

2016 Procedures Criteria

PATIENT:	Name	DOB	ID#	GROUP#
	Facility		Service Date	
PROVIDER:	Name		Fax#	Phone#
	Signature		Date	NPI/ID#

ICD-9:

ICD-10:

CPT®:

Subset: Total Joint Replacement (TJR), Hip^(1, 2, 3, 4, 5, 6, 7, 8, 9)**Requested Service:** Total Joint Replacement (TJR), Hip**Age:** Age ≥ 18**INSTRUCTIONS:** Choose one of the following options and continue to the appropriate section

10. Acute hip fracture by imaging
20. Avascular necrosis (osteonecrosis), femoral head
30. Bone tumor involving hip by imaging
40. Nonunion or malunion, articular fracture
50. Osteoarthritis or posttraumatic arthritis
60. Rheumatoid arthritis

 10. Acute hip fracture by imaging

1. Choose one:

- A) Comminuted or impacted acetabular fracture
- B) Displaced femoral head or neck fracture⁽¹⁰⁾
- C) Intertrochanteric or subtrochanteric fracture⁽¹¹⁾
- D) Arthritis of acetabulum or femoral head by imaging⁽¹²⁾
- E) Other clinical information (add comment)

- If option A or B selected, then go to question 2
- If option C selected, then go to question 3
- If option D selected, then go to question 4
- No other options lead to the requested service

2. Active infection⁽¹³⁾

- Yes
- No

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10. Acute hip fracture by imaging (*Continued...*)

- If option No selected, then the rule is satisfied; you may stop here (*Inpatient*)
- No other options lead to the requested service

3. Choose all that apply:

- A) Repair failed or not feasible
- B) No active infection⁽¹³⁾
- C) Other clinical information (add comment)

- If the number of options selected is 2 and option C not selected, then the rule is satisfied; you may stop here (*Inpatient*)
- No other options lead to the requested service

4. Arthritis by imaging, Choose all that apply:⁽¹⁴⁾

- A) Subchondral cysts
- B) Subchondral sclerosis
- C) Marginal erosions
- D) Periarticular osteophytes
- E) Periarticular osteopenia
- F) Joint subluxation
- G) Joint space narrowing
- H) Other clinical information (add comment)

- If 2 or more options A, B, C, D, E, F or G selected and option H not selected, then go to question 2
- No other options lead to the requested service

 20. Avascular necrosis (osteonecrosis), femoral head

1. Choose all that apply:

- A) Pain increased with initiation of activity
- B) Pain increased with weight bearing
- C) Pain interferes with ADLs
- D) Pain with ROM⁽¹⁵⁾
- E) Other clinical information (add comment)

- If 2 or more options A, B, C or D selected and option E not selected, then go to question 2
- No other options lead to the requested service

2. Choose all that apply:

- A) Limited ROM⁽¹⁶⁾
- B) Antalgic gait⁽¹⁷⁾
- C) Other clinical information (add comment)

20. Avascular necrosis (osteonecrosis), femoral head (*Continued...*)

- If 1 or more options A or B selected and option C not selected, then go to question 3
- No other options lead to the requested service

3. Avascular necrosis by imaging

- Yes
 No

- If option Yes selected, then go to question 4
- No other options lead to the requested service

4. Stage III or IV collapse of femoral head⁽¹⁸⁾

- Yes
 No

- If option Yes selected, then go to question 5
- If option No selected, then go to question 6

5. Active infection⁽¹³⁾

- Yes
 No

- If option No selected, then the rule is satisfied; you may stop here (*Inpatient*)
- No other options lead to the requested service

6. Treatment within last year, Choose all that apply:⁽¹⁹⁾

- A) NSAIDs or acetaminophen \geq 3 weeks⁽²⁰⁾
 B) PT or home exercise \geq 12 weeks⁽²¹⁾
 C) Activity modification \geq 12 weeks
 D) Other clinical information (add comment)

- If the number of options selected is 3 and option D not selected, then go to question 7
- No other options lead to the requested service

7. Choose all that apply:

- A) Continued symptoms or findings after treatment
 B) No active infection⁽¹³⁾
 C) Other clinical information (add comment)

