Cohere Medical Policy -
Hip Arthroplasty (Partial, Total, or Revision)

Clinical Guidelines for Medical Necessity Review

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This policy was reviewed by AAOS prior to publication.

Important Notices

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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: [**X**] Adult (18+ yo) | [**X**] 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.[1-4]

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[1-4]:
      - **ANY** of the following:
        - ◆ Failure of conservative management for greater than 3 months, including **ALL** of the following[2,4]:
          - 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)[2,4]; **AND**

- Physical therapy or physician-directed exercise program[5]; **AND**
- **ANY** of the following:
  - Corticosteroid injection if medically appropriate[2,4]; **OR**
  - Documentation that corticosteroid injection is contraindicated[2,4]; **OR**

◆ Documentation indicating that conservative, non-surgical management would be ineffective or counterproductive, including **ANY** of the following[2,4]:

- 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)[3,4]; **AND**

○ Radiograph shows **ANY** of the following evidence of osteoarthritis of the hip[1,4,6]:

◆ Joint space narrowing (less than 50%) with marginal osteophytes or subchondral sclerosis[1,4,6]; **OR**

◆ Collapsed femoral head with marginal osteophytes or subchondral sclerosis[1,4,6]; **OR**

◆ Joint space narrowing (greater than 50%)[1,4,6]; **OR**

◆ Complete joint space loss[1,4,6]; **OR**

- Malignancy involving bones or soft tissues of the pelvis or proximal femur[1,3]; **OR**
- Aseptic necrosis of the femoral head[1,3]; **OR**
- Displaced femoral neck fracture[2,3]; **OR**
- Non-union or malunion fracture of the femoral neck[2,3]; **OR**

- Acute fracture of the femoral head or neck that is untreatable with open reduction and internal fixation (ORIF)[2]; **OR**
- Fracture dislocation of the hip untreatable with ORIF[1,2]; **OR**

◆ The procedure is a **partial hip arthroplasty (hip hemiarthroplasty),** and **ANY** of the following is **TRUE**[2,7,8]:
- Displaced femoral head or neck fracture[7,8]; **OR**
- Acute fracture of the femoral head or neck that is untreatable with open reduction and internal fixation (ORIF)[2]; **OR**
- Avascular necrosis of the femoral head[1,2]; **OR**
- Non-union fracture of the femoral neck[1,2]; **OR**
- Degenerative arthritis of the femoral head only in which the acetabulum does not need replacement[1,2]; **OR**

◆ The procedure is a **revision of prior arthroplasty** and **ALL** of the following are **TRUE**[1,9,10]:
- The patient has significant hip pain[1,9,10]; **AND**
- The patient has **ANY** of the following:
  - Surgical management of total joint infection[1,9,10]; **OR**
  - Instability[1,9,10]; **OR**
  - Loosening of the prosthesis[1,9,10]; **OR**
  - Failure of the prosthesis[1,9,10]; **OR**
  - Periprosthetic fracture[1,9,10]; **OR**
  - Recurrent or irreducible hip dislocation[1,9,10]; **OR**
  - Tissue or systemic reaction to implant[1,9,10]; **OR**
  - Clinically significant leg-length inequality not amenable to conservative management.[1,9,10]

Non-Indications

➔ **Hip arthroplasty (partial, total, or revision)** is not considered appropriate if **ANY** of the following are **TRUE**[1,2,4]:
- ◆ Skeletal immaturity[11]; **OR**
- ◆ Active infection[1,2,4]; **OR**
- ◆ Rapidly progressive neurological disease, unless a concomitant displaced femoral neck fracture is present[1,2,4]; **OR**
- ◆ Absence or relative insufficiency of abductor musculature[1,2,4]; **OR**
- ◆ Neuropathic/neurotrophic arthritis.[1,2,4]

Level of Care Criteria

Inpatient or Outpatient

Procedure Codes (CPT/HCPCS)

CPT/HCPCS Code	Code Description/Definition
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.[7]

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.[12]

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.[2] 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.[2] *Management of Osteoarthritis of the Hip*, adopted in 2023, provides a robust set of clinical indications for surgical management of osteoarthritis, including hip arthroplasty.[4] 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.[4] 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.[13] 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.[14,15] 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.[16-19] Other ongoing research interrogates the impacts that biological sex, race, and socioeconomic status have on hip arthroplasty utilization and outcomes.[21-25]

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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	Annual policy review & restructure: • Improved and expanded references • Updated CPT codes • Updated recommended clinical approach to the current format. • Medical evidence section updated to align with current literature and professional society guidance. • Updated conservative care language to better reflect current standard language • Reordered indications to place total hip arthroplasty first • Conservative care updated to current standard internal language. • Fracture indications for THA expanded. • Modified steroid injection language for clarity. • Conservative care language modified to reflect non-opioid pain control.