Clinical Review Criteria Related to Total Hip Resurfacing

I. Criteria for Approval

A. Total hip resurfacing is considered medically necessary for use in select patients requiring primary hip resurfacing arthroplasty due to these conditions:

1. non-inflammatory arthritis (degenerative joint disease) such as:
   a. osteoarthritis
   b. traumatic arthritis
   c. avascular necrosis (see exception below)
   d. dysplasia/developmental dislocation of the hip.

2. inflammatory arthritis, such as rheumatoid arthritis.

B. Total hip resurfacing is intended for patients who are:

1. relatively young in age (less than or equal to 65 years old) and/or relatively physically active, AND
   a. expected to outlive conventional THR prosthesis and who, therefore, face the possibility of multiple revision procedures during their lifetime, AND
   b. have normal proximal femoral bone geometry and bone quality.

2. have radiographic evidence of joint damage and/or chronic pain or disability that interferes with daily activities AND a history of unsuccessful conservative treatment (12 weeks) clearly documented in the clinical notes. ***If conservative treatment is not appropriate, the clinical note must also reflect why it is not reasonable.

C. The surgeon performing the procedure has received the appropriate training from the manufacturer, and the resurfacing components have been FDA approved.

II. Required Documentation

A. Letter of medical necessity documenting pain at the hip joint that increases with activity or weight bearing and interferes with activities of daily living, AND
B. Physical findings reveal limited range of motion of the joint, pain with passive range of motion and antalgic gait, AND

C. Imaging documentation consistent with conditions described, AND

D. Documented bone-on-bone contact on imaging.

III. What is Not Covered

A. Infection or sepsis

B. Skeletally immature (under 21 years of age)

C. Vascular insufficiency, muscular atrophy, or neuromuscular disease severe enough to compromise implant stability or postoperative recovery

D. Bone stock inadequate to support the device including:
   1. severe osteopenia
   2. family history or severe osteoporosis or severe osteopenia
   3. osteonecrosis or avascular necrosis with >50% involvement of the femoral head
   4. multiple cysts of the femoral head >1cm.
      a. In cases of questionable bone stock, a dual-energy x-ray absorptiometry (DEXA) scan may be necessary to assess inadequate bone stock.

E. Females of child-bearing age

F. Known moderate-to-severe renal insufficiency

G. Immunosuppressed with diseases such as AIDS or receiving high doses of corticosteroids

H. BMI greater than 40

I. Known or suspected metal sensitivity (e.g., jewelry) or concern about effects of metal ions.
J. Metal-on-polyethylene total HRA is not covered in any patient population related to the poor clinical outcomes reported for metal-on-polyethylene implants for hip resurfacing.

IV. CPT/ ICD-10/ HCPCS Codes

Applicable Coding: Codes may not be all inclusive as the American Medical Association (AMA) code updates may occur more frequently or at different intervals than policy updates. These codes are not intended to be used for coverage determinations.

**CPT Code:**
27299 - Unlisted procedure, pelvis or hip joint

V. References

NCQA Standard, UM 2, Clinical Criteria for Utilization Management Decisions, Element A


VI. Summary of Changes

06/29/2017
- Added new Disclaimer
- References – Updated last accessed dates
VII. Review Dates

HNE Review Dates: 9/10/13; 9/9/14; 9/8/15; 6/14/16, 5/9/17
MHI Review Dates: 10/01/09, 09/9/14, 10/7/15, 6/30/16, 06/29/2017
Medical Guideline Disclaimer
The treating physician or primary care provider must submit to Minuteman the clinical evidence that the patient meets the
criteria for the treatment or surgical procedure. Without this documentation and information, Minuteman will not be able
to properly review the request for prior authorization. The clinical review criteria expressed herein reflects how
Minuteman determines whether certain services or supplies are medically necessary. Minuteman established the clinical
review criteria based upon a review of currently available clinical information (including, without limitation clinical
outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based
guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national
health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant
factors). Minuteman expressly reserves the right to revise these criteria as clinical information changes, and welcomes
further relevant information. Each benefit program defines which services are covered. The conclusion that a service or
supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or
paid for by Minuteman. If there is a discrepancy between this policy and a member's benefit program, the benefit program
will govern. In addition, coverage may be mandated by applicable legal requirements of a state, the federal government or
the Centers for Medicare & Medicaid Services (CMS). Minuteman has adopted the herein policy in providing management,
administrative and other services to its members.