



**Cohere Medical Policy -  
Hip Arthroplasty (Partial, Total, or Revision)**  
*Clinical Guidelines for Medical Necessity Review*

**Version:** 4  
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## Guideline Information:

**Specialty Area:** Disorders of the Musculoskeletal System

**Service Name:** Hip Arthroplasty

**Date of last literature review:** 1/10/2025

**Document last updated:** 2/17/2025

**Type:**  Adult (18+ yo) |  Pediatric (0-17yo)

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# Medical Necessity Criteria

## ***Service: Hip Arthroplasty (Partial, Total, or Revision)***

### **Recommended Clinical Approach**

Hip arthroplasty is a surgical intervention to reduce hip pain and restore function by replacing a damaged or diseased hip joint with an artificial prosthesis. It is appropriate in patients with persistent, disabling symptoms despite non-surgical management. Partial hip replacement (hemiarthroplasty) may be indicated when only the femoral side of the hip joint is damaged. Total hip arthroplasty replaces the ball and socket parts of the hip joint in cases of severe damage. If a patient has had a prior hip arthroplasty and presents with pain that may be due to infection, recurrent hip dislocation, aseptic loosening, excessive wear, mechanical failure, or fracture, then revision surgery may be indicated. Hip arthroplasty is generally well-tolerated with appropriate patient selection and confers an improved quality of life.<sup>1-4</sup>

### **Medical Necessity Criteria**

#### **Indications**

- **Hip arthroplasty** is considered appropriate if **ANY** of the following is **TRUE**:
- ◆ The procedure is a **total hip arthroplasty** and **ANY** of the following is **TRUE**:
    - The patient has hip arthritis and **ALL** of the following<sup>1-4</sup>:
      - **ANY** of the following:
        - ◆ Failure of conservative management for greater than 3 months, including **ALL** of the following<sup>2,4</sup>:
          - Anti-inflammatory medications, non-opioid analgesics, or prescription medications (e.g., oral steroids, neuropathic pain medications) if not contraindicated; **AND**
          - Ambulatory assist device (if medically appropriate)<sup>2,4</sup>; **AND**

- Physical therapy or physician-directed exercise program<sup>5</sup>; **AND**
- **ANY** of the following:
  - Corticosteroid injection if medically appropriate<sup>2,4</sup>; **OR**
  - Documentation that corticosteroid injection is contraindicated<sup>2,4</sup>; **OR**
- ◆ Documentation indicating that conservative, non-surgical management would be ineffective or counterproductive, including **ANY** of the following<sup>2,4</sup>:
  - Intractable pain or significant disabling interference with activities of daily living (ADLs); **OR**
  - Bone-on-bone articulation; **OR**
  - Severe deformity; **OR**
  - Failure of a previous osteotomy; **OR**
  - Malignancy of hip joint or adjacent soft tissues; **OR**
  - Avascular necrosis of the hip; **AND**
- The patient's symptoms have limited their activities of daily living (ADLs)<sup>3,4</sup>; **AND**
- Radiograph shows **ANY** of the following evidence of osteoarthritis of the hip<sup>1,4,6</sup>:
  - ◆ Joint space narrowing (less than 50%) with marginal osteophytes or subchondral sclerosis<sup>1,4,6</sup>; **OR**
  - ◆ Collapsed femoral head with marginal osteophytes or subchondral sclerosis<sup>1,4,6</sup>; **OR**
  - ◆ Joint space narrowing (greater than 50%)<sup>1,4,6</sup>; **OR**
  - ◆ Complete joint space loss<sup>1,4,6</sup>; **OR**
- Malignancy involving bones or soft tissues of the pelvis or proximal femur<sup>1,3</sup>; **OR**
- Aseptic necrosis of the femoral head<sup>1,3</sup>; **OR**
- Displaced femoral neck fracture<sup>2,3</sup>; **OR**
- Non-union or malunion fracture of the femoral neck<sup>2,3</sup>; **OR**

