HIP REPLACEMENT SURGERY
(ARTHROPLASTY)

Protocol: ORT015
Effective Date: June 1, 2017

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INSTRUCTIONS FOR USE
This protocol provides assistance in interpreting UnitedHealthcare benefit plans. When deciding coverage, the enrollee specific document must be referenced. The terms of an enrollee's document (e.g., Certificate of Coverage (COC) or Evidence of Coverage (EOC)) may differ greatly. In the event of a conflict, the enrollee's specific benefit document supersedes this protocol. All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements and the plan benefit coverage prior to use of this Protocol. Other Protocols, Policies and Coverage Determination Guidelines may apply. UnitedHealthcare reserves the right, in its sole discretion, to modify its Protocols, Policies and Guidelines as necessary. This protocol is provided for informational purposes. It does not constitute medical advice. This policy does not govern Medicare Group Retiree members.

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.

COMMERCIAL & MEDICAID COVERAGE RATIONALE


MCG™ Care Guidelines: Hip Arthroplasty, S-560
Clinical Indications for Procedure:

- Procedure is indicated for 1 or more of the following:
  - Degenerative joint disease as indicated by ALL of the following:
    - Presence of significant radiographic findings (e.g., hip joint destruction, severe narrowing, bone deformities, osteonecrosis)
    - Optimal medical management has been tried and failed (e.g., analgesics, NSAIDs, physical therapy)
    - Patient has failed or is not a candidate for more conservative measures (e.g., osteotomy, hemiarthroplasty)
Treatment is needed because of 1 or more of the following:
  • Disabling pain
  • Functional disability
  o Primary and secondary tumors involving the proximal femur
  o Osteonecrosis of femoral head
  o Developmental dysplasia of hip
  o Displaced fracture of the femoral neck in a patient without significant cognitive impairment
  o Acetabular fracture
    o Pertrochanteric fracture and 1 or more of the following:
      ▪ Ipsilateral hip osteoarthritis
      ▪ Ipsilateral avascular necrosis of the femoral head
      ▪ Inflammatory arthritis
      ▪ Comminuted, significantly displaced, or unstable fracture
      ▪ Poor bone quality (eg, thin cortices, wide intramedullary canal on imaging)
      ▪ Complication of internal fixation
      ▪ Neglected fracture
  o Failed previous hip fracture fixation
  o Revision of hip arthrodesis
    o Revision of previous arthroplasty or resurfacing indicated by 1 or more of the following:
      ▪ Instability of one or both components
      ▪ Fracture or mechanical failure of the implant
      ▪ Recurrent or irreducible dislocation
      ▪ Infection
      ▪ Treatment of a periprosthetic fracture
      ▪ Tissue or systemic reaction to metal implant
      ▪ Leg-length inequality

**End of MCG**


**MCG™ Care Guidelines: Hip: Displaced Fracture of Femoral Neck, Hemiarthroplasty, S-600 (ISC)**

**Clinical Indications for Procedure**
Procedure is indicated for 1 or more of the following:
  • Displaced fracture of femoral neck in older patient (eg, 65 years or older)
  • Fracture-dislocation of hip in older patient (eg, 65 years or older)
  • Reduction or fixation of hip fracture that cannot be maintained
  • Recent history of failed fixation of femoral neck fracture
  • Fracture of neck of femur with complete dislocation of femoral head
  • Fracture superimposed upon pre-existing lesions of hip (eg, radiation changes, severe arthritis)
  • Fracture of femoral neck in patient with psychosis or severe cognitive impairment
  • Pathologic fracture of femoral neck
  • Pertrochanteric fracture of femoral neck
  • Pertrochanteric fracture and 1 or more of the following:
Ipsilateral hip osteoarthritis
Ipsilateral avascular necrosis of the femoral head
Inflammatory arthritis
Comminuted, significantly displaced, or unstable fracture
Poor bone quality (eg, thin cortices, wide intramedullary canal on imaging)
Complication of internal fixation
Neglected fracture

***End of MCG

MEDICARE COVERAGE RATIONALE

Medicare does not have a National Coverage Determination, but does have a Local Coverage Determination for Nevada for Total Joint Arthroplasty (L34163) (Accessed April 2017).

