I. Policy: Hip Resurfacing Arthroplasty

II. Purpose/Objective:
   To provide a policy of coverage regarding Hip Resurfacing Arthroplasty

III. Responsibility:
   A. Medical Directors
   B. Medical Management

IV. Required Definitions

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions

Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
c. in accordance with current standards of good medical treatment practiced by the general medical community.
d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and

e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment

Medical Necessity shall mean a service or benefit that is compensable under the Medical Assistance Program and if it meets any one of the following standards:

(i) The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
(ii) The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or development effects of an illness, condition, injury or disability.
(iii) The service or benefit will assist the Member to achieve or maintain maximum functional
capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for members of the same age.

**DESCRIPTION:** Hip resurfacing arthroplasty involves the removal and replacement of the surface of the femoral head. This technique attempts to preserve femoral bone composition and structure, while maintaining normal femoral loading and stresses. The procedure has been suggested for a specific group of individuals as an alternative to total hip replacement.

**INDICATIONS:** Hip resurfacing arthroplasty is considered medically necessary when:

- The member is an active 65-year-old or less and likely to outlive a traditional prosthesis; and
- A diagnosis of non-inflammatory degenerative arthritis (e.g., osteoarthritis, avascular necrosis) or inflammatory arthritis (e.g., rheumatoid arthritis) has been established; and
- Nonsurgical management has failed and the member is a candidate for total hip replacement

**CONTRAINDICATIONS:** Hip resurfacing arthroplasty is contraindicated in members with any of the following:

- infection or sepsis
- skeletal immaturity
- vascular insufficiency, muscular atrophy, or neuromuscular disease severe enough to compromise implant stability or postoperative recovery
- bone stock inadequate to support the device
- females of child-bearing age due to unknown effect on the fetus of metal ion release
- known moderate to severe renal insufficiency
- immunosuppression with diseases such as AIDS or persons receiving high doses of corticosteroids
- severe obesity (BMI greater than 35)
- known or suspected sensitivity to the component metal(s) in the device

**EXCLUSIONS:** The Plan does NOT provide coverage for hip resurfacing arthroplasty for any indication not specifically listed in this document. Use outside of the identified criteria is considered experimental, investigational and unproven.

Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven is outlined in MP 15 - Experimental Investigational or Unproven Services or Treatment.

**CODING ASSOCIATED WITH:** Hip Resurfacing Arthroplasty

*The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at www.cms.gov or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements.*

S2118  Metal-on-Metal Total Hip resurfacing, including acetabular and femoral components

27299  Unlisted procedure, pelvis or hip joint


**LINE OF BUSINESS:**

Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD’s and NCD’s will supersede this policy For PA Medicaid Business segment, this policy applies as written.

**REFERENCES:**


Allison C. Minimally invasive hip resurfacing {Issues in emerging health technologies issue 65}. Ottawa: Canadian Coordinating Office for Health Technology Assessment; 2005. Available at www.cchota.ca


ECRI HTAIS Target database (online). Metal-on-Metal Total Hip resurfacing for Arthritis. Plymouth Meeting Pa; ECRI November 2006.

ECRI HTAIS Target database (online). Metal-on-Metal Total hip resurfacing for degenerative hip disease. Plymouth Meeting PA; ECRI November 4 2011


This policy will be revised as necessary and reviewed no less than annually.

Devised: 11/07

Revised: 11/08 (added coding), 12/11 (added indication)

Reviewed: 10/09, 11/10, 12/12, 12/13, 12/14, 12/15, 12/16, 11/17, 11/18