



**TOTAL HIP RESURFACING
ARTHROPLASTY
HS-082**



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**Total Hip Resurfacing
Arthroplasty**

Policy Number: HS-082

Original Effective Date: 2/16/2009

**Revised Date(s): 2/26/2010; 2/26/2011;
2/2/2012**

DISCLAIMER

The Clinical Coverage Guideline is intended to supplement certain standard WellCare benefit plans. The terms of a member's particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from this Coverage Position. For example, a member's benefit plan may contain specific exclusions related to the topic addressed in this Clinical Coverage Guideline. When a conflict exists between the two documents, the Member's Benefit Plan always supersedes the information contained in the Clinical Coverage Guideline. Additionally, Clinical Coverage Guidelines relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

APPLICATION STATEMENT

The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

BACKGROUND

Contemporary total hip resurfacing arthroplasty (HRA) is indicated for selected patients with radiographic evidence of joint damage and/or chronic pain or disability that interferes with daily activities and is refractory to conservative treatment. HRA may be considered an alternative to conventional total hip replacement (THR), particularly in young (age < 55 years), active patients with normal proximal femoral bone geometry and bone quality, who would potentially outlive the prostheses used in THR. In some cases, total HRA may also be viewed as a time-buying procedure to delay the need for a THR. Related disease conditions include, but are not limited to, osteoarthritis, rheumatoid arthritis, osteonecrosis, and traumatic arthritis.

HRA surgical procedures, prosthetic material and design, and prosthetic fixation methods have undergone several changes in the last two decades and continue to evolve. However, there are some features common to most contemporary HRA procedures. A metal-on-metal (M-M) prosthetic system, using a bearing made from high carbon containing cobalt-chromium (Co-Cr) alloy, has largely replaced the older metal-on-polyethylene prosthetic system. The surgical procedure typically involves the following basic steps: (1) the femur is separated from the acetabulum; (2) damaged areas are removed from the femur, and the femoral head is reshaped; (3) damaged cartilage and bone are removed from the acetabulum; (4) the acetabulum shell (or cup) prosthetic, which has a porous surface to facilitate cementless bone fusion, is pressed into place; (5) a hole is drilled into the femur to fit the shaft of the hollow metal hemisphere prosthetic (femoral shell); (6) cement is used to secure the femoral shell prosthetic into place on the reshaped femoral head; (7) the femur and acetabulum are put back together to form a new resurfaced M-M hip joint. At the present time, the Food and Drug Administration (FDA) has approved only one prosthetic joint system, the Birmingham Hip Resurfacing System (first manufactured by Midland Medical Technologies; acquired by Smith & Nephew Inc. in 2004), designed specifically for use in total HRA procedures.

The primary goals of both total HRA and THR are patient pain management and the anatomic reconstruction of the hip joint, resulting in favorable prosthetic joint load and function. Mechanically, the goals are to create a stable articulation with an optimal range of motion, restore biomechanics for muscular efficiency, and equalize limb lengths. Other essential objectives specific to HRA are to maintain or restore the anatomy of the femoral head and neck (head height, orientation, and neck offset) and to preserve the femoral and acetabular bone stock. Theoretical advantages of HRA compared with THR include the following: less bone destruction, less bone resection, normal femoral loading, avoidance of stress shielding, maximum proprioceptive feedback, restoration of normal anatomy, reduced risk of dislocation, less leg inequality problems, easier revision if necessary (Hayes, 2006).

POSITION STATEMENT

Total hip resurfacing **is considered medically necessary for *select members**** (see criteria below) with the following conditions:

1. Non-inflammatory arthritis (degenerative joint disease) such as:
 - **715.15 - 715.95** Osteoarthritis; **OR**,
 - **716.15** Traumatic arthritis; **OR**,
 - **733.42** Avascular necrosis; **OR**,
 - **718.75** Dysplasia/developmental dislocation of the hip

OR;

2. Inflammatory arthritis such as:
 - **714.0** Rheumatoid arthritis

Total hip resurfacing **is considered medically necessary** when the above indications are present and ALL of the following criteria are met:

