Kaiser Foundation Health Plan

Clinical Policy for Medical Necessity Criteria for Hip Arthroplasty

Department: Orthopedic Surgery	**Effective:** 6/2/2026
Policy #: NCP 17	**Last Reviewed:** 6/2/2026

Overview/Definitions

Medical necessity criteria and policy are applied only after member eligibility and benefit coverage is determined. Questions concerning member eligibility and benefit coverage need to be directed to Membership Services.

Coverage Determinations

Contractor	Determination Name/Number	Revision Date
For Medicare Members		
NCD	None	
LCD- Noridian Healthcare Solutions, LLC	L34163 "Total Hip Arthroplasty" Policy 17.1 does not apply to Medicare lines of business. Use the criteria in the LCD for Medicare Members.	11/06/2025
For Medicaid Members		
OR Medicaid	This policy does not apply.	
WA Medicaid	This policy does not apply.	
Commercial and Self-Funded Plans		
OR Commercial	This policy applies	
WA Commercial	This policy applies	
Self-funded Plans	This policy applies	

Clinical Indications for Non-Medicare Members

Total Hip Arthroplasty may be considered medically necessary ALL the following are met:

1) Pain and functional disability that interferes with Activities of Daily Living (ADL's) due to osteoarthritis, rheumatoid arthritis, avascular necrosis, or post-traumatic arthritis of the hip joint; AND

2) Limited range of motion (ROM), antalgic gait, and pain with passive ROM on physical examination; AND ONE of the following:

- Advanced joint disease as demonstrated by ALL the following:
  - Radiographic or imaging evidence in the last 12 months showing moderate to severe osteoarthritis; X-Ray findings should show at least ONE of the following:
    - Subchondral cysts or sclerosis; or
    - Periarticular osteophytes; or
    - Joint subluxation; or
    - Bone-on-Bone articulation; or
    - Moderate to severe joint space narrowing; or
    - Tonnis Grade 2 or 3 osteoarthritis (meaning cysts in femoral head or acetabulum, narrowing of joint space, lost sphericity of femoral head or avascular necrosis)
  - Documentation of the failure of non-surgical conservative management as shown by ALL of the following (If conservative management is not appropriate the medical record must clearly document why it's not medically reasonable):
    - Continuous use of Anti-inflammatory medication for a minimum of 6 weeks, including BOTH of the following, unless contraindicated:
      - Acetaminophen
      - Non-Steroidal anti-inflammatory drugs (oral preferred to topical unless contraindicated)
    - Trial of at least 3 Physical Therapy sessions in the last 12 months OR documentation that either:
      - Pain is so severe that Physical Therapy is not possible; OR
      - Patient has severe functional limitations to participating in Physical Therapy
  - BMI < 35: if BMI is > 40, optimization efforts must include ALL the following:

        - Documentation demonstrating active attempts towards weight loss as shown by sustained weight loss over 3-6 months
        - Documentation of stagnant weights despite documented active participation in a weight loss or exercise program
        - If optimization attempts are unsuccessful, the surgeon and patient may proceed if there is documentation of understanding of the risks through shared decision making. However, BMI > 40 is a relative contraindication. Despite not achieving this BMI, if the provider has documented adequate efforts to improve these parameters, the case will be reviewed on a case-by-case basis by a medical director.

    - If diabetic the HbgA1c < 7.5 (with the presence of of heart disease, no lower than 7.5), if A1C > 7.5 the following must be documented:
        - Must be involved with active medical management pre and post operatively

- Avascular Necrosis (AVN) as evidence by radiographic/imaging evidence showing AVN/bone infarct
- Inflammatory Arthritis (may include Rheumatoid Arthritis, Psoriatic Arthritis, Spondyloarthopathy, Gout/Pseudogout, Lupus, Non-DJD Arthritis, Hemophillia-related Arthritis, among others) as demonstrated by ALL the following:
    - Patient is actively followed by a Rheumatologist and has been judged to have exhausted non-surgical options including DMARDs
    - Radiographic evidence in the last 12 months showing moderate to severe osteoarthritis, including at least ONE of the following:
        - Subchondral cysts or sclerosis; OR
        - Periarticular osteophytes; OR
        - Joint subluxation; OR
        - Bone-on-bone articulation; OR
        - Moderate to severe joint space narrowing; OR
        - Tonnis Grade 2 or 3 osteoarthritis (meaning cysts in femoral head or acetabulum, narrowing of joint space, lost sphericity of femoral head or avascular necrosis)
    - Documentation of the failure of non-surgical conservative management as shown by the following (If conservative management

is not appropriate the medical record must clearly document why it's not medically reasonable):

