

PHP_7.01.80 Hip Resurfacing			
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Section:	7.0 Surgery	Page:	Page 1 of 18

State Guidelines

As of the publication of this policy, there are no applicable Medi-Cal guidelines (Provider Manual or All Plan Letter). Please refer to the Policy Statement section below.

Policy Statement

In the absence of any State Guidelines, please refer to the criteria below.

- I. Metal-on-metal total hip resurfacing with a device system approved by the U.S. Food and Drug Administration (FDA) may be considered **medically necessary** as an alternative to total hip replacement when the individual has **all** of the following criteria:
 - A. Is a candidate for total hip replacement
 - B. Is likely to outlive a traditional prosthesis
 - C. Does not have a [contraindication for total hip resurfacing](#)
- II. Partial hip resurfacing with an FDA approved device may be considered **medically necessary** in individuals with osteonecrosis of the femoral head who have one or more contraindications for metal-on-metal implants and meet **all** of the following criteria:
 - A. The individual is a candidate for total hip replacement
 - B. Is likely to outlive a traditional prosthesis
 - C. The individual has known or suspected metal sensitivity or concern about potential effects of metal ions
 - D. There is no more than 50% involvement of the femoral head
 - E. There is minimal change in acetabular cartilage or articular cartilage space identified on radiography
- III. All other types and applications of hip resurfacing are considered **investigational**.

Policy Guidelines

The U.S. Food and Drug Administration (FDA) lists several contraindications for total hip resurfacing. These contraindications include, but are not limited to, the following:

- Bone stock is inadequate to support the device due to:
 - severe osteopenia or a family history of severe osteoporosis or severe osteopenia
 - osteonecrosis or avascular necrosis with more than 50% involvement of the femoral head
 - multiple cysts of the femoral head (greater than 1 cm)
- Skeletal immaturity
- Vascular insufficiency, muscular atrophy, or neuromuscular disease severe enough to compromise implant stability or postoperative recovery
- Known moderate-to-severe renal insufficiency
- Severely overweight
- Known or suspected metal sensitivity
- Immunosuppressed or receiving high doses of corticosteroids

- Individuals with childbearing potential of childbearing age due to unknown effects on the fetus of metal ion release.

A 2012 FDA advisory panel of experts identified young males with larger femoral heads as the best candidates for hip resurfacing systems. The FDA has advised that a metal-on-metal hip implant should be selected only after determining that the benefit-risk profile of using a metal-on-metal hip implant outweighs that of using an alternative hip system. Factors to consider include the individual's age, sex, weight, diagnosis, and activity level. Individuals should be informed about the benefits and risks of metal-on-metal hip implants, including the risk that the hip implant may need to be replaced. Individual expectations and the potential complications of surgery with a metal-on-metal hip implant should be discussed.

Total hip resurfacing should be performed by surgeons adequately trained and experienced in the specific techniques and devices used.

Coding

See the [Codes table](#) for details.

Description

Hip resurfacing is an alternative to total hip arthroplasty (also known as hip replacement) for patients with advanced arthritis of the hip. Total hip resurfacing describes the placement of a shell that covers the femoral head together with implantation of an acetabular cup in patients with painful hip joints. Partial hip resurfacing is considered a treatment option for avascular necrosis with collapse of the femoral head. Available prostheses are metal-on-metal devices.

Summary of Evidence

For individuals who have an indication for hip replacement who would outlive a traditional prosthesis and have no contraindication for hip resurfacing who receive a metal-on-metal total hip resurfacing device, the evidence includes randomized controlled trials (RCTs), numerous large observational studies, large registry studies, and systematic reviews. Relevant outcomes are symptoms, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related morbidity. The efficacy of total hip resurfacing performed with current techniques is similar to that for total hip arthroplasty (THA) over the short-to-medium term, and total hip resurfacing may permit easier conversion to a THA for younger patients expected to outlive their prosthesis. Based on potential ease of revision of total hip resurfacing compared with THA, current evidence supports conclusions that hip resurfacing presents a reasonable alternative for active patients who are considered too young for THA when performed by surgeons experienced in the technique. The literature on adverse events (e.g., metallosis, pseudotumor formation, implant failure) is evolving as longer follow-up data become available. Due to the uncertain risk with metal-on-metal implants, the risk-benefit ratio needs to be considered carefully on an individual basis. In addition, emerging evidence has suggested an increased risk of failure in women, possibly due to smaller implant size. Therefore, these factors should also be considered in the overall patient evaluation for total hip resurfacing, and patients should make an informed choice with their treating physicians. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have an indication for hip replacement who would outlive a traditional prosthesis and have no contraindication for hip resurfacing who receive a partial hip resurfacing device, the evidence includes a comparative study. Relevant outcomes are symptoms, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related morbidity. Although evidence has shown better outcomes with total hip resurfacing than with partial hip resurfacing, partial hip resurfacing would be appropriate in younger patients with osteonecrosis who