- Acute fracture of the femoral head or neck that is untreatable with open reduction and internal fixation (ORIF)<sup>2</sup>; **OR**
- Fracture dislocation of the hip untreatable with ORIF<sup>1,2</sup>; **OR**
- ◆ The procedure is a **partial hip arthroplasty (hip hemiarthroplasty)**, and **ANY** of the following is **TRUE**<sup>2,7,8</sup>:
  - Displaced femoral head or neck fracture<sup>7,8</sup>; **OR**
  - Acute fracture of the femoral head or neck that is untreatable with open reduction and internal fixation (ORIF)<sup>2</sup>; **OR**
  - Avascular necrosis of the femoral head<sup>1,2</sup>; **OR**
  - Non-union fracture of the femoral neck<sup>1,2</sup>; **OR**
  - Degenerative arthritis of the femoral head only in which the acetabulum does not need replacement<sup>1,2</sup>; **OR**
- ◆ The procedure is a **revision of prior arthroplasty** and **ALL** of the following are **TRUE**<sup>1,9,10</sup>:
  - The patient has significant hip pain<sup>1,9,10</sup>; **AND**
  - The patient has **ANY** of the following:
    - Surgical management of total joint infection<sup>1,9,10</sup>; **OR**
    - Instability<sup>1,9,10</sup>; **OR**
    - Loosening of the prosthesis<sup>1,9,10</sup>; **OR**
    - Failure of the prosthesis<sup>1,9,10</sup>; **OR**
    - Periprosthetic fracture<sup>1,9,10</sup>; **OR**
    - Recurrent or irreducible hip dislocation<sup>1,9,10</sup>; **OR**
    - Tissue or systemic reaction to implant<sup>1,9,10</sup>; **OR**
    - Clinically significant leg-length inequality not amenable to conservative management.<sup>1,9,10</sup>

## Non-Indications

- **Hip arthroplasty (partial, total, or revision)** is not considered appropriate if **ANY** of the following are **TRUE**<sup>1,2,4</sup>:
- ◆ Skeletal immaturity<sup>1</sup>; **OR**
  - ◆ Active infection<sup>1,2,4</sup>; **OR**
  - ◆ Rapidly progressive neurological disease, unless a concomitant displaced femoral neck fracture is present<sup>1,2,4</sup>; **OR**
  - ◆ Absence or relative insufficiency of abductor musculature<sup>1,2,4</sup>; **OR**
  - ◆ Neuropathic/neurotrophic arthritis.<sup>1,2,4</sup>

## **Level of Care Criteria**

Inpatient or Outpatient

## **Procedure Codes (CPT/HCPCS)**

<b>CPT/HCPCS Code</b>	<b>Code Description/Definition</b>
26990	Incision and drainage, pelvis or hip joint area; deep abscess or hematoma
26991	Incision and drainage, pelvis or hip joint area; infected bursa
27030	Arthrotomy, hip, with drainage (eg, infection)
27125	Hemiarthroplasty, hip, partial (eg, femoral stem prosthesis, bipolar arthroplasty)
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
27236	Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement
27250	Closed treatment of hip dislocation, traumatic; without anesthesia
27299	Unlisted procedure, pelvis or hip joint

# Medical Evidence

Published in 2019, the Hip Fracture Evaluation with Alternatives of Total Hip Arthroplasty (HEALTH) trial, an expertise-based randomized controlled trial, enrolled 1495 patients across 10 countries to determine the most appropriate procedure to surgically manage hip fractures in older adults with displaced femoral neck fractures. Patients aged 50 and older underwent either total hip arthroplasty (THA) or hemiarthroplasty. The study team found similar mortality rates, no significant difference in the incidence of secondary procedures between groups, as well as what was ultimately deemed a “clinically unimportant” improvement among THA recipients as compared to hemiarthroplasty recipients. Therefore, the authors felt there to be limited advantages of THA with a higher risk profile in this patient population. This landmark study began to dismantle the traditional dogma of THA as the standard of care for patients of all ages with displaced femoral neck fractures.<sup>7</sup>

A 2021 meta-analysis of 40 studies comprising 3,561,446 hips found several patient-related risk factors that were associated with a higher risk of periprosthetic joint infection (PJI) after THA. High body mass index (BMI), femoral neck fracture, and opioid use conferred a higher risk of PJI. Interestingly, biological female sex, dislocation/dysplasia, and osteoarthritis were protective factors. The authors noted the importance of reducing the risk of PJI and subsequent revision or other invasive management by careful patient selection and optimization of modifiable risk factors.<sup>12</sup>

