HIP RESURFACING AND REPLACEMENT SURGERY (ARTHROPLASTY)

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APPLICATION

This policy does not apply to the states of Louisiana, Nebraska, New Jersey, and Tennessee.
• For the state of Louisiana, refer to the Medical Policy titled Hip Resurfacing and Replacement Surgery (Arthroplasty) (for Louisiana Only).
• For the state of Nebraska, refer to the Medical Policy titled Hip Resurfacing and Replacement Surgery (Arthroplasty) (for Nebraska Only).
• For the state of New Jersey, refer to the Medical Policy titled Hip Resurfacing and Replacement Surgery (Arthroplasty) (for New Jersey Only).
• For the state of Tennessee, refer to the Medical Policy titled Hip Resurfacing and Replacement Surgery (Arthroplasty) (for Tennessee Only).

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, [24th edition, 2020]:
• 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, [24th edition, 2020], Hip Resurfacing, S-565 (ISC).

Click here to view the MCG™ Care Guidelines.

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 Coverage Determination Guidelines may apply.
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 is available at (product code MEH, JDI, JDG, LWJ, LPH, LZO, KWY, and KWA): https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm. (Accessed January 19, 2020)

Total hip resurfacing systems are approved by the FDA Premarket Approval (PMA) process. Additional information is available at (product code NXT): https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMA/pma.cfm. (Accessed January 19, 2020)

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 and 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 21, 2020)

**POLICY HISTORY/REVISION INFORMATION**

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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, please 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 MCG™ Care Guidelines, 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.