

Medical Coverage Policy | Total Joint Arthroplasty – Hip and Knee



EFFECTIVE DATE: 08|01|2017
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OVERVIEW

Joint replacement surgery, also known as arthroplasty, has proved to be an important medical advancement. Arthroplasty surgery is most commonly performed for diseases that affect the function of the hip joint and knee joint, but is also performed on ankles, shoulders, and phalanges. In addition, the arthroplasty may be total (involving the entire joint) or partial (involving less than the entire joint).

This policy is applicable to BlueCHiP for Medicare only and addresses only total hip and knee replacement surgery.

The criteria in this policy is not to be applied for unicompartmental knee replacement surgery. Failed previous unicompartmental joint replacement is an indication for performing a total knee arthroplasty.

For Commercial products, please refer to the following policy: Preauthorization via Web-Based Tool for Procedures

MEDICAL CRITERIA

BlueCHiP for Medicare

Total Knee Arthroplasty (TKA)

TKA is considered reasonable and necessary for individuals with **one or more** of the following:

1. Advanced Joint disease as demonstrated by meeting all of the following (a,b,c):
 - a. The joint disease is evidenced by conventional radiography, or magnetic resonance imaging (MRI);

Arthritis of the knee is supported by X-ray or MRI. The X-ray or MRI should demonstrate one of the following:

 - Subchondral cysts,
 - Subchondral sclerosis,
 - Periarticular osteophytes,
 - Joint subluxation,
 - Joint space narrowing,
 - Avascular necrosis, or
 - Bone-on-bone articulations
 - b. Pain or functional disability attributable to the advanced joint disease. The extent to which pain or functional disability interferes with **one** of the following:
 - Activities of daily living (ADLs) functional disability, including, but are not limited to, dressing, feeding, toileting, grooming, physical ambulation (including balance/risk of falls), and bathing.
 - Increases with activity or increases with weight bearing.
 - c. Unsuccessful non-surgical medical management, when appropriate, and attempted for a minimum of 3 months. (When non-surgical medical management is not appropriate, the medical record must clearly document the basis for that conclusion.) Clinically appropriate non-surgical medical management typically includes **one or more** of the following:

- Anti-inflammatory medications and/or analgesics; and/or
 - Flexibility and muscle strengthening exercises; and/or
 - Supervised physical therapy; and/or
 - Assistive device use; and/or
 - Reasonable activity restrictions; and/or
 - Weight reduction as appropriate; and/or
 - Therapeutic injections into the joint as appropriate
2. Failure of a previous osteotomy; or
 3. Distal femur fracture; or
 4. Malignancy of the distal femur, proximal tibia, knee joint or adjacent soft tissues; or
 5. Failure of previous unicompartmental knee replacement; or
 6. Avascular necrosis of the knee; or
 7. Proximal tibia fracture

Replacement/Revision Knee Arthroplasty

Replacement/revision knee arthroplasty is considered reasonable and necessary for individuals with **one or more** of the following:

- Loosening of one or more component; or
- Fracture or mechanical failure of one or more components, or
- Infection, or
- Periprosthetic fracture of distal femur, proximal tibia or patella, or
- Progressive or substantial periprosthetic bone loss, or
- Bearing surface wear with symptomatic synovitis, or
- Implant or knee misalignment, or
- Knee stiffness/arthrofibrosis, or
- Tibiofemoral instability, or
- Extensor mechanism instability

Total Hip Arthroplasty (THA)

THA is considered reasonable and necessary for individuals with **one or more** of the following:

1. Advanced Joint disease as demonstrated by meeting all of the following (a,b,c):
 - a. Arthritis of the hip is supported by X-ray or MRI. The X-ray or MRI should demonstrate **one** of the following:
 - Subchondral cysts,
 - Subchondral sclerosis,
 - Periarticular osteophytes,
 - Joint subluxation,
 - Joint space narrowing,
 - Avascular necrosis, or
 - Bone on bone articulations
 - b. Pain or functional disability attributable to the advanced joint disease. The extent to which pain or functional disability interferes with **one** of the following
 - ADLs functional disability, including, but are not limited to, dressing, feeding, toileting, grooming, physical ambulation (including balance/risk of falls), and bathing.
 - Increases with activity or increases with weight bearing.
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- c. Unsuccessful non-surgical medical management, when appropriate, and attempted for a minimum of 3 months. (When non-surgical medical management is not appropriate, the medical record must clearly document the basis for that conclusion.) Clinically appropriate non-surgical medical management typically includes **one or more** of the following:
 - Anti-inflammatory medications and/or analgesics; and/or
 - Flexibility and muscle strengthening exercises; and/or
 - Supervised physical therapy; and/or
 - Assistive device use; and/or
 - Reasonable activity restrictions; and/or
 - Weight reduction as appropriate; and/or
 - Therapeutic injections into the joint as appropriate
2. Malignancy of the joint involving the bones or soft tissues of the pelvis or proximal femur; or
3. Avascular necrosis (osteonecrosis of femoral head); or
4. Fracture of the femoral neck; or
5. Acetabular fracture; or
6. Non-union or failure of previous hip fracture surgery; or
7. Mal-union of acetabular or proximal femur fracture

Replacement/Revision Hip Arthroplasty

Replacement/revision hip arthroplasty is considered reasonable and necessary for individuals with **one or more** of the following:

- Loosening of one or both components; or
 - Fracture or mechanical failure of the implant; or
 - Recurrent or irreducible dislocation; or
 - Infection; or
 - Treatment of a displaced periprosthetic fracture; or
 - Clinically significant leg length inequality not amenable to conservative management; or
 - Progressive or substantial bone loss; or
 - Bearing surface wear leading to symptomatic synovitis or local bone or soft tissue reaction;
- or
- Clinically significant audible noise; or
 - Adverse local tissue reaction.