The American Academy of Orthopaedic Surgeons (AAOS) has published two guidelines pertaining to hip arthroplasty. *Management of Hip Fractures in Older Adults*, adopted in 2021, recommends arthroplasty over fixation for unstable femoral neck fractures.<sup>2</sup> The authors cite a decreased rate of reoperation among arthroplasty patients, though they note no statistical difference in mortality upon composite analysis of the reference studies.<sup>2</sup> *Management of Osteoarthritis of the Hip*, adopted in 2023, provides a robust set of clinical indications for surgical management of osteoarthritis, including hip arthroplasty.<sup>4</sup> The clinical practice guideline supports the use of NSAIDs to relieve pain and facilitate movement. In addition, it endorses careful patient screening and appropriate optimization in order to improve surgical

outcomes.<sup>4</sup> The AAOS has also issued position statements pertaining to hip arthroplasty. Information statement 1047, published in 2016, acknowledges the increased patient safety risks conferred by tobacco use – including pneumonia, impeded healing, surgical site infection, postoperative cardiopulmonary events, and death.<sup>13</sup> The AAOS states that patients who are active smokers may reduce these risks through cessation of smoking prior to surgery; they also note the special role orthopaedic surgeons play in counseling patients on the benefits of reduced or eliminated tobacco use before surgery. Importantly, unconfirmed cessation is not endorsed as a hard stop to surgery; rather, the surgeon’s unique role as an advocate for preoperative smoking cessation is emphasized. Statements 1040 and 1184 discuss the impact of obesity on musculoskeletal conditions.<sup>14,15</sup> Statement 1184 endorses the importance of continued patient–surgeon conversation around the increased surgical risks associated with obesity, including increased complications and rates of hardware failure following hip replacement. Patients with morbid obesity (BMI of 40 or above) are encouraged to participate in a weight loss program, obtain weight reduction resources through their physician, rectify nutritional deficiencies, and consider a delay in surgical treatment if it would facilitate participation in weight loss interventions that may improve surgical outcomes. Statement 1040 reinforces the risks associated with obesity and total joint arthroplasty and encourages adequate patient counseling prior to surgery.

Social determinants of health remain an important area of ongoing orthopaedic surgery research, with recent literature raising questions regarding the healthcare disparities that may be potentiated by care limitations based on obesity and smoking status/nicotine dependence.<sup>16-19</sup> Other ongoing research interrogates the impacts that biological sex, race, and socioeconomic status have on hip arthroplasty utilization and outcomes.<sup>21-25</sup>

## References

1. Harkess JW, Crockarell JR. Arthroplasty of the hip. In: Azar FM, Beatty JH, editors. *Campbell's Operative Orthopaedics*. 14th ed. Philadelphia, PA: Elsevier; 2021:406–484.e12.
2. American Academy of Orthopaedic Surgeons Management of Hip Fractures in Older Adults Evidence-Based Clinical Practice Guideline. <https://www.aaos.org/hipfxcpq> Published 12/03/2021.
3. Gademan MG, Hofstede SN, Vliet Vlieland TP, et al. Indication criteria for total hip or knee arthroplasty in osteoarthritis: A state-of-the-science overview. *BMC Musculoskelet Disord*. 2016;17(1):463. doi: 10.1186/s12891-016-1325-z. PMID: 27829422.
4. American Academy of Orthopaedic Surgeons Management of Osteoarthritis of the Hip Evidence-Based Clinical Practice Guideline. [aaos.org/oahcpq2](https://www.aaos.org/oahcpq2) Published 12/01/2023.
5. American Academy of Orthopaedic Surgeons. OrthoInfo Hip Conditioning Program. Published May 2023. Accessed January 14, 2025. <https://orthoinfo.aaos.org/en/recovery/hip-conditioning-program/>
6. Ruiz Santiago F, Santiago Chinchilla A, Ansari A, et al. Imaging of hip pain: From radiography to cross-sectional imaging techniques. *Radiol Res Pract*. 2016;2016:6369237. doi: 10.1155/2016/6369237. PMID: 26885391.
7. Health Investigators. Total hip arthroplasty or hemiarthroplasty for hip fracture. *NEJM*. 2019;381(23):2199–2208. doi: 10.1056/NEJMoa1906190. PMID: 31557429.
8. Chammout G, Kelly-Pettersson P, Hedbeck CJ, et al. HOPE-Trial: hemiarthroplasty compared with total hip arthroplasty for displaced femoral neck fractures in octogenarians: a randomized controlled trial. *JBJS Open Access*. 2019 Apr 1;4(2):e0059. DOI: 10.2106/JBJS.OA.18.00059
9. Liu KL, Wu WT, Wang JH, et al. When and how do prosthetic hips fail after total hip arthroplasties? A retrospective study. *J Formos Med Assoc*. 2016;115(9):786–793. doi: 10.1016/j.jfma.2015.07.014. PMID: 26272352.
10. Kelmer G, Stone AH, Turcotte J, et al. Reasons for revision: Primary total hip arthroplasty mechanisms of failure. *J Am Acad Orthop Surg*. 2021;29(2):78–87. doi: 10.5435/JAAOS-D-19-00860. PMID: 32404682.
11. Van de Velde SK, Loh B, Donnan L. Total hip arthroplasty in patients 16 years of age or younger. *J Child Orthop*. 2017;11(6):428–433. doi: 10.1302/1863-2548.11.170085. PMID: 29263754.
12. Ren X, Ling L, Qi L, Liu Z, Zhang W, Yang Z, Wang W, Tu C, Li Z. Patients' risk factors for periprosthetic joint infection in primary total hip arthroplasty: a meta-analysis of 40 studies. *BMC Musculoskeletal Disorders*. 2021 Dec;22:1–7. <https://doi.org/10.1186/s12891-021-04647-1>

