

Preview questionnaire: Hip replacement surgery procedure, initial

For Blue Care Network HMOSM (commercial) and BCN AdvantageSM members

For Blue Cross Medicare Plus BlueSM PPO members

Effective May 13, 2018

Hip replacement surgery procedure, initial

Members must meet medical necessity criteria. Submit prior authorization requests through the e-referral system. The submitter will receive a prompt to complete a questionnaire to determine the appropriateness of the requested service. The questions are listed below.

If all questions are answered, e-referral will either approve or pend the case. If the case pends and the plan cannot authorize it, the plan will contact the provider for additional clinical information. Authorization is not a guarantee of payment.

Payment is based on established claim edits. Compliance with this prior authorization requirement will be monitored retrospectively.

Applicable procedure codes: *27130 and *27132

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- 1.*The Joint Replacement (Hip) Questionnaire is required [Questionnaire Assessment](#).
- 2.Please attach any clinical information you would like BCBSM to consider for this request from the patients medical record up in the Case Communication field.

See below for the questions you'll encounter in the e-referral system.

Joint Replacement (Hip)

Answering the question(s) below will provide additional information needed to process your request.

You must answer each question by choosing either Yes, No, Not Applicable or another appropriate option.

Q Does the patient have a bone tumor of the hip that was identified by imaging and no active infection?

A

Possible answers: Yes No No imaging performed NA

Q Does the patient have confirmation by imaging of a nonunion fracture of the hip (where the bone fails to heal after an extended recovery period) or a malunion fracture (where the bone heals in an abnormal position) AND the patient is symptomatic?

A

Possible answers: Yes No No imaging performed NA

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See below for the questions you'll encounter in the e-referral system. (continued)

You must answer each question by choosing either Yes, No, Not Applicable or another appropriate option.

Q Did the patient have an ACUTE HIP FRACTURE AND no active infection AND ANY of the following imaging results: 1. A comminuted fracture (where the bone breaks into several pieces). 2. A buckled / impacted fracture, where the ends of the broken bones drive into each other. 3. Displaced femoral head or neck fracture. 4. Intertrochanter or subtrochanteric fracture AND repair failed or not feasible. 5. Arthritis of acetabulum or femoral head by X-ray where TWO OR MORE of the following are present: subchondral cysts, subchondral sclerosis, marginal erosions, periarticular osteophytes, periarticular osteopenia, joint subluxation or joint space narrowing?

A Possible answers: Yes No No imaging performed NA

Q Does the patient have AVASCULAR NECROSIS / OSTEONECROSIS identified by imaging AND AT LEAST TWO of the following: 1. Hip pain that increases with initiation of activity. 2. Hip pain that increases when weight is put on the leg when walking. 3. Hip pain that interferes with activities of daily living (for example, eating, bathing, dressing, toileting, walking). 4. Hip pain with range of motion (active or passive) of the hip?

A Possible answers: Yes No No imaging performed NA

Q Does the patient have AVASCULAR NECROSIS / OSTEONECROSIS identified by imaging AND EITHER limited (active or passive) range of motion OR an antalgic gait (limp where weight-bearing occurs for the shortest possible time on the affected leg)?

A Possible answers: Yes No No imaging performed NA

Q Does the patient have AVASCULAR NECROSIS / OSTEONECROSIS identified by imaging AND EITHER Stage III or IV collapse of the femoral head OR continued symptoms or findings after treatment with ALL of the following (ALL 1 thru 3): 1. NSAIDS (non-steroidal anti-inflammatory drugs) or acetaminophen for at least 3 weeks (unless contraindicated/not tolerated). 2. Physician directed home exercise, or PT for at least 12 weeks. 3. Activity modification for at least 12 weeks?

A Possible answers: Yes No No imaging performed NA

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You must answer each question by choosing either Yes, No, Not Applicable or another appropriate option.

<p>Q</p> <p>A</p>	<p>Does the patient have OSTEOARTHRITIS OR POSTTRAUMATIC ARTHRITIS AND NO infection AND AT LEAST TWO of the following: 1. Hip pain that interferes with activities of daily living (for example, eating, bathing, dressing, toileting, walking). 2. Hip pain that increases with weight bearing activity or movement 3. Hip pain that increases with initiation of activity. 4. Hip pain with EITHER active or passive range of motion of the hip?</p> <p>Possible answers: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA</p>
<p>Q</p> <p>A</p>	<p>Does the patient have OSTEOARTHRITIS OR POSTTRAUMATIC ARTHRITIS AND BOTH limited range of motion (active OR passive) of the hip AND an antalgic gait (limp where weight-bearing occurs for the shortest possible time on the affected leg)?</p> <p>Possible answers: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA</p>
<p>Q</p> <p>A</p>	<p>Does the patient have OSTEOARTHRITIS OR POSTTRAUMATIC ARTHRITIS AND bone-on-bone contact identified by imaging?</p> <p>Possible answers: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No imaging performed <input type="checkbox"/> NA</p>
<p>Q</p> <p>A</p>	<p>Does the patient have OSTEOARTHRITIS OR POSTTRAUMATIC ARTHRITIS AND AT LEAST TWO of the following X-ray findings: 1. Subchondral cysts. 2. Subchondral sclerosis. 3. Periarticular osteophytes (bone spurs). 4. Joint subluxation (dislocation). 5. Joint space narrowing?</p> <p>Possible answers: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No imaging performed <input type="checkbox"/> NA</p>
<p>Q</p> <p>A</p>	<p>Does the patient have OSTEOARTHRITIS OR POSTTRAUMATIC ARTHRITIS AND continued symptoms/findings after treatment with ALL of the following (all 1 thru 3): 1. NSAID (non-steroidal anti-inflammatory drugs) for at least 3 weeks (unless contraindicated/not tolerated). 2. EITHER home exercise OR occupational therapy or physical therapy. 3. Activity modification for at least 12 weeks?</p> <p>Possible answers: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA</p>

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You must answer each question by choosing either Yes, No, Not Applicable or another appropriate option.

Q Does the patient have RHEUMATOID ARTHRITIS AND NO active infection AND AT LEAST TWO of the following: 1. Hip pain that interferes with activities of daily living (for example, eating, bathing, dressing, toileting, walking). 2. Hip pain that increases with initiation of activity. 3. Hip pain that increases when weight is put on the leg when walking. 4. Hip pain with EITHER active or passive range of motion of the hip. 5. Hip pain at night?

A Possible answers: Yes No No imaging performed NA

Q Does the patient have RHEUMATOID ARTHRITIS AND EITHER limited range of motion (active or passive) of the hip OR an antalgic gait (limp where weight bearing occurs for the shortest possible time on the affected leg)?

A Possible answers: Yes No No imaging performed NA

Q Does the patient have RHEUMATOID ARTHRITIS AND AT LEAST TWO of the following X-ray findings: 1. Subchondral cysts. 2. Marginal erosions. 3. Periarticular osteophytes (bone spurs). 4. Joint subluxation (dislocation). 5. Joint space narrowing?

A Possible answers: Yes No NA

Q Does the patient have RHEUMATOID ARTHRITIS AND continued symptoms/findings AFTER treatment within the last year with ALL of the following (ALL 1 thru 3): 1. Disease-specific treatment for rheumatoid arthritis FOR AT LEAST 12 weeks such as disease modifying antirheumatic drugs, methotrexate, oral steroids. 2. Physician directed home exercise, or PT for at least 12 weeks. 3. Activity modification for at least 12 weeks?

A Possible answers: Yes No NA