
<tr>
<th>Date</th>
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<tbody>
<tr>
<td></td>
<td>complete details on applicable updates to the MCG™ Care Guidelines</td>
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<tr>
<td></td>
<td>Updated list of applicable CPT codes; removed 27299</td>
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<tr>
<td></td>
<td>Updated supporting information to reflect the most current FDA and CMS information</td>
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<tr>
<td></td>
<td>Archived previous policy version 2018T0503P</td>
</tr>
</tbody>
</table>

**INSTRUCTIONS FOR USE**

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, please check the member specific benefit plan document and any applicable federal or state mandates. 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.

This Medical Policy may also be applied to Medicare Advantage plans in certain instances. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).

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