Total Joint Arthroplasty (L34163)
Total Hip Arthroplasty (THA)

Total hip replacement surgery is medically necessary when one or more of the following criteria* are met:

Advanced joint disease demonstrated by:

- Radiographic supported evidence or when conventional radiography is not adequate, magnetic resonance imaging (MRI) supported evidence (subchondral cysts, subchondral sclerosis, periarticular osteophytes, joint subluxation, joint space narrowing, avascular necrosis); and
- Pain that cannot be adequately controlled despite optimal conservative treatment or functional disability from injury due to trauma or arthritis of the joint); and
- If appropriate, history of unsuccessful conservative therapy (non-surgical medical management) that is clearly addressed in the pre procedure medical record. (If conservative therapy is not appropriate, the medical record must clearly document the rationale for why such approach is not reasonable); or
- Malignancy of the joint involving the bones or soft tissues of the pelvis or proximal femur; or
- Avascular necrosis (osteonecrosis of femoral head); or
- Fracture of the femoral neck; or
- Acetabular fracture; or
- Non-union or failure of previous hip fracture surgery; or
- Mal-union of acetabular or proximal femur fracture

*See Associated Information – Documentation Requirements for additional information.

Non-surgical medical management is usually but not always implemented prior to scheduling total joint surgery. Non-surgical treatment as clinically appropriate for the patient’s current episode of care typically includes one or more of the following:

- anti-inflammatory medications or analgesics, or
- flexibility and muscle strengthening exercises, or
- supervised physical therapy [Activities of daily living (ADLs) diminished despite completing a plan of care], or
- assistive device use, or
weight reduction as appropriate, or
therapeutic injections into the hip as appropriate.

Indications for Replacement/Revision of Total Hip Arthroplasty
- Loosening of one or both components; or
- Fracture or mechanical failure of the implant; or
- Recurrent or irreducible dislocation; or
- Infection; or
- Treatment of a displaced periprosthetic fracture; or
- Clinically significant leg length inequality not amenable to conservative management; or
- Progressive or substantial bone loss; or
- Bearing surface wear leading to symptomatic synovitis or local bone or soft tissue reaction; or
- Clinically significant audible noise; or
- Adverse local tissue reaction

Limitations
Total knee replacement or total hip replacement is **not medically necessary** when the following contraindications are present:
- Active infection of the hip or knee joint or active systemic bacteremia
- Active skin infection (exception recurrent cutaneous staph infections) or open wound within the planned surgical site of the hip or knee
- Rapidly progressive neurological disease except in the clinical situation of a concomitant displaced femoral neck fracture

The following conditions are relative contraindications to total knee or total hip replacement and if such surgery is performed in the presence of these conditions, it is expected that the rationale for proceeding with the surgery under such circumstances is clearly documented in the medical record:
- Absence or relative insufficiency of abductor musculature
- Any process that is rapidly destroying bone
- Neurotrophic arthritis

For Medicare and Medicaid Determinations Related to States Outside of Nevada:
Please review Local Coverage Determinations that apply to other states outside of Nevada.

**Important Note:** Please also review local carrier Web sites in addition to the Medicare Coverage database on the Centers for Medicare and Medicaid Services’ Website.

**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: [http://www.accessdata.fda.gov/scripts/cdrh/devicesatfda/index.cfm](http://www.accessdata.fda.gov/scripts/cdrh/devicesatfda/index.cfm). Accessed April 2017.
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.

**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® Codes</th>
<th>Description</th>
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<tr>
<td>27120</td>
<td>Acetabuloplasty; (e.g., Whitman, Colonna, Haygroves, or cup type)</td>
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<td>27122</td>
<td>Acetabuloplasty; resection, femoral head (e.g., Girdlestone procedure)</td>
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<td>27125</td>
<td>Hemiarthroplasty, hip, partial (e.g., femoral stem prosthesis, bipolar arthroplasty)</td>
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<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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<td>27132</td>
<td>Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft</td>
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<td>27134</td>
<td>Revision of total hip arthroplasty; both components, with or without autograft or allograft</td>
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<tr>
<td>27137</td>
<td>Revision of total hip arthroplasty; acetabular component only, with or without autograft or allograft</td>
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<tr>
<td>27138</td>
<td>Hip Revision of total hip arthroplasty; femoral component only, with or without allograft</td>
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*CPT® is a registered trademark of the American Medical Association*

**PROTOCOL HISTORY/REVISION INFORMATION**

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The foregoing Health Plan of Nevada/Sierra Health & Life Health Operations protocol has been adopted from an existing UnitedHealthcare coverage determination guideline that was researched, developed and approved by the UnitedHealthcare Coverage Determination Committee.