13. American Academy of Orthopaedic Surgeons. Information Statement 1047: Tobacco Use and Orthopaedic Surgery. Published February 2016. Accessed January 3, 2025.  
<https://www.aaos.org/globalassets/about/bylaws-library/information-statements/1047-tobacco-use-and-orthopaedic-surgery-3.pdf>.
14. American Academy of Orthopaedic Surgeons. Information Statement 1040: Obesity and Musculoskeletal Care. Published June 2022. Accessed January 3, 2025.  
<https://www.aaos.org/globalassets/about/bylaws-library/information-statements/1040-obesity-and-musculoskeletal-care.pdf>.
15. American Academy of Orthopaedic Surgeons. Information Statement 1184: The Impact of Obesity on Bone and Joint Health. Published March 2015. Accessed January 3, 2025.  
<https://www.aaos.org/contentassets/1cd7f41417ec4dd4b5c4c48532183b96/1184-the-impact-of-obesity-on-bone-and-joint-health1.pdf>.
16. Sabesan VJ, Rankin KA, Nelson C. Movement is life—optimizing patient access to total joint arthroplasty: Obesity disparities. *JAAOS*. 2022 Nov 1;30(21):1028–35.
17. O'connor MI, Burney III D, Jones LC. Movement Is Life—Optimizing Patient Access to Total Joint Arthroplasty: Smoking Cessation Disparities. *JAAOS*. 2022 Nov 15;30(22):1055–8.
18. Connors JP, Strecker S, Nagarkatti D, Carangelo RJ, Witmer D. Increasing Body Mass Index Not Associated With Worse Patient-Reported Outcomes After Primary THA or TKA. *JAAOS*. 2022 May 13:10–5435.
19. Hamilton WG. No Smoking Allowed: Is the Operating Room the Next Place That Smoking Patients Undergoing Total Joint Arthroplasty Will Be Banned?: Commentary on an article by Eric H. Tischler, BA, et al.:“Smoking Increases the Rate of Reoperation for Infection within 90 Days After Primary Total Joint Arthroplasty”. *JBJS*. 2017 Feb 15;99(4):e17.
20. Zalikha AK, Almsaddi T, Nham F, Hussein IH, El-Othmani MM. Comorbidity, Racial, and Socioeconomic Disparities in Total Knee and Hip Arthroplasty at High Versus Low-Volume Centers. *JAAOS*. 2023 Mar 1;31(5):e264–70.
21. Woolley KA, Chi H, Allahabadi S, et al. Sex-based differences in the utilization of shoulder, hip, and knee arthroplasty. *JAAOS Global Research & Reviews*. 2023 Aug 1;7(8):e23.

