Clinical Policy: Hip Resurfacing

Common Name: Hip Resurfacing

Definition: Hip resurfacing is a viable alternative to total hip arthroplasty for patients under 65 years of age. The procedure is used for the treatment of severe pain and disability associated with advanced joint disease that has responded poorly to conservative medical therapies.

Device Capture: Product Line + Devices

I. Criteria for Inclusion

Hip resurfacing is considered medically necessary for the following:

A. Degenerative joint disease as indicated by all of the following:
   1. Osteoarthritis, post-traumatic arthritis, rheumatoid arthritis, or osteonecrosis confirmed by standing x-rays with documentation of all of the following:
      a. Significant (at least moderate-to-severe) joint destruction
      b. Descriptive criteria including at least two of the following:
         i. Subchondral cysts
         ii. Subchondral sclerosis
         iii. Joint space narrowing
         iv. Joint subluxation
         v. Osteophyte formation
   2. Symptoms correlate with hip pathology, supported by physical exam findings (e.g. antalgic gait, pain or limitation with range of motion)
   3. Patient is physically active and a candidate for primary total hip arthroplasty, but would likely outlive the traditional prosthesis lifespan
   4. Proximal femoral bone quality and geometry are normal, with femoral head size of 46 mm or greater if female and 50 mm or greater if male
   5. Presence of significant pain or disability that interferes with ability to perform daily activities that has failed to improve with at least 3 months of conservative treatment, including all of the following, unless contraindicated:
      a. Analgesics or anti-inflammatory medications
      b. Activity modification
      c. Weight reduction as appropriate
         i. For patients with BMI 30 to 35, medical record must document weight discussion
         ii. For patients with BMI 35 to 40, medical record must document plan for weight loss
         iii. BMI greater than 40 is a contraindication for total hip replacement unless significant weight loss has been clearly documented
      d. Use of an assistive device, when indicated
II. Criteria for Exclusion
A. In persons with any of the following contraindications, hip resurfacing is considered not medically necessary:
1. Active systemic infection or active skin infection of the joint or planned surgical site
2. Proven hypersensitivity to metal used in resurfacing
3. Morbid obesity (BMI greater than 40)
4. Skeletal immaturity or age over 65 years
5. Suboptimal bone quality to support the implant
6. Avascular necrosis of the femoral head with greater than 50% involvement, multiple cysts of the femoral head greater than 1 cm, or poor bone quality of the femoral head and neck
7. Anatomic abnormality of the femoral head that cannot be sufficiently restored
8. Those with renal failure, who are immunocompromised, or on high-dose corticosteroids
9. Inadequate motor strength of the limb or severe vascular deficiency
10. Tobacco or nicotine use within 2 months prior to procedure
B. Hip resurfacing is not considered to be medically necessary in female patients with a femoral head size of less than 46mm, and male patients with a femoral head size of less than 50mm, as studies have shown inferior implant survivorship outcomes when compared to total hip replacement in these patient groups.
C. For persons with significant co-morbidities or complications, the medical record must contain documentation of the risk/benefit of hip resurfacing.

III. Device Considerations
A. Only implants with FDA approval are considered to be medically appropriate

IV. Surgical Considerations
A. Pre-Operative Considerations:
1. Preoperative care planning needs may include
   a. Routine preoperative evaluation
   b. Preoperative treatment, procedures, and stabilization, including
      i. Hip digital x-rays with templating
      ii. Hip CT with 3D reconstruction for templating and intraoperative computer-assisted navigation
      iii. Ruling out sources of infection, including dental and lower urinary tract infections
      iv. Dental prophylaxis as indicated
   c. Preoperative discharge planning as appropriate
B. Intra-Operative Considerations:
1. Epidural anesthesia
2. Antibacterial wipes
3. Antibacterial nasal swab
C. Post-Operative & Inpatient Considerations:
   a. Hospital evaluation and care needs may include:
   b. Diagnostic test scheduling and completion, including:
      i. Complete blood count, PT and INR monitoring
      ii. Lower extremity Doppler study
   c. Treatment and procedure scheduling and completion, including:
      i. IV antibiotics
ii. DVT prophylaxis
iii. Wound management
iv. Pain management
d. Consultation, assessment, and other services scheduling and completion, including:
i. Physical therapy
ii. Occupational therapy
iii. Gait training
e. Monitoring patient's status for deterioration and comorbid conditions; key items include:
i. Neurovascular status
ii. Transfusion need
iii. Assessment of wound healing
iv. Cardiac and respiratory status

