HIP REPLACEMENT SURGERY (ARTHROPLASTY)

Policy Number: CS055.F

Effective Date: April 1, 2017

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INSTRUCTIONS FOR USE

This Medical Policy provides assistance in interpreting UnitedHealthcare benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced. The terms of the federal, state or contractual requirements for benefit plan coverage may differ greatly from the standard benefit plan upon which this Medical Policy is based. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage supersedes this Medical Policy. All reviewers must first identify member eligibility, any federal or state regulatory requirements, and the contractual requirements for benefit plan coverage prior to use of this Medical Policy. Other Policies and Coverage Determination Guidelines may apply. UnitedHealthcare reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary. This Medical Policy 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. 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.

BENEFIT CONSIDERATIONS

Before using this policy, please check the federal, state or contractual requirements for benefit coverage.

COVERAGE RATIONALE

For information regarding medical necessity review, when applicable, see MCG™ Care Guidelines, 21st edition, 2017, Hip Arthroplasty, S-560 (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 federal, state or contractual requirements 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 Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>27120</td>
<td>Acetabuloplasty; (e.g., Whitman, Colonna, Haygroves, or cup type)</td>
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<tr>
<td>27122</td>
<td>Acetabuloplasty; resection, femoral head (e.g., Girdlestone procedure)</td>
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<tr>
<td>27125</td>
<td>Hemiarthroplasty, hip, partial (e.g., femoral stem prosthesis, bipolar arthroplasty)</td>
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### CPT Code
<table>
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<th>CPT Code</th>
<th>Description</th>
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<tr>
<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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<tr>
<td>27132</td>
<td>Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft</td>
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<tr>
<td>27134</td>
<td>Revision of total hip arthroplasty; both components, with or without autograft or allograft</td>
</tr>
<tr>
<td>27137</td>
<td>Revision of total hip arthroplasty; acetabular component only, with or without autograft or allograft</td>
</tr>
<tr>
<td>27138</td>
<td>Revision of total hip arthroplasty; femoral component only, with or without allograft</td>
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### 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 December 21, 2016)

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

### CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Medicare does not have a National Coverage Determination (NCD) for hip replacement surgery. Local Coverage Determinations (LCDs) exist; see the LCDs for Total Joint Arthroplasty, Major Joint Replacement (Hip and Knee) and Surgery: Major Joint Replacement (Hip and Knee). (Accessed December 21, 2016)

### POLICY HISTORY/REVISION INFORMATION

<table>
<thead>
<tr>
<th>Date</th>
<th>Action/Description</th>
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| 04/01/2017| • Reformatted and reorganized policy; transferred content to new template  
            • Revised coverage rationale; replaced references to "MCG™ Care Guidelines, 20th edition, 2016" with "MCG™ Care Guidelines, 21st edition, 2017" (refer to 21st edition for complete details on applicable updates to the MCG™ Care Guidelines)  
            • Updated list of applicable CPT codes; revised description for 27120, 27122, 27125, 27130, 27132, 27134, 27137, and 27138  
            • Archived previous policy version CS055.E |