Bilateral Surgery

When bilateral TKA or bilateral THA is performed, the criteria listed above and documentation requirements above apply to the each joint upon which surgery is performed.

PRIOR AUTHORIZATION

Prior authorization is required for BlueChip for Medicare via the online tool for participating providers. See the Related Policies section.

POLICY STATEMENT

BlueCHiP for Medicare

Total Joint Arthroplasty is medically necessary when the criteria above have been met.

COVERAGE

Benefits may vary between groups and contracts. Please refer to Evidence of Coverage for applicable surgery benefit/coverage.

BACKGROUND

Total Knee Arthroplasty (TKA)

The knee joint includes the lower end of the femur, the upper end of the tibia and the patella. The knee joint has three compartments, the medial, the lateral and the patellofemoral. The surfaces of these compartments are normally covered with articular cartilage and are bathed in synovial fluid. The most common reason for knee arthroplasty is arthritis of the knee joint. Arthritis may cause pain, stiffness, or other symptoms which limit normal activities such as walking, squatting, and climbing stairs. Additional indications for knee arthroplasty include osteonecrosis, malignancy, and other degenerative conditions. The goal of knee arthroplasty is to relieve pain and improve or increase patient function.

Total Hip Arthroplasty (THA) (TKA)

The hip joint is made up of two components: a ball (femoral head) and socket (acetabulum). These components are covered with articular cartilage and are bathed in synovial fluid produced by a synovial membrane. Hip arthroplasty is most often performed due to symptoms arising from arthritis, osteonecrosis, malignancy, and degenerative conditions. The goal of hip arthroplasty is to relieve pain and improve or increase patient function.

Revision Arthroplasty

Revision arthroplasty is performed on an individual who has had a prior hip or knee arthroplasty. Revision arthroplasty may be needed when pain or other symptoms occur as a result of failure of the prior surgery. Failure may occur as a result of infection of the joint, bone loss in the structures supporting the prosthesis, fracture, aseptic loosening of the components, wear of the prosthetic components, and for other reasons.

CODING

BlueCHiP for Medicare

The following codes are medically necessary when the medical criteria has been met:

Hip

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

Knee

27447 Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)

27486 Revision of total knee arthroplasty, with or without allograft; 1 component

27487 Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component

RELATED POLICIES

Preauthorization via Web-Based Tool for Procedures

PUBLISHED

Provider Update January 2019

Provider Update August 2017

REFERENCES

1. Other MAC LCDs; Palmetto GBA Local Coverage Determination DL33050 for Total Joint Arthroplasty; Noridian Healthcare Solutions, LLC LCD L33494, Total Joint Arthroplasty; and First Coast Service Options, Inc. LCD L32078 for Major Joint Replacement (Hip and Knee); whose sources include:
2. Ackerman IN, Bennell KL, Osbourne RH, et al. Decline in health-related quality of life reported by more

than half of those waiting for joint replacement surgery: a prospective cohort study. *BMC Musculoskeletal Disorders*. 2011;12:108

3. Agency for Healthcare Research and Quality (AHRQ). [TotalJoint](#)

4. Dennis DA, Berry DJ, Engh G. AAOS Symposium: Revision total knee Arthroplasty. *Journal of the American Academy of Orthopaedic Surgeons*. 2008;16(8):442-454.

5. Emedicine. [Total Knee Arthroplasty](#) Accessed 9/9/2014.

6. Feeley BT, Gallo RA, Sherman S, Williams RJ. Management of osteoarthritis of the knee in the active patient. *Journal of the American Academy of Orthopaedic Surgeons*. 2010;18(7):406-416.

7. InterQual® 2011 Procedures Adult Criteria, Total Joint Replacement, Knee and Hip & Removal and Replacement, Total Joint Replacement Knee and Hip. McKesson Corporation.

8. Milliman Care Guidelines® 2011. Inpatient and Surgical Care 15th Edition. Knee Arthroplasty and Hip Arthroplasty. Milliman Care Guidelines LLC.

9. O'Connor M. Implant Survival, knee function and pain relief after TKA: Are there differences between men and women? *Clinical Orthopaedics & Related Research*. 2011;469(7):1846-1851.

10. Orthopedic Connection (2013) [Total Knee Replacement](#) Accessed 9/9/2014.

11. Richmond J, Hunter D, Irrgang J, et al. Treatment of osteoarthritis of the knee (non-arthroplasty). *J Amer Acad Orthop Surg*. 2009;17(9):591-600.

12. U.S. National Library of Medicine, [National Institute of Health. Hip joint replacement](#) Accessed 9/9/2014.

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