Hip Joint Replacements

Policy Number:	**M20160630054**
Effective Date:	**8/15/2016**
Sponsoring Department:	**Health Care Services**
Impacted Department(s):	**Health Care Services**

Type of Policy: ☒ Internal ☒ External

Data Classification: ☐Confidential ☐Restricted ☒Public

Applies to (Line of Business):

☐ Corporate (All)
☒ State Products, if yes which plan(s): ☒MediSource; ☒ MediSource Connect; ☒Child Health Plus ☒Essential Plan
☐ Medicare, if yes, which plan(s): ☐MAPD; ☐PDP; ☐ISNP; ☐CSNP
☒ Commercial, if yes, which type: ☒Large Group; ☒Small Group; ☒Individual
☒ Self-Funded Services *(Refer to specific Summary Plan Descriptions (SPDs) to determine any pre-authorization or pre-certification requirements and coverage limitations. In the event of any conflict between this policy and the SPD of a Self-Funded Plan, the SPD shall supersede the policy.)*

Excluded Products within the Selected Lines of Business (LOB)

N/A

Applicable to Vendors? Yes ☐ No☒

Purpose and Applicability:

To set forth the medical necessity criteria for **total hip arthroplasty (THA).**

Policy:

Background:
Osteoarthritis is the leading indication for joint replacement surgery. Osteoarthritis is the imbalance of breakdown and repair of tissues within a synovial joint. The etiology of osteoarthritis is varied and includes genetic factors, trauma, femoral and acetabular morphology, overuse, and infection. The benefits of surgical treatment of osteoarthritis of the hip include relief of pain and improved function.

Most patients with deterioration of the hip joint present with pain, which is usually localized to the anterior hip or groin or present in the posterior buttock and trochanteric region and can radiate to the thigh or knee. Pain may occur with activity but can also be present at rest and often exacerbated by weightbearing or initial movement. Patients frequently describe "stiffness" or "tightness" of the hip, and loss of motion is often noted. Patient limitations include disrupted sleep, walking issues, donning shoes and socks, utilizing stairs, or getting into and out of a car. The patient may also need an assistive device such as a cane.

Total hip arthroplasty is typically an elective procedure. A conservative approach aimed at treating the underlying disease is necessary before THA. For patients with osteoarthritis, this includes nonoperative treatment measures, such as weight reduction, physical therapy, nonsteroidal anti-inflammatory drugs (NSAIDs), assistive devices (e.g., a cane), and intraarticular glucocorticoid injections.

The patient and physician must review the potential benefits and risks prior to a decision to proceed with the THA procedure. A thorough preoperative evaluation must be conducted to confirm hip pathology as the source of symptoms and disability and ensure the appropriateness of surgery as well as to assist with surgical planning. The evaluation includes a review of the patient's history, a physical examination, imaging and laboratory studies, and a review of treatment alternatives.

Bilateral Surgery: When bilateral THA is performed, the criteria listed above and requirements in Notes below apply to each joint upon which surgery is performed.

When infection is the reason for revision THA surgery, laboratory and/or pathology reports must be in the medical record and all documentation regarding treatment of the infection and a physician note indicating that it is appropriate to proceed with surgery should be in the medical record.

Removal and revision surgery due to post total hip replacement metallosis alone, without evidence of loosening or malposition, is considered experimental and investigational because there is insufficient clinical evidence in the published peer-reviewed medical literature.

Serum metal ion laboratory findings alone would rarely be a sole indication for revision procedures unless those levels have been determined to be at a toxic level and attributed only to the hip prostheses. vs. other causes such as work exposure, or oral supplements. It is recommended that a consultation with a toxicologist be performed to support this assessment.

Otherwise, Independent Health will review requests for revisions related to metallosis indications utilizing the criteria from the American Academy of Orthopedic Surgeons Information Statement Current Concerns with Metal-on-Metal Hip Arthroplasty (available at:

https://www.aaos.org/globalassets/about/bylaws-library/information-statements/1035-current-concerns-with-metal-on-metal-hip-arthroplasty.pdf).

Medicare Advantage: There is currently a Local Coverage Determination (LCD) and a Local Coverage Article (LCA) for total joint arthroplasty. Please refer to the links listed in the Reference section for Medicare Advantage members.

