Medical Management Policy

Service: Hip Replacement Surgery (Total Hip Arthroplasty, Hemiarthroplasty, Hip Resurfacing Arthroplasty, Revision or Replacement of Total Hip Arthroplasty)

PUM 250-0015-1812

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<th>Medical Policy Committee Approval</th>
<th>09/27/19</th>
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<tr>
<td>Effective Date</td>
<td>01/01/20</td>
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<tr>
<td>Prior Authorization Needed</td>
<td>Yes</td>
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Disclaimer: This policy is for informational purposes only and does not constitute medical advice, plan authorization, an explanation of benefits, or a guarantee of payment. Benefit plans vary in coverage and some plans may not provide coverage for all services listed in this policy. Coverage decisions are subject to all terms and conditions of the applicable benefit plan, including specific exclusions and limitations, and to applicable state and federal law. Some benefit plans administered by the organization may not utilize Medical Affairs medical policy in all their coverage determinations. Contact customer services as listed on the member card for specific plan, benefit, and network status information.

Medical policies are based on constantly changing medical science and are reviewed annually and subject to change. The organization uses tools developed by third parties, such as the evidence-based clinical guidelines developed by MCG to assist in administering health benefits. This medical policy and MCG guidelines are intended to be used in conjunction with the independent professional medical judgment of a qualified health care provider. To obtain additional information about MCG, email medical.policies@wpsic.com.

Related Medical Policies:

- Non-covered Services and Procedures
- Pneumatic Compression Devices

Description:

Hip arthroplasty is the surgical replacement of damaged bone and cartilage from the hip joint with a man-made implant.

- NOTE: Only devices/prosthetics approved by the U.S. FDA (United States Food and Drug Administration) may be used. It is the surgeon’s responsibility to ensure the device/prosthetic used is FDA-approved. See also, Limitations of Coverage.

I. Indications of Coverage:

A. Hip Arthroplasty is considered medically necessary for any of the following conditions (1. through 11. below):

1. Degenerative joint disease (DJD) when ALL (a. through d.) of the following are met:
a. The individual has trialed analgesic/anti-inflammatory medication for at least 2 weeks, unless contraindicated.
b. Moderate to severe arthritis shown on imaging
c. Documentation of at least one of the following:
   i. Average pain level of 6 or greater on a scale of 0 to 10
   ii. Intermittent or continuous pain that is causing a functional disability that interferes with ADLs (activities of daily living)
   iii. Oxford Hip score of 29 or less
d. Examination reveals at least one of the following: Pain with passive range of motion (ROM) of the hip, decreased ROM of the hip, or antalgic gait.

2. Acute femoral neck or acetabular fracture

3. Intertrochanteric hip fracture or pertrochanteric hip fracture with any one or more of the following:
   a. Avascular necrosis of femoral head on same hip
   b. The fracture is unstable or significantly displaced
   c. The fracture is comminuted (broken, crushed, or splintered into more than two pieces)
   d. Inflammatory arthritis also present
   e. Bone quality is poor
   f. Osteoarthritis of the same hip
   g. Internal fixation complication
   h. Neglected fracture (There has been a delay from time of injury to seeking medical treatment)

4. Failed repair / failed healing of previous hip fracture that is causing pain or functional disability that interferes with ADLs

5. Malignancy affecting the pelvic bones or soft tissues

6. Malignancy affecting the proximal femur

7. Hip dysplasia

8. Chronic dislocation of hip

9. Hemophilic arthropathy with documentation of all of the following: Advanced arthritic changes, decreased range of motion, pain or functional disability that interferes with ADLs, and other interventions
(e.g., synovectomy, arthrodesis, or osteotomy) are not appropriate or have failed.

10. Congenital deformity that is causing pain or functional disability that interferes with ADLs

11. Symptomatic osteonecrosis of the femoral head with collapse or imaging demonstrating arthritis (Ficat stage II or higher).

B. **Revision of Previous Hip Arthroplasty Procedure** is considered medically necessary for **any** of the following conditions that are causing the individual pain or functional disability that interferes with ability to perform ADLs:

1. Mechanical failure, fracture, or loosening of prosthetic (demonstrated on imaging)

2. Nonunion of previous hip replacement (demonstrated on imaging)

3. Recurrent hip dislocations (demonstrated on imaging) that are non-responsive to conservative management

4. Hip dislocation that is irreducible

5. Periprosthetic infection (culture or gram stain confirmed)

6. Periprosthetic fracture (demonstrated on imaging)

7. Leg length discrepancy that is significant and affects gait or functional ability

8. Metallosis or hypersensitivity reaction caused by previous hip implant

II. **Inpatient or Ambulatory Surgery Setting and Length of Stay**

A. Ambulatory surgery may be appropriate (at the surgeon’s discretion) for select individuals less than 65 years of age.

B. Inpatient hospital admission with **2-day postoperative length of stay** is medically necessary for most individuals. **Inpatient hospitalizations that extend beyond the 2-day length of stay** require review of updated clinical documentation to determine if continued acute inpatient level of care is medically necessary.
Conditions that may require inpatient hospitalization beyond a 2-day postoperative stay (medical necessity review by the health plan is required) include, but are not limited to:

- Nausea or vomiting, not controlled with antiemetic(s), that impacts the individual’s ability to take oral pain medication and maintain adequate oral intake of food and fluids
- Inability to void or have bowel movement despite appropriate interventions and treatment
- Pulmonary complication
- Thromboembolism
- Postoperative delirium or altered mental status from individual’s baseline
- Operative site complication
- Uncontrolled pain despite appropriate interventions and treatment
- Postoperative anemia requiring blood transfusion(s)
- Unstable vital signs
- Neurovascular complication of operative limb
- Complication of co-morbid medical condition

Please see MCG Hip Arthroplasty ORG: S-560 (ISC) for additional information regarding extended stay criteria.

