MEDICAL POLICY	Hip: Total Joint Arthroplasty (Medicare Only)
Effective Date: 7/1/2022  7/1/2022 Medical Officer Date	Medical Policy Number: 133 Medical Policy Committee approved Date: 11/12; 1/14; 1/15; 4/15; 8/16; 10/17; 12/18; 3/2020; 05/2021; 2/2022; 3/2022; 6/2022

See Policy CPT CODE section below for any prior authorization requirements

SCOPE:

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as "Company" and collectively as "Companies").

APPLIES TO:

Medicare only

MEDICARE POLICY CRITERIA

The following Centers for Medicare & Medicaid Service (CMS) guidelines should be utilized for medical necessity coverage determinations. Click the link provided in the table below to access applicable medical necessity criteria. All listed guidelines apply.

Notes:

- Some hip arthroplasty procedures may be reviewed for both medical necessity and inpatient site of service, the latter of which is performed using the separate Surgical Site of Service medical policy (MP184). See *Billing Guidelines* below.
- This Medicare medical policy does not address hip resurfacing, which may be considered medically necessary.

Service	Medicare Guidelines
Total Hip Arthroplasty (THA)	Local Coverage Determination (LCD): Total Hip Arthroplasty (L36573)

POLICY GUIDLEINES

Utilization Guidelines

These services are expected to be performed as indicated by current medical literature and/or standards

of practice. When services are performed in excess of established parameters they may be subject to review for medical necessity.

The devices/implants utilized for total hip replacement surgeries are regulated by the FDA as medical devices. The devices used should be class II or class III devices that meet the requirements outlined in CFR 21, Chapter 1, subchapter H, Part 888.

BILLING GUIDELINES

General

See associated local coverage article (LCA) for additional coding and billing guidance:

- LCA: Billing and Coding: Total Hip Arthroplasty (A57684)

Surgical Site of Service (SOS) Review

The LCA A57684 states, "Review of the medical record must indicate that inpatient hospital care was medically necessary, reasonable, and appropriate for the diagnosis and condition of the beneficiary at any time during the stay. The beneficiary must demonstrate signs and/or symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis."

- **Separate SOS Review Required:** CPT code 27130 is **not** included on the Medicare Inpatient Only list. Therefore, in addition to general medical necessity review using this policy, CPT code 27130 may require inpatient site of service review, which is performed using criteria found in the separate *Surgical Site of Service* medical policy (MP184).

- **Separate SOS Review Not Required:** The remaining hip arthroplasty CPT codes require medical necessity review using criteria found in this Medicare medical policy, but they are **not** subject to the site of service policy criteria because they are included on the Medicare Inpatient Only list.

CPT CODES

Medicare Only	
Prior Authorization Required	
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft
27132	Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft

27134	Revision of total hip arthroplasty; both components, with or without autograft or allograft
27137	Revision of total hip arthroplasty; acetabular component only, with or without autograft or allograft
27138	Revision of total hip arthroplasty; femoral component only, with or without allograft

INSTRUCTIONS FOR USE

Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days notice of policy changes that are restrictive in nature.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement.

REGULATORY STATUS

Mental Health Parity Statement

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.