- Pain at the hip joint increases with activity or weight bearing and interferes with activities of daily living; **AND**,
- Physical findings reveal reproducible pain with passive range of motion (ROM) testing **AND** limited range of motion of the joint **AND** an antalgic gait (a method of ambulating that lessens the painful symptoms, for example, limping); **AND**,
- Imaging documentation is consistent with the conditions described above (for example, subcondral cysts, subchondral sclerosis, periarticular osteophytes, joint subluxation, or joint spacing narrowing); **AND**,
- Either bone-on-bone contact is documented on imaging **OR** failed conservative therapy is documented. Failed conservative therapy is the persistence of symptoms after a recent twelve-week trial of physical therapy **AND** a recent four-week trial of anti-inflammatory medication (or analgesic medication when anti-inflammatory medication is contraindicated) used on a regular basis; **AND**,
- The surgeon performing the procedure has received the appropriate training and procedure updates from the manufacturer/distributor as required by the FDA. **NOTE:** Surgeons listed on the website www.birminghamhipresurfacing.com/index.cfm have met these requirements.)

* Total hip resurfacing **is considered medically necessary** for *select members* who meet the following criteria:

- Fit, active members who are younger than age 55; **AND**,
- Have normal proximal femoral bone geometry and bone quality; **AND**,
- Would otherwise receive a conventional primary total hip replacement (THR), but are likely to live longer than a conventional THR is expected to last

Total hip resurfacing is contraindicated in the following instances and **is NOT a covered benefit**:

- Members with infection or sepsis; **OR**,
- Members who are skeletally immature (under twenty one years of age); **OR**,
- Members with any vascular insufficiency, muscular atrophy, or neuromuscular disease severe enough to compromise implant stability or postoperative recovery); **OR**,
- Members with bone stock inadequate to support the device including these cases**:
 - Members with severe osteopenia; **OR**,
 - Members with a family history of severe osteoporosis or severe osteopenia; **OR**,
 - Members with osteonecrosis or avascular necrosis (AVN) with > 50% involvement of the femoral head regardless of FICAT Grade); **OR**,
 - Members with multiple cysts of the femoral head (> 1cm);
- Females of child-bearing age; **OR**,
- Members with known moderate to severe renal insufficiency;); **OR**,
- Members who are immunosuppressed with diseases such as AIDS or persons receiving high doses of corticosteroids;); **OR**,
- Members who are severely overweight (BMI greater than 35); **OR**,
- Members with known or suspected metal sensitivity.

** NOTE: In cases of questionable bone stock, a dual-energy x-ray absorptiometry (DEXA) scan may be necessary to assess inadequate bone stock.

CODING

Covered CPT® Codes

27130 Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft

Covered ICD-9-CM Procedure Codes

00.85 Total hip resurfacing, acetabulum and femoral head; hip resurfacing arthroplasty, total

HCPCS Level II Code

S2118* Metal-on-metal total hip resurfacing, including acetabular and femoral components.

***S- Codes are NON COVERED FOR MEDICARE – Refer to HCPCS Level II Temporary National Codes**

Covered ICD-9-CM Diagnosis Codes

714.0 Rheumatoid arthritis

715.15 Osteoarthritis, localized, primary, pelvic region and thigh

715.25 Osteoarthritis, localized, secondary, pelvic region and thigh

715.35 Osteoarthritis, localized, not specified whether primary or secondary, pelvic region and thigh

715.95 Osteoarthritis, unspecified whether generalized or localized, pelvic region and thigh

716.15 Traumatic Arthropathy pelvic region and thigh

718.75 Developmental Dislocation of pelvic region and thigh

733.42 Aseptic necrosis of head and neck of femur

***Current Procedural Terminology (CPT®) ©2012 American Medical Association: Chicago, IL.**

REFERENCES

Peer Reviewed

1. Hayes Directory. (2006, July 13). Total hip resurfacing arthroplasty. Retrieved from <http://www.hayesinc.com>
2. Hayes Directory. (2006, May 16). Femoral head resurfacing arthroplasty for the treatment of osteonecrosis. Retrieved from <http://www.hayesinc.com>

Government Agencies, Professional and Medical Organizations

1. BlueCross BlueShield TEC Assessment. (2007, June). Metal-on-metal total hip resurfacing. Volume 22, No. 3.
2. Centers for Medicare and Medicaid Services. (2008, September 21). Local coverage determination for hip resurfacing prosthesis, total (femoral and acetabular) (L26133). Mutual of Omaha.

HISTORY AND REVISIONS

Date	Action
2/2/2012	<ul style="list-style-type: none">• Approved by MPC. No changes.
12/1/2011	<ul style="list-style-type: none">• New template design approved by MPC.
2/26/2011	<ul style="list-style-type: none">• Approved by MPC.