Medical Necessity Guidelines: Inpatient Setting for Elective Total Joint Arthroplasty; Hip and Knee

Effective: January 1, 2021

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request.	**Yes ☐ No☒**

Applies to:
COMMERCIAL Products
☒Tufts Health Plan Commercial products; Fax: 617.972.9409
☒Tufts Health Freedom Plan products; Fax: 617.972.9409
- CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

TUFTS HEALTH PUBLIC PLANS Products
☒Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax:888.415.9055
☒Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404
☒Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 857.304.6304
*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.

SENIOR Products
- Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) – Refer to the Tufts Health Plan SCO Prior Authorization List
- Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List

OVERVIEW

Providers and patients have recognized the benefits associated with procedures performed in the outpatient setting with same day discharge to home. The Centers for Medicare & Medicaid Services (CMS) have recently made decisions to remove total knee arthroplasty and total hip arthroplasty from the Medicare inpatient-only (IPO) list of procedures and allow for these procedures to be performed in an outpatient setting.
Although it is appropriate for total joint arthroplasty procedures, hip and knee, to be performed in the outpatient setting, there is a select group of patients for whom elective hip or knee arthroplasty may be more appropriately performed in the inpatient setting.

NOTE: Total hip arthroplasty and total knee arthroplasty procedures are subject to National Imaging Associates' (NIA) prior authorization requirements. Refer to Spinal Conditions Management Programs page.

CLINICAL COVERAGE CRITERIA

Tufts Health Plan will allow elective total joint arthroplasty, hip and knee, to be performed in the inpatient setting for certain groups of patients when criteria are met. The inpatient criteria for elective joint arthroplasty, hip and knee, detailed below will apply when the elective procedure is to be performed for one of the following conditions at an inpatient level of care:

- Osteoarthritis
- Post-traumatic arthritis
- Avascular necrosis (osteonecrosis), tibial plateau or femoral condyle
- Avascular necrosis (osteonecrosis), femoral head
- Nonunion or malunion, articular fracture

INPATIENT CRITERIA for ELECTIVE JOINT ARTHROPLASTY, HIP and KNEE

I. Criteria A, B C, D or E must be met:

A. Planned surgery is for removal and/or revision of initial joint prosthesis

OR

B. Planned surgery is for **bilateral** hip or knee joint replacement

OR

C. Member has ONE of the following co-morbidities and this co-morbidity increases surgical risk:

1. Moderate to severe chronic lung disease (e.g. chronic obstructive pulmonary disease, asthma, interstitial lung disease, pulmonary hypertension, respiratory failure)
2. Heart failure defined as New York Heart Association (NYHA) Classification III and IV
3. Unstable angina, with continued symptoms
4. Moderate to severe cirrhosis defined as Pugh-Child score B and C
5. Chronic kidney disease moderate-severe defined as stage G3b, End stage renal disease (ESRD)
6. History of thromboembolic event(s), history of blood clotting or bleeding disorders
7. Poorly controlled diabetes mellitus (DM), defined as A1C≥8 and/or short-term need for frequent blood sugar monitoring and adjustments in treatment
8. BMI ≥ 40 kg/m²
9. Untreated obstructive sleep apnea

OR

D. Member does not have appropriate resources to support outpatient post-operative care due to one or more of the following barriers:

1. Member lives alone and has no available caregiver
2. History of pain management difficulty
3. Impaired functional status unrelated to joint condition
4. Impaired safety awareness (e.g. cognitive, visual, speech) which may negatively impact post-operative rehabilitation at home, including compliance with post-procedure protocol

OR

E. Member is high anesthesia risk defined as American Society of Anesthesiologists Anesthesia Physical Classification System III or IV

CODES

NOTE: The following CPT code(s) are subject to National Imaging Associates' (NIA) prior authorization requirements. Refer to:
https://tuftshealthplan.com/documents/providers/guidelines/clinical-resources/spinal-conditions-management-programs

Table 1: CPT Codes

CPT Code	Description
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft
27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)

REFERENCES

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12. Courtney PM1, Froimson MI2, Meneghini RM3, Lee GC4, Della Valle CJ.Can Total Knee Arthroplasty Be Performed Safely as an Outpatient in the Medicare Population?
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APPROVAL HISTORY

September 16, 2020: Reviewed by the Integrated Medical Policy Advisory Committee

Subsequent endorsement date(s) and changes made:

- October 21, 2020: Reviewed by IMPAC, renewed without changes

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.