have contraindications for a metal-on-metal prosthesis. These factors should be considered in the overall patient evaluation for total hip resurfacing, and patients should make an informed choice with their treating physicians. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

Additional Information

Not applicable.

Related Policies

- Surgical Treatment of Femoroacetabular Impingement

Benefit Application

Blue Shield of California Promise Health Plan is contracted with L.A. Care Health Plan for Los Angeles County and the Department of Health Care Services for San Diego County to provide Medi-Cal health benefits to its Medi-Cal recipients. In order to provide the best health care services and practices, Blue Shield of California Promise Health Plan has an extensive network of Medi-Cal primary care providers and specialists. Recognizing the rich diversity of its membership, our providers are given training and educational materials to assist in understanding the health needs of their patients as it could be affected by a member's cultural heritage.

The benefit designs associated with the Blue Shield of California Promise Medi-Cal plans are described in the Member Handbook (also called Evidence of Coverage).

Regulatory Status

In 2006, the Birmingham Hip Resurfacing System (Smith & Nephew Orthopaedics), a metal-on-metal resurfacing system, was approved by the U.S. Food and Drug Administration (FDA) through the premarket approval process for use in patients requiring primary hip resurfacing arthroplasty for noninflammatory or inflammatory arthritis. This decision was primarily based on a series of 2203 patients (2385 hips) who received this device by a single surgeon in England. A number of post-approval conditions were required, including the following items:

- Study longer-term safety and effectiveness through 10-year follow-up of the first consecutive 350 cases in the 2385 hip case cohort that was part of the premarket approval.
- Study the "learning curve" and the longer-term safety and effectiveness of the Birmingham Hip Resurfacing system in the United States by studying 350 patients at up to 8 sites where clinical and radiographic data will be assessed annually through 5 years and at 10 years. Also, determine cobalt and chromium serum concentration and renal function in these patients at 1, 4, and 10 years.
- Implement a training program to provide clinical updates to investigators.

Two additional metal-on-metal hip resurfacing systems have been approved: in 2007, the Cormet™ Hip Resurfacing System (Corin) and, in 2009, the Conserve® Plus Total Hip Resurfacing System (MicroPort Orthopedics). Both implants were approved for skeletally mature patients with either: noninflammatory degenerative arthritis (e.g., osteoarthritis and avascular necrosis); or inflammatory arthritis (e.g., rheumatoid arthritis). (Note: patients with the latter arthritis might be individuals who, due to younger age or increased activity level, may not be suitable for traditional THA because it would increase the possibility of requiring ipsilateral hip joint revision.)

Various devices have been cleared for marketing by the FDA through the 510(k) process for partial hip (femoral) resurfacing. Some surgeons may be using a femoral resurfacing component together with an acetabular cup (total arthroplasty component) as an off-label application.

FDA product code: NXT.

Health Equity Statement

Blue Shield of California Promise Health Plan's mission is to transform its health care delivery system into one that is worthy of families and friends. Blue Shield of California Promise Health Plan seeks to advance health equity in support of achieving Blue Shield of California Promise Health Plan's mission.

Blue Shield of California Promise Health Plan ensures all Covered Services are available and accessible to all members regardless of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56, and that all Covered Services are provided in a culturally and linguistically appropriate manner.

Rationale

Background

Total Hip Resurfacing

Hip resurfacing is an alternative to total hip arthroplasty (THA; also known as total hip replacement) for patients with advanced arthritis of the hip. Total hip resurfacing describes the placement of a shell that covers the femoral head together with implantation of an acetabular cup. Partial hip resurfacing is considered a treatment option for avascular necrosis with collapse of the femoral head.

