HIP RESURFACING AND REPLACEMENT SURGERY  
(ARTHROPLASTY)

Policy Number: SURGERY 087.14 T2  
Effective Date: April 1, 2019

Table of Contents  
Page  
CONCLUSIONS OF COVERAGE ........................................ 1  
COVERAGE RATIONALE ........................................ 1  
DOCUMENTATION REQUIREMENTS ............................ 1  
APPLICABLE CODES ........................................ 3  
U.S. FOOD AND DRUG ADMINISTRATION .................... 3  
REFERENCES ................................................ 3  
POLICY HISTORY/REVISION INFORMATION .................. 3  
INSTRUCTIONS FOR USE ........................................ 4

CONDITIONS OF COVERAGE

<table>
<thead>
<tr>
<th>Applicable Lines of Business/Products</th>
<th>This policy applies to Oxford Commercial plan membership.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Type</td>
<td>General benefits package</td>
</tr>
<tr>
<td>Referral Required</td>
<td>No</td>
</tr>
<tr>
<td>(Does not apply to non-gatekeeper products)</td>
<td></td>
</tr>
<tr>
<td>Authorization Required</td>
<td>Yes</td>
</tr>
<tr>
<td>(Precertification always required for inpatient admission)</td>
<td></td>
</tr>
<tr>
<td>Precertification with Medical Director Review Required</td>
<td>Yes</td>
</tr>
<tr>
<td>Applicable Site(s) of Service</td>
<td>Inpatient, Outpatient</td>
</tr>
<tr>
<td>(If site of service is not listed, Medical Director review is required)</td>
<td></td>
</tr>
</tbody>
</table>

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 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).

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.
Required Clinical Information

Acetabuloplasty and Displaced Fracture of Femoral Neck, Hemi-Arthroplasty

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 support at least one of the following:
  - Surgery is bilateral
  - Member has significant co-morbidities; include the list of comorbidities and current treatment
  - Member does not have appropriate resources to support post-operative care after an outpatient procedure; include the barriers to care as an outpatient

Hip Arthroplasty

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 (cardiovascular diseases, hypertension, diabetes, cancer, pulmonary diseases, neurodegenerative diseases)
- Therapies tried and failed of the following including dates:
  - Orthotics
  - Medications/injections
  - Physical therapy
  - Surgical
  - Other pain management procedures
- Documentation that more conservative measures have been considered (e.g., osteotomy, hemiarthroplasty)
- Documentation that member has failed or is not a candidate for more conservative measure (e.g., osteotomy, hemiarthroplasty)
- Date of failed previous hip fracture fixation, if applicable
- If the location is being requested as an inpatient stay, provide medical notes to support at least one of the following:
  - Surgery is bilateral
  - Member has significant co-morbidities; include the list of comorbidities and current treatment
  - Member does not have appropriate resources to support post-operative care after an outpatient procedure; include the barriers to care as an outpatient
- For revision surgery, include documentation of the complication and complete (staged) surgical plan

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:
  - Arthrex
  - BioMet
  - Conformis
  - Consensus
  - DePuy Synthes
  - Other (include name and reason for this selection)
- Provide the fixation type from the following:
  - Cemented
Additional Clinical Information

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

- Cemented with antibiotic impregnated
- Non-cemented
- Other (if another fixation type, then explain)
- Cannot identify fixation prior to procedure

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 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>

CPT® is a registered trademark of the American Medical Association

<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)

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](https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmncfm). (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)

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)

REFERENCES

The foregoing Oxford policy has been adapted from an existing UnitedHealthcare national policy that was researched, developed and approved by UnitedHealthcare Medical Technology Assessment Committee. [2019T0503Q]

POLICY HISTORY/REVISION INFORMATION

<table>
<thead>
<tr>
<th>Date</th>
<th>Action/Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>09/23/2019</td>
<td>Documentation Requirements</td>
</tr>
<tr>
<td></td>
<td>• Updated and reformatted documentation requirements</td>
</tr>
</tbody>
</table>
## INSTRUCTIONS FOR USE

This Clinical Policy provides assistance in interpreting UnitedHealthcare Oxford 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 Oxford reserves the right to modify its Policies as necessary. This Clinical Policy is provided for informational purposes. It does not constitute medical advice.

The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members.

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

<table>
<thead>
<tr>
<th>Date</th>
<th>Action/Description</th>
</tr>
</thead>
</table>
| 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 complete details on applicable updates to the MCG™ Care Guidelines  
  - Updated list of applicable CPT codes; removed 27299  
  - Updated supporting information to reflect the most current FDA information  
  - Archived previous policy version SURGERY 087.13 T2 |