- If the number of options selected is 2, then the rule is satisfied; you may stop here (*Inpatient*)
- No other options lead to the requested service

 30. Bone tumor involving hip by imaging

1. Active infection⁽¹³⁾

- Yes
 No

- If option No selected, then the rule is satisfied; you may stop here (*Inpatient*)
 - No other options lead to the requested service
-

 40. Nonunion or malunion, articular fracture

1. Choose all that apply:

- A) Symptomatic nonunion or malunion of fracture by imaging
 B) No active infection⁽¹³⁾
 C) Other clinical information (add comment)

- If the number of options selected is 2 and option C not selected, then the rule is satisfied; you may stop here (*Inpatient*)
 - No other options lead to the requested service
-

 50. Osteoarthritis or posttraumatic arthritis

1. Choose all that apply:

- A) Pain increased with initiation of activity
 B) Pain increased with weight bearing
 C) Pain interferes with ADLs
 D) Pain with ROM⁽¹⁵⁾
 E) Other clinical information (add comment)

- If 2 or more options A, B, C or D selected and option E not selected, then go to question 2
 - No other options lead to the requested service
-

2. Choose all that apply:⁽²²⁾

- A) Limited ROM⁽¹⁶⁾
 B) Antalgic gait⁽¹⁷⁾
 C) Other clinical information (add comment)

- If the number of options selected is 2 and option C not selected, then go to question 3
 - No other options lead to the requested service
-

3. Bone-on-bone contact by imaging⁽²³⁾

- Yes
 No

50. Osteoarthritis or posttraumatic arthritis (*Continued...*)

- If option Yes selected, then go to question 4
- If option No selected, then go to question 5

4. Active infection⁽¹³⁾

- Yes
- No

- If option No selected, then the rule is satisfied; you may stop here (*Inpatient*)
- No other options lead to the requested service

5. Arthritis by imaging, Choose all that apply:⁽²⁴⁾

- A) Subchondral cysts
- B) Subchondral sclerosis
- C) Periarticular osteophytes
- D) Joint subluxation
- E) Joint space narrowing
- F) Other clinical information (add comment)

- If 2 or more options A, B, C, D or E selected and option F not selected, then go to question 6
- No other options lead to the requested service

6. Treatment within last year, Choose all that apply:^(25, 26)

- A) NSAIDs or acetaminophen \geq 3 weeks⁽²⁷⁾
- B) PT or home exercise \geq 12 weeks^(28, 21)
- C) Activity modification \geq 12 weeks
- D) Other clinical information (add comment)

- If the number of options selected is 3 and option D not selected, then go to question 7
- No other options lead to the requested service

7. Choose all that apply:

- A) Continued symptoms or findings after treatment
- B) No active infection⁽¹³⁾
- C) Other clinical information (add comment)

- If the number of options selected is 2, then the rule is satisfied; you may stop here (*Inpatient*)
- No other options lead to the requested service

 60. Rheumatoid arthritis

1. Choose all that apply:

60. Rheumatoid arthritis (*Continued...*)

- A) Pain increased with initiation of activity
- B) Pain increased with weight bearing
- C) Pain interferes with ADLs
- D) Pain with ROM⁽¹⁵⁾
- E) Pain at night
- F) Other clinical information (add comment)

- If 2 or more options A, B, C, D or E selected and option F not selected, then go to question 2
- No other options lead to the requested service

2. Choose all that apply:⁽²²⁾

- A) Limited ROM⁽¹⁶⁾
- B) Antalgic gait⁽¹⁷⁾
- C) Other clinical information (add comment)

- If the number of options selected is 2 and option C not selected, then go to question 3
- No other options lead to the requested service

3. Arthritis by imaging, Choose all that apply:

- A) Subchondral cysts
- B) Marginal erosions
- C) Periarticular osteopenia
- D) Joint space narrowing
- E) Joint subluxation
- F) Other clinical information (add comment)

- If 2 or more options A, B, C, D or E selected and option F not selected, then go to question 4
- No other options lead to the requested service

