HIP RESURFACING AND REPLACEMENT SURGERY (ARTHROPLASTY)

Policy Number: 2018T05030  Effective Date: July 1, 2018

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INSTRUCTIONS FOR USE

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.

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

Hip Replacement Surgery (Arthroplasty)

Hip replacement surgery (arthroplasty) is proven and/or medically necessary in certain circumstances. For applicable clinical coverage criteria, see the following MCG™ Care Guidelines, 22nd edition, 2018:

- Hip Arthroplasty, S-560 (ISC).
Hip Resurfacing Arthroplasty

Hip resurfacing is proven and/or medically necessary in certain circumstances. For applicable clinical coverage criteria, see MCG™ Care Guidelines, 22nd edition, 2018, Hip Resurfacing, S-565 (ISC).

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>
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<tbody>
<tr>
<td>27120</td>
<td>Acetabuloplasty (e.g., Whitman, Colonna, Haygroves, or cup type)</td>
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<tr>
<td>27122</td>
<td>Acetabuloplasty; resection, femoral head (e.g., Girdlestone procedure)</td>
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<tr>
<td>27125</td>
<td>Hemiarthroplasty, hip, partial (e.g., femoral stem prosthesis, bipolar arthroplasty)</td>
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<tr>
<td>27130</td>
<td>Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft</td>
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<tr>
<td>27132</td>
<td>Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft</td>
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<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>
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<tr>
<td>27299</td>
<td>Unlisted procedure, pelvis or hip joint</td>
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<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
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<tr>
<td>S2118</td>
<td>Metal-on-metal total hip resurfacing, including acetabular and femoral components</td>
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U.S. FOOD AND DRUG ADMINISTRATION (FDA)

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/pmncfm. (Accessed April 12, 2018)

The FDA-approved total hip arthroplasty (THA) devices are generally approved for the same indications, including any or all of the following:
- Severe hip pain and disability due to osteoarthritis (OA), rheumatoid arthritis (RA), traumatic arthritis (TA), polyarthritis, collagen disorders, avascular necrosis of the femoral head, or nonunion of prior femoral fracture.
- Congenital hip dysplasia, protrusio acetabuli (bulging of the femoral head into the pelvis), or slipped capital femoral epiphysis.
- Disability due to previous fusion.
- Acute femoral neck fracture.

Total hip resurfacing systems are approved by the FDA Premarket Approval (PMA) process. The FDA approved total hip resurfacing systems include the Cormet Hip Resurfacing System™ (Corin USA, Tampa, FLA) and the CONSERVE® Plus Total Resurfacing Hip System (Wright Medical Technology, Inc., Arlington, TN).

The Birmingham Hip Resurfacing (BHR) System received FDA approval on May 9, 2006 and is intended for use in patients requiring primary hip resurfacing arthroplasty due to:
- Non-inflammatory arthritis (degenerative joint disease) such as osteoarthritis, traumatic arthritis, avascular necrosis, or dysplasia/developmental dislocation of the hip (DDH); or
- Inflammatory arthritis such as rheumatoid arthritis.

In June of 2015, Smith & Nephew withdrew the BHR System from the US market.
The Cormet Hip Resurfacing System received FDA approval in July 2007 and is intended for use in resurfacing hip arthroplasty for reduction or relief of pain and/or improved hip function in skeletally mature patients having the following conditions:
- Non-inflammatory degenerative arthritis such as osteoarthritis and avascular necrosis;
- Inflammatory arthritis such as rheumatoid arthritis.

The Cormet Hip Resurfacing System is intended for patients who, due to their relatively younger age or increased activity level, may not be suitable for traditional total hip arthroplasty due to an increased possibility of requiring ipsilateral hip joint revision. Additional information is available at: 

The CONSERVE Plus Hip system received FDA approval on November 3, 2009 and is intended for use in resurfacing hip arthroplasty for reduction or relief of pain and/or improved hip function in skeletally mature patients having the following conditions:
- Non-inflammatory arthritis (degenerative joint disease) such as osteoarthritis, traumatic arthritis, avascular necrosis, or dysplasia/developmental dislocation of the hip (DDH); or
- Inflammatory arthritis such as rheumatoid arthritis.


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. Local Coverage Determinations (LCDs) exist; see the LCDs for Lower Extremity Major Joint Replacement (Hip and Knee), Major Joint Replacement (Hip and Knee), Surgery: Major Joint Replacement (Hip and Knee) and Total Joint Arthroplasty.

Medicare does not have an NCD for total hip resurfacing arthroplasty (THRA). Local Coverage LCDs specifically for THRA do not exist at this time. However, LCDs exist for CPT codes 27125 and 27130. Refer to the LCDs for Lower Extremity Major Joint Replacement (Hip and Knee), Major Joint Replacement (Hip and Knee), Surgery: Major Joint Replacement (Hip and Knee) and Total Joint Arthroplasty.

(Accessed April 25, 2018)

POLICY HISTORY/REVISION INFORMATION

<table>
<thead>
<tr>
<th>Date</th>
<th>Action/Description</th>
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<tbody>
<tr>
<td>07/01/2018</td>
<td>Revised coverage rationale:</td>
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<tr>
<td></td>
<td>o Added language to indicate:</td>
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<tr>
<td></td>
<td>▪ Hip replacement surgery (arthroplasty) is proven and/or medically necessary in certain circumstances</td>
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<tr>
<td></td>
<td>▪ Hip resurfacing is proven and/or medically necessary in certain circumstances</td>
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<tr>
<td></td>
<td>o Replaced language indicating &quot;for information regarding medical necessity review, when applicable, see MCG™ Care Guidelines, 22nd edition, 2018&quot; with &quot;for applicable clinical coverage criteria, see MCG™ Care Guidelines, 22nd edition, 2018&quot;</td>
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<td>▪ Archived previous policy version 2018T0503N</td>
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