III. Postoperative Rehabilitation

A. Outpatient or Home Therapy:

Postoperative physical therapy in the outpatient or home setting is appropriate for most individuals who have undergone hip arthroplasty surgery. Outpatient and home therapy services require prior authorization. The hospital discharge planner or member should call the number on the member’s health plan ID card to verify available benefits and prior authorization process.

B. Inpatient Rehabilitation Facility:

Admission with a 5-day length of stay at an inpatient rehabilitation facility is medically necessary following hip replacement surgery for individuals who meet both 1. and 2. below:

1. The individual must meet one of the following (a., b., or c.):
   a. Individual has undergone bilateral hip replacements
   b. Individual is 85 years old or greater
c. Individual has a body mass index of 50 or greater

**AND**

2. The individuals must also have all of the following:
   
a. The ability and commitment to actively participate in 3 or more hours of therapy on 5 or more days a week  
b. Intensive skilled therapy needs (including, but not limited to: Pain management techniques, gait training, fall prevention, balance, and safety training, and adaptive equipment training)  
c. Skilled nursing service needs (including, but not limited to: Medical condition monitoring, reinforcement of therapy skills, patient or caregiver education)

**NOTE:** Inpatient rehabilitation facility stay beyond 5 days will require review by the Health Plan to determine medical necessity. There must be documentation of rationale/reasons the individual is not medically able to discharge home with or without home services or transition to a lower level of care. Please see MCG Inpatient Rehabilitation Facility (Acute Rehabilitation): Hip Arthroplasty ORG: I-5560 (RFC) for additional information regarding extended stay criteria.

**C. Skilled Nursing Facility (SNF):**

1. Admission with **3-day length of stay** at a skilled nursing facility is medically necessary for individuals who have undergone a hip arthroplasty surgery and are unable to discharge home with home services or outpatient therapy. **There must be documentation of rationale/reasons the individual is medically unable to discharge from hospital to home with home services or outpatient therapy and one of the following:**
   
a. Skilled therapy needs

   or

   b. Skilled nursing need of intravenous medication administration or complex wound care

2. Extension of the 3-day length of stay is not routinely necessary for most individuals. **A review by the Health Plan is required to determine the medical necessity of requests to extend the 3-day length of stay.** Documentation must include the medical rationale/reasons the individual is not able to transition home with
home services or outpatient therapy and one of the following (a. or b. below):

a. The individual has been actively participating in therapy (has completed at least 3 therapy sessions in the initial 3-day stay and 5 therapy sessions per week during any extension of stay), has made measurable progress with therapy, and continued progress is anticipated

or

b. The individual continues to have a daily skilled nursing need of intravenous medication administration or complex wound care that cannot be performed at a lower level of care

Limitations of Coverage:

1. Review contract and endorsements for exclusions and prior authorization or benefit limits or requirements

2. If used for a condition/diagnosis other than is listed in the Indications of Coverage, it will be denied as experimental, investigational, and unproven to affect health outcomes

3. If used for a condition/diagnosis that is listed in the Indications of Coverage, but the criteria are not met, it will be denied as not medically necessary

4. All of the following (a. through m.) will be denied as experimental, investigational, and unproven to affect health outcomes:
   
a. Patient-specific instruments
b. Custom implants/prostheses (such as, but not limited to the Conformis Hip System) and imaging related to these
c. Metal on metal hip resurfacing for individuals greater than 65 years old
d. Intraoperative surgical navigation (including, but not limited to intellijoint HIP®)
e. Home use of CPM (continuous passive motion) devices and related equipment/supplies
f. Use of a device/prosthetic that has not been approved by the U.S. FDA for the specific use planned
g. iovera® System
h. Coolief® Cooled RF (radiofrequency)
i. Viscosupplementation, hyaluronic acid injections
j. Stem cell therapy or stem cell injections
k. Platelet-rich plasma injections
1. Nerve block or radiofrequency ablation (RFA) of the articular branches of the femoral or obturator nerve (or other peripheral nerves)
2. Cryotherapy, cold therapy devices
3. HipGrid® System with PhantomMSK, HipGrid®, HipGrid Nine®
4. Bone marrow aspirate concentrate (BMAC) injection/treatment
5. Microfragmented adipose tissue (MFAT) injection/treatment (such as, but not limited to Lipogems®)
6. Platelet Lysate (PL)

**Documentation Required:**

1. History and physical notes (including physical/functional impairments and pain caused by hip)
2. Imaging studies
3. Documentation of conservative treatment trials (medication, physical therapy, etc.)
4. Therapy evaluation and daily progress notes (for review of extensions for inpatient rehabilitation facility or skilled nursing facility)
5. Nursing assessment and progress notes (for review of extensions for skilled nursing facility due to nursing need as indicated above in section III, C., 2.)

**Medical Policy Review History:**

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Approved by the Medical Director