4. Treatment within last year, choose all that apply:⁽¹⁹⁾

- A) Disease modifying antirheumatic drugs (DMARDs) \geq 12 weeks⁽²⁹⁾
- B) PT or home exercise \geq 12 weeks^(30, 21)
- C) Activity modification \geq 12 weeks
- D) Other clinical information (add comment)

- If the number of options selected is 3 and option D not selected, then go to question 5
- No other options lead to the requested service

5. Choose all that apply:

- A) Continued symptoms or findings after treatment
- B) No active infection⁽¹³⁾
- C) Other clinical information (add comment)

60. Rheumatoid arthritis (*Continued...*)

- If the number of options selected is 2, then the rule is satisfied; you may stop here (*Inpatient*)
 - No other options lead to the requested service
-

Notes

(1)

I/O Setting: Inpatient

(2)

These criteria include the following procedure:

Arthroplasty, Total, Hip

(3)

Def: Arthroplasty is the surgical reconstruction or replacement of a painful, damaged joint due to degeneration (e.g., arthritis), trauma, or deformity.

(4)

Total knee replacements, total hip replacements, and unicondylar replacements can be done using a minimally invasive technique. More research is needed to study the short- and long-term outcomes of these approaches, including the potential risks and benefits, compared to traditional replacement techniques (Smith et al., *Int Orthop* 2011, 35: 173-84; Hernandez-Vaquero et al., *BMC Musculoskelet Disord* 2010, 11: 27; Khanna et al., *Orthop Clin North Am* 2009, 40: 479-89, viii).

(5)

Hip resurfacing has emerged as an alternative to total joint replacement for younger, more athletic patients because it preserves bone stock and reportedly allows a return to higher levels of activity. A review of current surgical trends in hip arthroplasty has reported high level of satisfaction with functional outcome with this procedure; however, unresolved issues include a greater risk of femoral neck fracture, metal ion release, and an increased revision rate with metal-on-metal hip resurfacing (Marshall et al., *Clin Orthop Relat Res* 2014, 472: 2217-30).

(6)

Although initial studies have shown favorable outcomes for the use of computer-assisted and robotic techniques in knee and hip arthroplasty, further research is needed to determine the advantages and cost-effectiveness of these approaches (Bar et al., *Acta Orthop Traumatol Turc* 2011, 45: 185-9; Reininga et al., *BMC Musculoskelet Disord* 2010, 11: 92).

(7)

Increased body mass index (BMI) is associated with a higher risk of wound complications, the need for revisional surgery, and a slower recovery rate; however, multiple studies have shown that patients have overall improved function and decreased pain after total hip replacement, irrespective of BMI, suggesting that high BMI should not be a barrier to surgery (Carroll et al., *Clin Microbiol Infect* 2014, 20: 130-5; Wallace et al., *Osteoarthritis Cartilage* 2014, 22: 918-27). Patients with a normal BMI may report less postoperative pain and better function than those with a high BMI; however, these differences are greatly outweighed by the substantial improvements on pain and postoperative function seen across all patients following hip arthroplasty (Judge et al., *Osteoarthritis Cartilage* 2014, 22: 431-9). Interventions for weight loss should be offered to overweight patients (National Institute for Health and Care Excellence (NICE), *Osteoarthritis. Clinical Guideline 177. Feb. 2014 [cited July 2015]*).

(8)

The available literature, including systematic reviews and meta-analyses, indicates that smoking cessation starting at least 4 to 8 weeks prior to surgery reduces the risk of wound-healing complications and respiratory complications (Wong et al., *Can J Anaesth* 2012, 59: 268-79; Myers et al., *Archives of internal medicine* 2011, 171: 983-9). Despite this, current guidelines on the care and management of osteoarthritis from the National Institute for Health Care and Excellence (NICE) state that patient factors, including smoking, should not be barriers to referral for joint surgery. Patients are encouraged to quit and to participate in smoking cessation programs, which improve the outcomes of surgery and reduce the risk of surgical site infection, poor bone healing, and other postoperative complications (National Institute for Health and Care Excellence (NICE), *Osteoarthritis. Clinical Guideline 177. Feb. 2014 [cited July 2015]*). The effect of smoking on postoperative complications after joint replacement surgery remains unclear. A retrospective study using data from the national VA Surgical Quality Improvement Program investigated the impact of smoking at the time of surgery on 30-day postoperative complications after total knee and hip replacement. The study showed that smokers had a 41% increased risk of surgical site infections compared with nonsmokers. Current smokers had an increased risk for 30-day postoperative pneumonia and an increased mortality at 1 year compared with nonsmokers (Singh et al., *Arthritis Care Res (Hoboken)* 2011, 63: 1365-74).

