

Document ID#: 2143440
Subject: Total Joint Replacement, Removal/Replacement
Effective Date: January 1, 2010

Clinical Documentation and Prior Authorization Required	√	Type of Review - Case Management	
Not Covered		Type of Review – Precertification Department	√
		Administrative Process (Internal Use Only)	LPN

Note: Background, product, and disclaimer information is located at the end of this document.

Effective January 1, 2010 Tufts Health Plan will be requiring prior authorization for certain elective joint replacement procedures for members 18 and older.

In order to obtain prior authorization for these joint replacement procedures, an InterQual® SmartSheet™ for Total Joint Replacement, Removal/Replacement must be completed and faxed to the Tufts Health Plan Precertification Department at 617-972-9409.

InterQual® SmartSheets™ for this procedure are available by logging on to our web site and accessing the Prior Authorization InterQual® Criteria Link under the Clinical Resources section. If you are not a Tufts Health Plan Registered Provider, please click on the [Provider Log-in](#) and follow instructions.

PROCEDURES REQUIRING PRIOR AUTHORIZATION:

Tufts Health Plan will be using the InterQual® SmartSheet™ for the following diagnoses and associated CPT codes only:

Associated CPT Code ¹	Description/Diagnosis	Tufts Health Plan Organization Policy Note
23472, 27130, 27132, 27447	Osteoarthritis	None
23472, 27130, 27132, 27447	Avascular necrosis (osteonecrosis), humeral head, femoral head, or tibial plateau/femoral condyle	None
23472, 27130, 27132, 27447	Nonunion/malunion, articular fracture	None
23472, 27130, 27132, 27447	Rheumatoid arthritis	None
23472, 27130, 27132, 27447	Bone tumor by imaging	None
27130, 27132	Acute femoral neck fracture	None
23332, 27134, 27137, 27138, 27486, 27487, 27488	Fractured prosthesis/cement by x-ray	None
23332, 27134, 27137, 27138, 27486, 27487, 27488	Dislocation 2 or more episodes by x-ray	None
23332, 27134, 27137, 27138, 27486, 27487, 27488	Worn/dislocated plastic insert by x-ray; malposition of acetabular or femoral component	None
23332	Humeral component valgus/varus greater than 30 degrees by x-ray	None
23332, 27134, 27137, 27138, 27486, 27487, 27488	Loosening of prosthesis/cement	None
23332, 27134, 27137, 27138, 27486,	Joint infection within 12 weeks of joint	None

27487, 27488	replacement	
23332, 27134, 27137, 27138, 27486, 27487, 27488	Joint infection greater than 12 weeks post joint replacement	None
27134, 27137, 27138	Thigh pain with uncemented component	None

¹ A complete description of the associated CPT codes is included within this Medical Necessity Guideline

Codes

The following CPT codes require prior authorization:

Code	Description
23332	Removal of foreign body, shoulder; complicated (e.g., total shoulder)
23472	Arthroplasty, total shoulder (glenoid and proximal humeral replacement (e.g., total shoulder))
27130	Total Hip Replacement
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
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; one component
27487	Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component
27488	Removal of prosthesis, including total knee prosthesis, methylmethacrylate with or without insertion of spacer, knee

Approval History

Reviewed by the Medical Affairs Medical Policy Committee on June 6, 2009 for January 1, 2010 effective date.

Subsequent Endorsement Date(s) and Changes Made

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for Tufts Health Plan benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. Tufts Health Plan makes 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, but 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 the Tufts Health Plan service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. Tufts Health Plan revises and updates Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

Medical Necessity Guidelines apply to all fully insured Tufts Health Plan products unless otherwise noted in this guideline or the Member's benefit document. This guideline does not apply to Tufts Health Plan Medicare Preferred or to certain delegated service arrangements. 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. Applicable state or federal mandates will take precedence. Providers in the New Hampshire service area are subject to CIGNA HealthCare's provider arrangement for the purpose of CareLinkSM.

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.