Total hip resurfacing has been investigated in patients with osteoarthritis, rheumatoid arthritis, and advanced avascular necrosis as an alternative to THA, particularly in young active patients who would potentially outlive a total hip prosthesis. Therefore, hip resurfacing could be viewed as a time-buying procedure to delay the need for a THA. Proposed advantages of total hip resurfacing compared with THA include preservation of the femoral neck and femoral canal, thus facilitating revision or conversion to total hip resurfacing, if required. In addition, the resurfaced head is more similar in size to the normal femoral head, thus increasing the stability and decreasing the risk of dislocation compared with THA.

Total hip resurfacing has undergone various evolutions, with modifications in prosthetic design and composition and implantation techniques. For example, similar to total hip prostheses, the acetabular components of total hip resurfacing have been composed of polyethylene. However, over time it became apparent that device failure was frequently related to the inflammatory osteolytic reaction to polyethylene debris wear particles. Metal acetabular components have since been designed to improve implant longevity. Sensitivity to wear particles from metal-on-metal chromium and cobalt implant components are of increasing concern.

Literature Review

Evidence reviews assess the clinical evidence to determine whether the use of technology improves the net health outcome. Broadly defined, health outcomes are the length of life, quality of life, and ability to function - including benefits and harms. Every clinical condition has specific outcomes that are important to patients and managing the course of that condition. Validated outcome measures are necessary to ascertain whether a condition improves or worsens; and whether the magnitude of that change is clinically significant. The net health outcome is a balance of benefits and harms.

To assess whether the evidence is sufficient to draw conclusions about the net health outcome of technology, 2 domains are examined: the relevance, and quality and credibility. To be relevant, studies must represent 1 or more intended clinical use of the technology in the intended population and compare an effective and appropriate alternative at a comparable intensity. For some conditions, the alternative will be supportive care or surveillance. The quality and credibility of the evidence depend on study design and conduct, minimizing bias and confounding that can generate incorrect findings. The randomized controlled trial (RCT) is preferred to assess efficacy; RCTs are rarely large enough or long enough to capture less common adverse events and long-term effects. Other types of studies can be used for these purposes and to assess generalizability to broader clinical populations and settings of clinical practice.

Total Hip Resurfacing

Clinical Context and Therapy Purpose

The purpose of total hip resurfacing is to provide a treatment option that is an alternative to or an improvement on existing therapies, such as conventional surgical methods, in individuals with an indication for hip replacement who are undergoing total hip arthroplasty (THA) and would potentially outlive the prosthesis.

The following PICO was used to select literature to inform this review.

Populations

The relevant population of interest is individuals with an indication for hip replacement who would outlive a traditional prosthesis and who have no contraindication for hip resurfacing. Younger, physically active individuals are the most suitable candidates for total hip resurfacing.

Interventions

The therapy being considered is total hip resurfacing. Total hip resurfacing describes the placement of a shell that covers the femoral head together with implantation of an acetabular cup. The procedure has evolved since its inception, with modifications in prosthetic design and composition, and implantation techniques.

Comparators

Comparators of interest include conventional THA.

Outcomes

The general outcomes of interest are symptoms, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related morbidity.

The existing literature evaluating total hip resurfacing has varying lengths of follow-up, up to 10 years.

Study Selection Criteria

Methodologically credible studies were selected using the following principles:

1. To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs.
2. In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
3. To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
4. Studies with duplicative or overlapping populations were excluded.

Review of Evidence

Technology Assessment

This review was informed by a Technology Evaluation Center (TEC) Assessment (2007) that evaluated studies of patients with advanced degenerative joint disease of the hip who received a total hip resurfacing device and who reported data on short- and long-term clinical outcomes, including benefits and harms, as an alternative to THA.¹ The Assessment included an RCT² and 12 uncontrolled series, along with U.S. Food and Drug Administration (FDA) premarket application submission data,³ and information from the Australian Orthopedic Association National Joint Replacement Registry.⁴ The aggregate data suggested that total hip resurfacing treated patients who do not require a revision have substantial symptomatic reductions in pain and improvements in hip function over presurgical status.