(9)

InterQual® Procedures criteria are derived from the systematic, continuous review and critical appraisal of the most current evidence-based literature and include input from our independent panel of clinical experts. To generate the most appropriate recommendations, a comprehensive literature review of the clinical evidence was conducted. Sources searched included PubMed, Agency for Healthcare Research and Quality (AHRQ) Comparative Effectiveness Reviews, the Cochrane Library, Choosing Wisely, Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations, the National Institute of Health and Care Excellence (NICE), and the National Guideline Clearinghouse. Other medical literature databases, medical content providers, data sources, regulatory body

websites, and specialty society resources may also have been used. Relevant studies were assessed for risk of bias following principles described in the Cochrane Handbook. The resulting evidence was assessed for consistency, directness, precision, effect size, and publication bias. Observational trials were also evaluated for the presence of a dose-response gradient and the likely effect of plausible confounders.

(10)

Multiple studies have shown that patients treated with total joint replacement (TJR) after a displaced femoral neck fracture have better outcomes in comparison with hemiarthroplasty (replacing the ball but not the socket) or internal fixation. Advantages of TJR include a lower dislocation rate, improved functional outcomes (e.g., less pain, increased mobility), and longer length of time between revision surgeries (Burgers et al., *Int Orthop* 2012, 36: 1549-60; Gao et al., *Clin Orthop Relat Res* 2012, 470: 1782-91).

(11)

Unstable intertrochanteric fractures are associated with higher rates of morbidity and mortality. In the elderly, the inability to resume full weight bearing after repair of the fracture can be attributed to osteoporosis, comminution, and instability. Total hip replacement allows for early ambulation, increased stability, earlier return to previous level of function, and little risk of mechanical failure (Sidhu et al., *Int Orthop* 2010, 34: 789-92).

(12)

Total hip replacement is a definitive treatment option for hip fractures in patients with existing arthritis (Su and Su, *Bone Joint J* 2014, 96-B: 43-7).

(13)

Infection is an absolute contraindication to joint replacement unless totally eradicated. Active infection in any location may seed a new prosthesis. The infection should be aggressively treated prior to the replacement surgery with anti-infectives. Anti-infectives may be continued after the replacement to prevent reinfection of the site.

(14)

Common posttraumatic arthritis findings may include joint space narrowing, osteophytes, or subchondral sclerosis. Osteoarthritis is characterized by the formation of osteophytes, subchondral sclerosis, subchondral cysts, loose bodies, and joint space narrowing. Rheumatoid arthritis can present as subchondral cysts, marginal erosions, parietal osteopenia, joint subluxation, or joint space narrowing.

(15)

Although certain conditions are more likely to cause pain with passive ROM, patients who experience pain with either active or passive ROM should be further evaluated to rule out potential causes for the discomfort.

(16)

In the hip, internal rotation is usually the most significantly affected. External rotation and hip flexion are affected to a variable degree.

(17)

Def: An antalgic gait is a limp where weight-bearing occurs for the shortest possible time on the affected leg.

(18)

The Ficat classification is a commonly used method to stage avascular necrosis of the femoral head. It is based on both imaging and clinical features. Stage III is demonstrated by a positive x-ray with signs of collapse (e.g., crescent sign), as well as an abnormal MRI and bone scan. Hip pain is increased in Stage III, and there is more limited range of motion. Stage IV collapse demonstrates progressive loss of articular cartilage, presence of osteoarthritis, decreased joint space, and collapse of the femoral head (Beaule and Amstutz, *J Am Acad Orthop Surg* 2004, 12: 96-105).

