Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines:

Inpatient Setting for Elective Total Joint Arthroplasty; Hip and Knee

Effective: January 1, 2026

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request to the FAX numbers below	Yes ☐ No ☒
Notification Required IF REQUIRED, concurrent review may apply	Yes ☐ No ☒

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products; 800-232-0816
☒ Tufts Health Plan Commercial products; 617-972-9409

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); 888-415-9055
☒ Tufts Health Together – MassHealth Accountable Care Partnership Plans; 888-415-9055
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; 857-304-6404
☒ Tufts Health One Care – A dual-eligible product; 857-304-6304

Senior Products

☐ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); 617-972-9409
☐ Tufts Medicare Preferred HMO, (a Medicare Advantage product); 617-972-9409
☐ Tufts Medicare Preferred PPO, (a Medicare Advantage product); 617-972-9409

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

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 Evolent's prior authorization requirements. Refer to Spinal Conditions Management Programs page.

Clinical Guideline Coverage Criteria

The 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:

1. Osteoarthritis
2. Post-traumatic arthritis

3. Avascular necrosis (osteonecrosis), tibial plateau or femoral condyle
4. Avascular necrosis (osteonecrosis), femoral head
5. Nonunion or malunion, articular fracture

Inpatient Criteria for Elective Joint Arthroplasty, Hip and Knee

The Plan considers elective joint arthroplasty for hip and knee in the inpatient setting when **ONE** of the following criteria is met:

1. Planned surgery is for the removal and/or revision of initial joint prosthesis
2. Planned surgery is for **bilateral** hip or knee joint replacement
3. Member has **ONE** of the following co-morbidities that increases surgical risk
    a. Moderate to severe chronic lung disease (e.g., chronic obstructive pulmonary disease, asthma, interstitial lung disease, pulmonary hypertension, respiratory failure)
    b. Heart failure defined as New York Heart Association (NYHA) Classification III and IV
    c. Unstable angina, with continued symptoms
    d. Moderate to severe cirrhosis defined as Pugh-Child score B and C
    e. Chronic kidney disease moderate-severe defined as stage G3b, End stage renal disease (ESRD)
    f. History of thromboembolic event(s), history of blood clotting or bleeding disorders
    g. Poorly controlled diabetes mellitus (DM), defined as A1C≥8 and/or short-term need for frequent blood sugar monitoring and adjustments in treatment
    h. BMI ≥ 40 kg/m²
    i. Untreated obstructive sleep apnea
4. Member does not have appropriate resources to support outpatient post-operative care due to **ONE** of the following barriers:
    a. Member lives alone and has no available caregiver
    b. History of pain management difficulty
    c. Impaired functional status unrelated to joint condition
    d. Impaired safety awareness (e.g., cognitive, visual, speech) which may negatively impact post-operative rehabilitation at home, including compliance with post-procedure protocol
5. Member is high risk anesthesia risk defined as American Society of Anesthesiologists Anesthesia Physical Classification System III or IV

Codes

The following code(s) are subject to Evolent's prior authorization requirements:

Table 1: CPT/HCPCS Codes

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:

1. ASA Physical Classification System. ASA House of Delegates/Executive Committee. Last Amended: October 23, 2019. Accessed October 28, 2023 @ asahq.org/standards-and-guidelines/asa-physical-status-classification-system.
2. American College of Surgeons Surgical Risk Calculator accessed October 28, 2023 @ riskcalculator.facs.org/RiskCalculator/PatientInfo.jsp.
3. Bilimoria KY, Liu Y, Paruch JL, et al. Development and evaluation of the universal ACS NSQIP surgical risk calculator: a decision aid and informed consent tool for patients and surgeons. J Am Coll Surg. 2013;217(5):833-42.e423. doi:10.1016/j.jamcollsurg.2013.07.385.
4. Greenky MR, Wang W, Ponzio DY, Courtney PM. Total Hip Arthroplasty and the Medicare Inpatient-Only List: An Analysis of Complications in Medicare-Aged Patients Undergoing Outpatient Surgery. J Arthroplasty. 2019;34(6):1250-1254. doi:10.1016/j.arth.2019.02.03.

5. MLN Matters Article, MM10417, January 2018 Update of the Hospital Outpatient Prospective Payment System (OPPS) accessed at cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10417.pdf October 28, 2023.
6. Department of Health and Human Services. Centers for Medicare & Medicaid Services: 42 CFR Parts 405, 410, 412, 414, 416, 419, and 486. Federal Register; Vol. 84, No. 218:61142-61492.
7. Total Hip and Total Knee Replacement Outpatient Specifications. Manual for Joint Commission National Quality Measures (v2019A) Discharges 07-01-19 (3Q19) through 12-31-19 (4Q19).
8. Kort MP, Bemelmans YFL, et. Al. Patient selection criteria for outpatient joint arthroplasty. Knee Surg Sports Traumatol Arthrosc.Epub 2016 Apr 22.
9. Moore M, BS, Brigati D, MD, et. Al. Enhanced Selection of Candidates for Same-Day and Outpatient Total Knee Arthroplasty.
10. American Association of Hip and Knee Surgeons Position Statement on Outpatient Joint Replacement. Accessed on February 24, 2020 @ aahks.org/position-statements/outpatient-joint-replacement/.
11. Edelman A, MD, MBA Outpatient Total Knee Arthroplasty: Anesthetic Implications. Accessed October 20, 2023 @ anes-conf.med.umich.edu/conferences/pv/presentations2019/Edelman%20OutPt_Joints_PV19_Final.pdf
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?
13. Inker LA, MD, Astor BC, PhD, et. Al. KDOQI US Commentary on the 2012 KDIGO Clinical Practice Guideline for the Evaluation and Management of CKD.

Approval And Revision 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
- October 20, 2021: Reviewed by IMPAC, renewed without changes
- February 1, 2022: Template Updated
- November 16, 2022: Reviewed by MPAC, renewed without changes for THP and adopted for integration by Harvard Pilgrim Health Care (HPHC) effective January 1, 2023
- November 16, 2023: Reviewed by MPAC, renewed without changes
- November 2023: Unify name changed to One Care effective January 1, 2024
- November 21, 2024: Reviewed by MPAC, renewed without changes, effective January 1, 2025
- December 13, 2024: Reviewed and approved by the UM Committee, effective January 1, 2025
- November 19, 2025: Reviewed by MPAC for annual review, renewed without changes effective January 1, 2026
- December 2025: Administrative updates effective January 1, 2026
- December 8, 2025: Reviewed by UM Committee for annual review, renewed without changes effective January 1, 2026

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. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

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.