Patient Selection Criteria

Nunley et al (2009) reviewed 207 publications, most of which had little or no description of the patient population, small sample sizes, poor study designs, limited control of bias, and inadequate statistical analysis.⁵ The literature showed no clear consensus on the upper age limit for male patients, but the most commonly used criterion was age (<65 years). Nine articles suggested that female patients should be cautiously evaluated before performing hip resurfacing, especially if they are postmenopausal or have decreased bone mineral density. Some data reviewed was from the Australian Joint Replacement Registry, in which women 65 or older were observed to have a revision rate of 11% at 4 years.⁴ This was compared with men younger than 55 years of age who had a revision rate of less than 2%. Both of these cohorts (older women and younger men) have revision rates of 2% after THA. The Nunley et al (2009) review also indicated that obesity, defined as body mass index (BMI) greater than 35 kg/m², can be viewed as a relative contraindication to total hip resurfacing but not THA. Femoral head cysts, head-neck junction abnormalities, and poor bone density may also be considered risk factors for implant failure. At the time of this review, the literature on metal sensitivity and the presence of aseptic lymphocytic vasculitis-associated lesions was evolving, and the potential for transplacental transfer of metal ions was a concern for young female patients with the potential to become pregnant in the future. Reviewers concluded that the best candidates for hip resurfacing were men younger than age 65 with osteoarthritis and relatively normal bony morphology.

Total Hip Resurfacing Versus Standard Total Hip Arthroplasty Systematic Reviews

Za et al (2024) published a systematic review and meta-analysis that compared the outcomes of hip resurfacing and THA in the treatment of hip osteoarthritis.⁶ A total of 8 RCTs involving 844 patients (n=387 hip resurfacing; n=469 THA) were included. The mean follow-up was 7.72 years. No significant differences were found between groups in terms of University of California Los Angeles (UCLA) and Western Ontario and McMaster Universities Osteoarthritis Index (WOMAC) scores, revision rates, infection, aseptic loosening, or pseudotumor occurrence (all p>0.05). However, the dislocation rate was significantly lower in the hip resurfacing group (0.72% vs 4%; p=0.04). Metal ion levels were evaluated in some studies, with slightly higher chromium levels observed in THA patients postoperatively. The most common cause of revision in hip resurfacing was aseptic loosening (48%), while adverse reactions to metal debris were the leading cause in THA (30.77%).

Multiple additional qualitative systematic reviews have been published comparing total hip resurfacing to standard THA with short- to mid-term follow-up. Quesada et al (2008) reported that advantages of total hip resurfacing may include possible bone conservation on the femoral side, lower dislocation rates, more range of motion, more normal gait pattern, increased activity levels, increased ease of insertion with proximal femoral deformities or retained hardware, and straightforward revision.⁷ Possible disadvantages of resurfacing were reported to be increased difficulty performing the procedure, increased acetabular bone stock loss, femoral neck fractures, and the effects of metal ions. In their systematic review, Marker et al (2009) described 7 comparative studies that assessed "return to sports and activity" which revealed either similar outcomes for total hip resurfacing and THA procedures or advantages for the total hip resurfacing group.⁸ An additional

4 studies, 3 assessing gait and 1 assessing postural balance, revealed similar or better outcomes for total hip resurfacing than THA. In a review focused on metal-on-metal total hip resurfacing versus THA in individuals younger than 65 years (Jiang et al [2011]; 4 RCTs; N=968), hip function scores were similar between groups, although the resurfacing group showed higher activity levels.⁹ Another systematic review (18 RCTs; N=776 patients) aimed at comparing resurfacing hip arthroplasty and THA in younger patients (less than 65 years old) found that there were no statistically significant differences between hip resurfacing and THA in terms of functional outcomes, complication rates, and revision rates.¹⁰