(19)

External joint support is important adjunctive therapy in most cases. Canes, crutches, or walkers can be used to decrease weight-bearing load and alleviate symptoms. Immobilization devices (e.g., splints, taping, braces, immobilizers) can be used to restrict movement, thereby reducing pain, improving stability, and decreasing the risk of falling.

(20)

NSAIDs are preferred for pain management because of their anti-inflammatory effect; however, these drugs may be contraindicated in patients with certain medical conditions or comorbidities (e.g., pregnancy, peptic ulcer disease, decreased renal function, asthma). In these cases, acetaminophen can be used as an alternative to NSAIDs for pain management.

(21)

This criteria point includes therapy by provider instruction to the patient, as well as supervised training through formal therapy (e.g., PT, OT). Therapy may not be appropriate if symptoms have been present for a long time and exercise has been attempted previously, or if symptoms are severe on presentation. The decision to recommend a home (i.e., unsupervised) therapy program or supervised therapy is a matter of clinical judgment.

(22)

Weakness of hip abductors and flexors is a late sign of arthritis of the hip. Crepitus may also be noted but must be assessed on flexion and extension since crepitus on rotation could indicate bursitis instead of arthritis.

(23)

Surgery is appropriate for symptomatic patients with severe osteoarthritis causing bone-on-bone contact. Patients without bone-on-bone contact should try a course of medical treatment before considering if joint replacement is necessary.

(24)

Common posttraumatic arthritis findings may include joint space narrowing, osteophytes, or subchondral sclerosis. Osteoarthritis is characterized by the formation of osteophytes, subchondral sclerosis, subchondral cysts, loose bodies, and joint space narrowing.

(25)

External joint support is important adjunctive therapy in most cases. Canes, crutches, or walkers can be used to decrease weight-bearing load and alleviate symptoms. Providing patients with advice on appropriate footwear, walking aids, and assistive technologies is recommended to help reduce pain, improve stability, and decrease the risk of falling in patients with osteoarthritis (National Institute for Health and Care Excellence (NICE), Osteoarthritis. Clinical Guideline 177. Feb. 2014 [cited July 2015]).

(26)

Current guidelines recommend that accurate information, both verbal and written, be offered to all patients with osteoarthritis, and education should be an ongoing, integral part of the management plan (National Institute for Health and Care Excellence (NICE), Osteoarthritis. Clinical Guideline 177. Feb. 2014 [cited July 2015]). Evidence shows that although there may be an additional increase in cost during implementation, a combination of preoperative education and physiotherapy may lower medical costs associated with joint replacement surgery (Jordan et al., *Physiotherapy* 2014, 100: 305-12; Brooks, *Bone Joint J* 2013, 95-B: 67-9; Ibrahim et al., *Bone Joint J* 2013, 95-B: 1587-94).

(27)

Pharmacological pain management with oral or topical NSAIDs is an important adjunctive therapy in the treatment of osteoarthritis (Massey et al., *The Cochrane database of systematic reviews* 2014: CD007402). While current guidelines from the National Institute for Health Care Excellence (NICE) recommend acetaminophen or topical NSAIDs as first-line pharmacological agents over oral NSAIDs, they acknowledge that recent evidence has shown reduced efficacy of acetaminophen in the management of osteoarthritis (National Institute for Health and Care Excellence (NICE), Osteoarthritis. Clinical Guideline 177. Feb. 2014 [cited July 2015]). A patient's medical history, medications, and comorbidities should be considered when choosing appropriate pharmacological pain treatment.

(28)

Conservative therapy is first-line treatment for pain in patients with osteoarthritis. All relevant guidelines recommend exercise as core treatment for osteoarthritis of the hip and knee (McAlindon et al., *Osteoarthritis Cartilage* 2014, 22: 363-88; National Institute for Health and Care Excellence (NICE), Osteoarthritis. Clinical Guideline 177. Feb. 2014 [cited July 2015]; American Academy of Orthopaedic Surgeons (AAOS), *Treatment of Osteoarthritis of the Knee*. 2013; Fernandes et al., *Ann Rheum Dis* 2013, 72: 1125-35; Hochberg et al., *Arthritis Care Res (Hoboken)* 2012, 64: 465-74). Several systematic reviews confirm the effectiveness of exercise therapy (Anwer et al., *J Geriatr Phys Ther* 2015; Fransen et al., *Cochrane Database Syst Rev* 2015, 1: CD004376; Fransen et al., *Cochrane Database Syst Rev* 2014, 4: CD007912; Uthman et al., *BMJ* 2013, 347: f5555; Shamlivan TA et al., *Physical Therapy Interventions for Knee Pain Secondary to Osteoarthritis. Comparative Effectiveness Review No. 77*. 2012).