- Trial of at least 3 Physical Therapy sessions in the last 12 months OR documentation of why such approach is not feasible such as:
  - Rapid progression or advancement of radiographic arthritic severity; OR
  - Diagnosis of severe arthtritis or bone-on-bone arthritis on medical imaging studies; OR
  - Rapid or progressive flexion contraction; OR
  - Medical or social confounding factors that preclude the safety or feasibility of conservative treatment

- BMI < 35: if BMI is > 40, optimization efforts must include ALL the following:
  - Documentation demonstrating active attempts towards weight loss as shown by sustained weight loss over 3-6 months
  - Documentation of stagnant weights despite documented active participation in a weight loss or exercise program
  - If optimization attempts are unsuccessful, the surgeon and patient may proceed if there is documentation of understanding of the risks through shared decision making. However, BMI > 40 is a relative contraindication. Despite not achieving this BMI, if the provider has documented adequate efforts to improve these parameters, the case will be reviewed on a case-by-case basis by a medical director.

- If diabetic the HbgA1c < 7.5 (with the presence of of heart disease, no lower than 7.5), if A1C > 7.5 the following must be documented:
  - Must be involved with active medical management pre and post operatively

- Revision of previous arthroplasty as indicated by ALL of the following:
  - Patient has ANY of the following indications:
    - Aseptic loosening of one or more components confirmed by imaging; OR
    - Symptomatic synovitis or local bone or soft tissue reaction caused by bearing surface wear; OR
    - Component instability; OR

        - Peri-prosthetic fracture; OR
        - Fracture, mechanical failure, or recall of component; OR
        - Peri-prosthetic infection; OR
        - Progressive or substantial peri-prosthetic bone loss; OR
        - Recurrent or irreducible dislocation; OR
        - Recurrent, disabling pain associated with clinically significant limb-length inequality or audible noise
    - Conservative therapy is not indicated
    - BMI < 35: if BMI is > 40, optimization efforts must include ALL the following:
        - Documentation demonstrating active attempts towards weight loss as shown by sustained weight loss over 3-6 months
        - Documentation of stagnant weights despite documented active participation in a weight loss or exercise program
        - If optimization attempts are unsuccessful, the surgeon and patient may proceed if there is documentation of understanding of the risks through shared decision making. However, BMI > 40 is a relative contraindication. Despite not achieving this BMI, if the provider has documented adequate efforts to improve these parameters, the case will be reviewed on a case-by-case basis by a medical director.

    - If diabetic the HbgA1c < 7.5 (with the presence of of heart disease, no lower than 7.5), if A1C > 7.5 the following must be documented:
        - Must be involved with active medical management pre and post operatively

- Hip Arthroplasty may be considered medically necessary if ANY of the following are present:
    - Acute hip fracture by imaging (prior authorization not required when admitted through the emergency room)
    - Conversion of prior hip surgery due to progression of disease or failure, including ANY of these:
        - Previous open or closed reduction and internal fixation of the femur or acetabulum; OR
        - Intramedullary nail; OR
        - Hemiarthroplasty; OR
        - Hip resurfacing; OR

        - Hip fusion and resection arthroplasty ("Gridlestone" procedure)
    - Conservative therapy is not indicated

Exclusions

Hip Arthroplasty is not considered medically necessary due to being contraindicated in the following cases:

- Active infection of the hip joint or active systemic bacteremia
- Active skin infection within the planned surgical approach
- Unstable angina
- Dementia that interferes with successful rehabilitation
- Lack of caregiver or unsuitable home situation for rehabilitation
- Patients who are non-ambulatory at baseline

Coding

CPT Codes	Description
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

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History Details

Type	Action	Date
Review/Revised	Reviewed at UM Quality Oversight Committee	5/19/26