Commercial, MediSource, MediSource Connect, Child Health Plus and Essential Plan:
MediSource, MediSource Connect, Child Health Plus and Essential Plan cover partial hip replacements, total hip replacements and revisions utilizing the criteria below :

Clinical Indications:

Hip joint procedures may be medically necessary when **ALL** of the following criteria are met:

- **1 or more** of the following procedures:
  - Partial Hip Replacement and **1 or more** of the following:
    - A non-displaced intracapsular fracture is present and surgical fixation is not considered a reasonable option
    - An impacted fracture, partially displaced fracture, completely displaced or comminuted fracture of the femoral neck or femoral head is present and conservative management or surgical fixation is not considered a reasonable option
    - Tönnis Grade 3 osteoarthritis or avascular necrosis with collapse of the femoral head and **ALL** of the following:
      - Function-limiting pain at short distances (e.g., walking less than ¼ mile, limiting activity to two city blocks, the equivalent to walking the length of a shopping mall) for at least three (3) months duration
      - Loss of hip function secondary to osteoarthritis which interferes with the ability to carry out age-appropriate activities of daily living and/or their demands of employment
  - Total Hip Arthroplasty (THA) and **1 or more** of the following:
    - Advanced Joint disease, Tonnis Grade 3 and **ALL** of the following:
      - The joint disease is evidenced by conventional radiography, or magnetic resonance imaging (MRI)
      - Pain or functional disability attributable to the advanced joint disease
      - Unsuccessful non-surgical medical management, when appropriate and attempted for a minimum of 3 months
    - Malignancy of the joint involving the bones or soft tissues of the pelvis or proximal femur
    - Avascular necrosis (osteonecrosis of femoral head)
    - Fracture of the femoral neck
    - Acetabular fracture
    - Non-union or failure of previous hip fracture surgery

- Mal-union of acetabular or proximal femur fracture

- Replacement/Revision Hip Arthroplasty and **1 or more** of the following :
  - Loosening of one or both components
  - Fracture or mechanical failure of the implant
  - Recurrent or irreducible dislocation
  - Infection
  - Treatment of a displaced periprosthetic fracture
  - Clinically significant leg length inequality not amenable to conservative management
  - Progressive or substantial bone loss
  - Bearing surface wear leading to symptomatic synovitis or local bone or soft tissue reaction
  - Clinically significant audible noise
  - Adverse local tissue reaction

- Documentation in the medical record of **1 or more** of the following
  - When any procedure above is indicated for advanced joint disease, **ALL** of the following:
    - Arthritis of the hip supported by X-ray or MRI. The X-ray or MRI should demonstrate **1 or more** of the following:
      - Subchondral cysts
      - Subchondral sclerosis
      - Periarticular osteophytes
      - Joint subluxation
      - Joint space narrowing
      - Avascular necrosis
      - Bone on bone articulations
    - The extent to which pain or functional disability interferes with ADLs (functional disability), increases with activity, or increases with weight bearing. (ADLs include, but are not limited to, dressing, feeding, toileting, grooming, physical ambulation [including balance/risk of falls], and bathing.)
    - Documented clinical assessment of the member by the requesting provider within 3 months of the request
    - **1 or more** of the following:
      - Documentation reflected in the member's medical records required of non-surgical medical management measures by the requesting provider, ordered by them or other health professionals during the patient's course of treatment for a period of 3 months for the condition(s) and **ALL** of the following:
        i. Documentation establishes a history of a reasonable attempt at conservative therapy as appropriate for the patient member in their current episode of care
        ii. Documentation includes the start date of each therapy and the concluding date of therapy with the results of therapy included

iii. Documentation includes a combination of strategies to reduce inflammation, alleviate pain, and improve function, including **2 or more** of the following:
   a. Prescription and nonprescription anti-inflammatory medications and/or analgesics; including outcomes of medication therapy, the medication name, dosage and frequency documented in the medical record by the ordering provider, including the start and end dates of medication therapies
   b. Flexibility and muscle strengthening exercises; the description of flexibility and muscle strengthening exercises as ordered by the provider and outcomes of flexibility and muscle strengthening exercises is required to be documented in the medical record
   c. Assistive device use; the description of an assistive device as ordered by the provider and outcomes its use is required to be documented in the medical record
   d. Reasonable activity restrictions; modifications restrictions; the description of activity modification as ordered by the provider and outcomes of modification is required to be documented in the medical record
   e. Weight reduction as appropriate; start and end date of weight reduction and results of any reduction is required to be documented in the medical record
   f. Therapeutic injections into the joint as appropriate; procedure report submission required, and outcomes of therapy documented in the medical record

- Failure of the conservative strategies above and 12 to 24 weeks of supervised physical therapy based on age/BMI; complete therapy progress note documentation submission by the therapy provider is required (If physical therapy is not appropriate [such as for progressive flexion contracture or avascular necrosis with collapse of the femoral head for example], the medical record must clearly document why such approach is not reasonable.)