D. Discharge Planning & Considerations
1. Discharge planning includes:
   a. Assessment of needs and planning for care, including:
i. Develop treatment plan (involving multiple providers as needed).
ii. Evaluate and address preadmission functioning as needed.
iii. Evaluate and address patient or caregiver preferences as indicated.
iv. Identify skilled services needed at next level of care, with specific attention to:
   • Medication management, adherence instruction, and side effects assessment
   • Pain management
   • Rehabilitation therapy or equipment coordination
   • Wound or dressing management
   v. Evaluate and address psychosocial status issues as indicated
b. Early identification of anticipated discharge destination; options include:
i. Home, considerations include:
   • Access to follow-up care
   • Home safety assessment
   • Self-care ability, if appropriate
   • Caregiver need, ability, and availability
ii. Post-acute skilled care or custodial care, as indicated
c. Transition of care plan complete, which may include:
i. Patient and caregiver education complete
ii. Medication reconciliation completion includes:
   • Compare patient's discharge list of medications (prescribed and over-the-counter) against physician's admission or transfer orders.
   • Assess each medication for correlation to disease state or medical condition.
   • Report medication discrepancies to prescribing physician, attending physician, and primary care provider, and ensure accurate medication order is identified.
   • Provide reconciled medication list to all treating providers.
   • Confirm that patient, family, or caregiver can acquire medication.
   • Educate patient, family, and caregiver.
      1) Provide complete medication list to patient, family, or caregiver.
      2) Confirm that patient, family, or caregiver understands importance of presenting personal medication list to all providers at each care transition, including all physician appointments.
3) Confirm that patient, family, or caregiver understands reason, dosage, and timing of medication (eg, use "teach-back" techniques).

iii. Plan communicated to patient, caregiver, and all members of care team, including:
   - Inpatient care and service providers
   - Primary care provider
   - All post-discharge care and service providers

iv. Post-discharge appointment plans made as needed, which may include:
   - Primary care provider
   - Anticoagulation monitoring
   - Orthopedic surgeon
   - Rehabilitation therapy services

v. Post-discharge testing and procedure plans made, which may include:
   - Laboratory testing
   - Referrals made for assistance or support, which may include:
     - Financial, for follow-up care, medication, and transportation
     - Smoking cessation counseling or treatment

vi. Medical equipment and supplies coordinated (ie, delivered or delivery confirmed) which may include:
   - Ambulation devices (eg, cane, crutches, walker)
   - Antiembolic or compression stockings
   - Bath and toilet aids
   - Syringes and needles for subcutaneous injections
   - Wound care supplies

V. Coding

A. CPT

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<th>Code</th>
<th>Description</th>
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<tr>
<td>27120</td>
<td>Hip Acetabuloplasty; (eg, Whitman, Colonna, Haygroves, or cup type)</td>
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<tr>
<td>27122</td>
<td>Hip Acetabuloplasty; resection, femoral head (eg, Girdlestone procedure)</td>
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<tr>
<td>27125</td>
<td>Hemiarthroplasty, hip, partial (eg, femoral stem prosthesis, bipolar arthroplasty)</td>
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<td>27033</td>
<td>Arthrotomy, hip, including exploration or removal of loose or foreign body</td>
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<tr>
<td>27122</td>
<td>Acetabuloplasty; resection, femoral head (eg, Girdlestone procedure)</td>
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<td>27236</td>
<td>Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement</td>
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<td>27299</td>
<td>Unlisted procedure, pelvis or hip joint</td>
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B. HCPCS

No HCPCS codes

C. ICD-10 Procedure

No ICD-10 Procedure codes

D. ICD-10 Diagnosis

All associated ICD-10 Diagnosis codes
References

Regulatory Data

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<tr>
<th>Policy Number/Name:</th>
<th>PA.CP.MP.OR.1026 Hip Resurfacing</th>
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<tr>
<td>Initial Approval and Effective Date:</td>
<td>02/05/2015</td>
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<tr>
<td>Reviewed Dates:</td>
<td>02/05/2015; 11/20/2015; 8/2/2016; 2/17/2017; 11/30/2017; 2/19/2019; 12/12/2019</td>
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<td>Approval Authority:</td>
<td>Utilization Management Committee</td>
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<td>Business Owner:</td>
<td>Utilization Management</td>
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<td>Applicable lines of business:</td>
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<td>Board approval, if appropriate:</td>
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URAC Standards: 

State Requirements:

CMS/Federal Requirements:

Corresponding policies:

Reviews, Revisions, and Approvals

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<tr>
<td>New Policy created.</td>
<td>03/20</td>
<td>6/29/2020</td>
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<td>Policy administered by Turning Point Healthcare Solutions</td>
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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by PA Health & Wellness, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a
contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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