HIP RESURFACING AND REPLACEMENT SURGERY (ARTHROPLASTY)

Guideline Number: MMG057.J **Effective Date**: April 1, 2019

Instructions for Use

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Related Policies

None

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).

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

Joint Replacement – 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)
- Specify which implant brand or manufacturer to be used (e.g., Arthrex, Consensus, DePuy Synthes, Zimmer BioMet, DJO Surgical, MicroPort, Smith & Nephew, Stryker, or Other and include name and reason for this selection)
- Specify which manufacturer model to be used (e.g., Asphere, Biolox Delta, Compress, Duracon, Kinective, Pinnacle)
- Provide the fixation type from the following:
  - Cemented
  - Cemented with antibiotic impregnated
  - Non-cemented
  - Other - If another fixation type then explain
- Current medical notes indicating:
  - Condition requiring procedure
  - Severity of pain and details of functional disability(ies) interfering with activities of daily living (preparing meals, dressing, driving, walking)
  - Co-morbid medical condition(s)
  - Pertinent physical examination of the relevant joint

Required Clinical Information
Joint Replacement – Acetabuloplasty and Displaced Fracture of Femoral Neck, Hemi-Arthroplasty

- Physician's treatment plan including pre-op discussion
- 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

Joint Replacement – Hip Arthroplasty

Medical notes documenting **all** of the following:

- Complete report(s) of diagnostic imaging (MRI, CT Scan, X-rays and Bone Scan)
- Specify which implant brand or manufacturer to be used (e.g., Arthrex, Consensus, DePuy Synthes, Zimmer BioMet, DJO Surgical, MicroPort, Smith & Nephew, Stryker, or Other and include name and reason for this selection)
- Specify which manufacturer model to be used (e.g., Asphere, Biolox Delta, Compress, Duracon, Kinective, Pinnacle)
- Provide the fixation type from the following:
  - Cemented
  - Cemented with antibiotic impregnated
  - Non-cemented
  - Other - If another fixation type then explain
- Current medical notes indicating:
  - 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
- For revision surgery include documentation of the complication and complete (staged) surgical plan
- 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

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 guideline 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 Guidelines may apply.

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

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 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

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).

GUIDELINE HISTORY/REVISION INFORMATION

Date	Action/Description
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 MMG057.I

INSTRUCTIONS FOR USE

This Medical Management Guideline 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 benefit plan. In the event of a conflict, the member specific benefit plan document governs. Before using this guideline, 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 Management Guideline 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. UnitedHealthcare West Medical Management 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.

Member benefit coverage and limitations may vary based on the member's benefit plan Health Plan coverage provided by or through UnitedHealthcare of California, UnitedHealthcare Benefits Plan of California, UnitedHealthcare of Oklahoma, Inc., UnitedHealthcare of Oregon, Inc., UnitedHealthcare Benefits of Texas, Inc., or UnitedHealthcare of Washington, Inc.