- Adherence to a tobacco-cessation program resulting in abstinence from tobacco for at least 6 weeks prior to surgery is recommended. Or in smokers, medical documentation must state the provider reviewed the benefits of smoking cessation prior to elective surgery as it appears to improve a number of outcomes such as wound healing and postoperative pulmonary recovery
- **1 or more** of the following:
   i. The member's BMI is less than 40 and/or they have no medical comorbidities
   ii. For members with BMI > 40, at least six (6) months of provider-directed non-surgical management has failed (Provider-directed non-surgical management may be inappropriate. The medical record must clearly document why provider-directed non-surgical management is not appropriate)

iii. For patients with significant conditions or co-morbidities (such as coronary artery disease or obstructive pulmonary disease), the risk/benefit of the hip joint procedure was appropriately addressed in the medical record
iv. For members with diabetes every effort was made to ensure it is well controlled. For members with poor control as evidenced by an elevated HbA1c levels (> 8.5%), every effort was made to optimize glycemic levels prior to elective surgery. Or if optimization was not possible, there is documentation that the surgeon has reviewed the increased risks associated with joint replacement procedures with the member prior to the procedure

- That non-surgical medical management may be inappropriate, ineffective, or counterproductive as evidenced by **1 or more** of the following:
  - Bone on bone articulation
  - Severe deformity
  - Severe pain (particularly at rest) and significant disabling interference with activities of daily living (ADL)
- For Total Hip Arthroplasty indications other than advanced joint disease, **ALL** of the following when indicated:
  - Supporting evidence (e.g., pathology reports and referral from an Oncologist for a malignancy of the joint or X-ray of a fracture)
  - The extent to which pain or functional disability interferes with ADLs and increases with initiation of activities or weight bearing

- Partial hip replacement is **NOT COVERED** for Any of the following:
  - Active local or systemic infection
  - Osseous abnormalities that cannot be optimally managed prior to surgery which would increase the likelihood of a poor surgical outcome (i.e., inadequate bone stock to support the implant) unless the procedure is being performed for a fracture indication
  - One or more uncontrolled or unstable medical conditions that would significantly increase the risk of morbidity (e.g., cardiac, pulmonary, liver, genitourinary, or metabolic disease; hypertension; abnormal serum electrolyte levels)
  - Vascular insufficiency, significant muscular atrophy of the leg, or neuromuscular disease severe enough to compromise implant stability or post-operative recovery
  - Severe immunocompromised state
  - Charcot joint
  - Inflammatory arthropathy affecting both the femoral head and acetabulum

- Total Hip Arthroplasty is **NOT COVERED** for Any of the following:
  - Active infection of the hip or active systemic bacteremia
  - Active skin infection (exception recurrent cutaneous staph infections) or open wound within the planned surgical site of the hip
  - Rapidly progressive neurological disease except in the clinical situation of a concomitant displaced femoral neck fracture
  - Removal and revision surgery due to post total hip replacement metallosis alone, without evidence of loosening or malposition, **is considered experimental and investigational**

Pre-Authorization Required? Yes ☒ No ☐

Preauthorization is required for this service with the exception of Medicare lines of business.

Definitions

Tönnis classification system consists of progressive degrees of degenerative changes to the hip. Grade 0 indicates a hip absent of arthrosis. Grade 1 indicates slight narrowing of the joint space, slight lipping at the joint margin, and slight sclerosis of the femoral head or acetabulum; Grade 2 indicates the presence of small bony cysts, further narrowing of the joint space, and moderate loss of femoral head sphericity; Grade 3 is the most severe and indicates large cysts, severe narrowing of the joint space, severe femoral head deformity, and avascular necrosis.

Total hip arthroplasty (THA) is a procedure whereby the diseased articular surfaces are replaced with synthetic materials with the goal of relieving pain and improving joint kinematics and function.

References

Related Policies, Processes and Other Documents

N/A

Non-Regulatory references

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Regulatory References

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This policy contains medical necessity criteria that apply for this service. Please note that payment for covered services is subject to eligibility criteria, contract exclusions and the limitations noted in the member's contract at the time the services are rendered.

Version Control

Signature / Approval on File? Yes ☒ No☐

Revision Date	Owner	Notes
2/1/2026	Health Care Services	Reviewed
8/1/2025	Health Care Services	Revised- Formatting only
4/1/2025	Health Care Services	Reviewed
2/1/2024	Health Care Services	Revised
8/1/2023	Health Care Services	Reviewed
11/1/2022	Health Care Services	Revised
8/1/2022	Health Care Services	Revised
2/1/2022	Health Care Services	Revised
12/1/2021	Health Care Services	Revised
9/1/2021	Health Care Services	Revised
6/1/2020	Health Care Services	Revised
7/1/2019	Medical Management	Reviewed
8/1/2018	Medical Management	Reviewed
8/1/2017	Medical Management	Reviewed