HIP RESURFACING AND REPLACEMENT SURGERY (ARTHROPLASTY)

Policy Number: SURGERY 087.13 T2 **Effective Date**: December 1, 2018

Instructions for Use

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Related Policies
None

CONDITIONS OF COVERAGE

Applicable Lines of Business/Products	This policy applies to Oxford Commercial plan membership.
Benefit Type	General benefits package
Referral Required (Does not apply to non-gatekeeper products)	No
Authorization Required (Precertification always required for inpatient admission)	Yes [1]
Precertification with Medical Director Review Required	Yes[1]
Applicable Site(s) of Service (If site of service is not listed, Medical Director review is required)	Inpatient, Outpatient
Special Considerations	[1]Precertification with review by a Medical Director or their designee is required.

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, 22nd edition, 2018:

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

Hip Resurfacing Arthroplasty

Hip resurfacing is proven and medically necessary in certain circumstances. For medical necessity 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 may apply.

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CPT Code	Description
27120	Acetabuloplasty; (e.g., Whitman, Colonna, Haygroves, or cup type)
27122	Acetabuloplasty; resection, femoral head (e.g., Girdlestone procedure)
27125	Hemiarthroplasty, hip, partial (e.g., femoral stem prosthesis, bipolar arthroplasty)
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft
27132	Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft
27134	Revision of total hip arthroplasty; both components, with or without autograft or allograft
27137	Revision of total hip arthroplasty; acetabular component only, with or without autograft or allograft
27138	Revision of total hip arthroplasty; femoral component only, with or without allograft
27299	Unlisted procedure, pelvis or hip joint

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HCPCS Code	Description
S2118	Metal-on-metal total hip resurfacing, including acetabular and femoral components

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/pmn.cfm. (Accessed August 4, 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, protrusia 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 HRA 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 HRA 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: http://www.accessdata.fda.gov/cdrh_docs/pdf5/P050016b.pdf. (Accessed August 8, 2018)

The CONSERVE Plus Hip system received FDA approval on November 3, 2009 and is intended for use in HRA for reduction or relief of pain and/or improved hip function in skeletally mature patients having the following conditions:

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- 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.

Additional information is available at: http://www.accessdata.fda.gov/cdrh_docs/pdf3/P030042a.pdf. (Accessed August 8, 2018)

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. [*2018T0503P*]

POLICY HISTORY/REVISION INFORMATION

Date	Action/Description

12/01/2018	• Reorganized policy template:
	  ○ Simplified and relocated *Instructions for Use*
	  ○ Removed *Benefit Considerations* section
	• Updated coverage rationale; modified language to clarify:
	  ○ The listed services are proven ***and*** medically necessary in certain circumstances
	  ○ See the referenced MCG™ Care Guidelines for *medical necessity* clinical coverage criteria
	• Archived previous policy version SURGERY 087.12 T2

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.

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