22. Chen A, Paxton L, Zheng X, Peat R, Mao J, Liebeskind A, Gressler LE, Marinac-Dabic D, Devlin V, Cornelison T, Sedrakyan A. Association of sex with risk of 2-year revision among patients undergoing total hip arthroplasty. *JAMA network open*. 2021 Jun 1;4(6):e2110687-.
23. Dubin J, Bains S, Ihekweazu UN, Mont MA, Delanois R. Social Determinants of Health in Total Joint Arthroplasty: Income. *The Journal of arthroplasty*. 2024 Mar 14.
24. Delanois RE, Sax OC, Wilkie WA, Douglas SJ, Mohamed NS, Mont MA. Social determinants of health in total hip arthroplasty: are they associated with costs, lengths of stay, and patient reported outcomes?. *The Journal of arthroplasty*. 2022 Jul 1;37(7):S422-7.
25. Dubin J, Bains S, Ihekweazu UN, Mont MA, Delanois R. Social determinants of health in total joint arthroplasty: race. *The Journal of arthroplasty*. 2024 Jun 1;39(6):1394-6.
26. Ravi B, Pincus D, Khan H, Wasserstein D, Jenkinson R, Kreder HJ. Comparing complications and costs of total hip arthroplasty and hemiarthroplasty for femoral neck fractures: a propensity score-matched, population-based study. *JBJS*. 2019 Apr 3;101(7):572-9. DOI: 10.2106/JBJS.18.00539
27. Houdek MT, Watts CD, Wyles CC, Trousdale RT, Milbrandt TA, Taunton MJ. Total hip arthroplasty in patients with cerebral palsy: a cohort study matched to patients with osteoarthritis. *JBJS*. 2017 Mar 15;99(6):488-93. DOI: 10.2106/JBJS.16.00528
28. Mundi R, Pincus D, Schemitsch E, Ekhtiari S, Paterson JM, Chaudhry H, Leis JA, Redelmeier DA, Ravi B. Association between periprosthetic joint infection and mortality following primary total hip arthroplasty. *JBJS*. 2024 Sep 4;106(17):1546-52. DOI: 10.2106/JBJS.23.01160
29. Ocokoljic A, Krivec L, Alimy AR, Simon A, Strahl A, Beil FT, Rolvien T. Short-term prediction of clinical and radiographic contralateral hip osteoarthritis after index total hip arthroplasty. *Archives of Orthopaedic and Trauma Surgery*. 2024 Dec;145(1):1-0. <https://doi.org/10.1007/s00402-024-05615-9>
30. Zampogna B, Ferrini A, Zampoli A, Talesa GR, Giusti S, Papalia GF, Vorini F, Papalia R. Total hip arthroplasty in patients under 35 years: a systematic review of the last 2 decades studies. *Hip International*. 2025 Jan;35(1):92-101.

31. Fassihi SC, Lee R, Quan T, Tran AA, Stake SN, Unger AS. Total hip arthroplasty in patients with sickle cell disease: a comprehensive systematic review. *The Journal of Arthroplasty*. 2020 Aug 1;35(8):2286–95. <https://doi.org/10.1016/j.arth.2020.04.014>
32. McCormick KL, Mastroianni MA, Kolodychuk NL, Herndon CL, Shah RP, Cooper HJ, Sarpong NO. Complications and Survivorship After Aseptic Revision Total Hip Arthroplasty: Is There a Difference by Surgical Approach?. *The Journal of Arthroplasty*. 2025 Jan 1;40(1):203–7.
33. Patel I, Nham F, Zalikha AK, El-Othmani MM. Epidemiology of total hip arthroplasty: demographics, comorbidities and outcomes. *Arthroplasty*. 2023 Jan 3;5(1):2. <https://doi.org/10.1186/s42836-022-00156-1>
34. Fontalis A, Epinette JA, Thaler M, Zagra L, Khanduja V, Haddad FS. Advances and innovations in total hip arthroplasty. *SICOT-J*. 2021;7. PMID: 33843582
35. Tokgöz E. Preexisting conditions leading to total hip arthroplasty. In *Total hip arthroplasty: Medical and biomedical engineering and science concepts 2022* Oct 20 (pp. 25–43). Cham: Springer International Publishing.

# Clinical Guideline Revision History/Information

Original Date: June 30, 2021		
Review History		
Version 2	10/6/2023	
Version 3	7/18/2024	Updated language regarding conservative treatment.
Version 4	2/20/2025	<p>Annual policy review &amp; restructure:</p> <ul style="list-style-type: none"> <li>● Improved and expanded references</li> <li>● Updated CPT codes</li> <li>● Updated recommended clinical approach to the current format.</li> <li>● Medical evidence section updated to align with current literature and professional society guidance.</li> <li>● Updated conservative care language to better reflect current standard language</li> <li>● Reordered indications to place total hip arthroplasty first</li> <li>● Conservative care updated to current standard internal language.</li> <li>● Fracture indications for THA expanded.</li> <li>● Modified steroid injection language for clarity.</li> <li>● Conservative care language modified to reflect non-opioid pain control.</li> </ul>