(29)

Disease-specific treatment should be initiated upon diagnosis. Methotrexate is the first-line disease modifying antirheumatic drug (DMARD) used for treating active rheumatoid arthritis with optimal dosage by 8 weeks. Follow-up should be provided by 3 months in anticipation of a stable medication regime within 6 months (Smolen et al., *Annals of the rheumatic diseases* 2014, 73: 492-509). Short-term glucocorticoid therapy, including intra-articular injection, can relieve pain, improve range of motion, and decrease morning stiffness while minimizing inflammation and disease progression. Combination therapy of methotrexate and biologics can improve clinical response and functional capacity in patients not responding to monotherapy (Singh et al., *Arthritis Rheumatol* 2016, 68: 1-26; Gaujoux-Viala et al., *Joint, bone, spine: revue du rhumatisme* 2014, 81: 287-97).

(30)

In a systematic review, resistance exercises for patients with rheumatoid arthritis was safe and improved muscle strength and walking performance while decreasing disability (Baillet et al., *Rheumatology* 2012, 51: 519-27). Patients with rheumatoid arthritis should, therefore, be encouraged to include simple dynamic exercises as part of their overall management regime (e.g., physio-therapy, physical therapy, diet) (Gaujoux-Viala et al., *Joint, bone, spine: revue du rhumatisme* 2014, 81: 287-97; Scottish Intercollegiate Guidelines Network (SIGN), *Management of early rheumatoid arthritis*. SIGN publication no. 123. 2011).

ICD-9 (circle all that apply): 171.3, 239.2, 714.0, 714.1, 714.2, 714.30, 714.31, 714.32, 714.33, 714.4, 715.15, 715.25, 715.35, 715.95, 716.15, 733.40, 733.42, 733.43, 733.49, 733.81, 733.82, 81.51, 820.00, 820.01, 820.02, 820.03, 820.09, 820.10, 820.11, 820.12, 820.13, 820.19, 820.20, 820.21, 820.22, 820.30, 820.31, 820.32, 820.8, 820.9, Other_____

ICD-10-CM (circle all that apply): D49.2, M05.00, M05.30, M05.60, M06.1, M06.9, M08.00, M08.3, M08.40, M12.00, M12.559, M16.10, M16.7, M16.9, M87.059, M87.08, S12.000K, S12.001K, S12.100K, S12.101K, S12.200K, S12.201K, S12.300K, S12.301K, S12.400K, S12.401K, S12.500K, S12.501K, S12.600K, S12.601K, S32.9XXK, S72.009A, S72.009B, S72.009C, S72.019A, S72.019B, S72.019C, S72.023A, S72.023B, S72.023C, S72.026A, S72.026B, S72.026C, S72.033A, S72.033B, S72.033C, S72.036A, S72.036B, S72.036C, S72.043A, S72.043B, S72.043C, S72.046A, S72.046B, S72.046C, S72.099A, S72.099B, S72.099C, S72.109A, S72.109B, S72.109C, S72.143A, S72.143B, S72.143C, S72.146A, S72.146B, S72.146C, S72.23XA, S72.23XB, S72.23XC, S72.26XA, S72.26XB, S72.26XC, S72.90XK, S72.90XM, S72.90XN, S72.90XP, S72.90XQ, S72.90XR, S82.90XK, S82.90XM, S82.90XN, S82.90XP, S82.90XQ, S82.90XR, Other_____

ICD-10-PCS (circle all that apply): 0SR90J9, 0SR90JA, 0SR90JZ, 0SRB0J9, 0SRB0JA, 0SRB0JZ, Other_____

CPT® (circle all that apply): 27090, 27091, 27130, 27132, C1776, S2118, Other_____