Randomized Controlled Trials

Haddad et al (2015) published an RCT that was intended to evaluate clinical and functional outcomes of total hip resurfacing using the Birmingham system and to compare it to a cementless hip arthroplasty in patients under the age of 55 years.¹¹ Between 1999 and 2002, 80 patients were enrolled in the trial; however, only 24 consented to random allocation to treatment (11 to total hip resurfacing, 13 to THA). Eighteen patients refused total hip resurfacing and chose to undergo THA with a 32-mm bearing; 38 patients selected total hip resurfacing. The mean follow-up for all patients was about 12 years (range, 10 to 14 years). Patients were assessed clinically and radiologically at 1 year, 5 years, and 10 years. Outcome measures included Oxford Hip Score, Harris Hip Score, UCLA, and University College Hospital functional scores. No differences were observed between the 2 groups in the Oxford Hip Score, Harris Hip Score, or in the quality of life scores. At 10 years, more patients who underwent total hip resurfacing than those who underwent THA were able to run (53% vs. 19%; $p=.1$), to participate in sports activities (86% vs. 52%; $p=.09$), and perform heavy manual labor (20% vs. 13%; $p=.19$), respectively, although these outcomes were not statistically significant. Patients who had undergone total hip resurfacing exhibited significantly higher functional status scores than those who received a cementless THA at 10 years. Blood levels of cobalt and chromium ions were reported for 72 patients (49 THA, 23 total hip resurfacing); at 5- and 10-year follow-ups, all remained below a 7 parts per billion (ppb) threshold for toxicity.

Cohort Studies

Mont et al (2007) compared gait analysis in 15 patients after successful total hip resurfacing versus 15 patients who had a successful THA using a small femoral head, and with 10 patients who had osteoarthritis and 30 age and sex-matched controls from a normative database.¹² Walking speed (1.3 m/s) was faster in the total hip resurfacing group than in the THA group (1.0 m/s) or osteoarthritis group (1.0 m/s). Measurement of abductor and extension moments found that the gait of patients following total hip resurfacing was closer to normal than the gait of patients who had undergone THA.

Total Hip Resurfacing Versus Large-Head Total Hip Arthroplasty

Randomized Controlled Trials

Two controlled trials randomized patients to total hip resurfacing or THA with a large diameter metal-on-metal implant.^{13,14} Lavigne et al (2010) tested the hypothesis that the observed improvement in activity with total hip resurfacing is due to patient selection bias or to the larger femoral head with total hip resurfacing.¹³ To test this hypothesis, 48 patients were randomized to total hip resurfacing or large-head THA. The patients and evaluators at the gait laboratory were kept blinded to the type of arthroplasty until 1 year after surgery. There were no differences between groups for most of the measures at 3, 6, and 12 months postsurgery. Specifically, similar results were observed for normal and fast walking, postural evaluations, Timed Up & Go test, hop test, and hip flexor and abductor strength ratio. The total hip resurfacing group performed better during the Functional Reach Test, and the THA group completed the step test 3 seconds faster than the total hip resurfacing group. The Western Ontario and McMaster Universities Osteoarthritis Index, 36-Item Short-Form Health Survey, Merle D'Aubigne, and UCLA Activity Scores were similar in both groups.

Garbuz et al (2010) randomized 107 patients to total hip resurfacing or large-head metal-on-metal THA.¹⁴ There were no differences in the Western Ontario and McMaster Universities Osteoarthritis

Index or 36-Item Short-Form Health Survey scores for the 73 patients who had been followed for at least 1 year. However, for the subset of patients who had been tested for serum levels of cobalt and chromium, cobalt was 10-fold higher and chromium was 2.6-fold higher in the large-head metal-on-metal THA group than in the total hip resurfacing group. This was a 46-fold increase from baseline in serum cobalt and a 10-fold increase from baseline in serum chromium for the large diameter head THA group, possibly related to particulate wear at the head-neck junction. Both studies supported the hypothesis that the improved activity observed in total hip resurfacing patients is due to the larger diameter components used in resurfacing.

Revision Rates

Systematic Reviews

Jiang et al (2011) published a systematic review comparing revision rates for metal-on-metal total hip resurfacing with those for THA from 4 randomized or controlled trials with 968 patients younger than 65 years.⁹ Analysis found increased rates of revision with total hip resurfacing at 1 to 10-year follow-ups; the relative risk was 2.60. However, this analysis did not evaluate the effect of age, bearing head size, or sex on revision rates.

Another systematic review by Kumar et al (2022) compared mid- to long-term outcomes for hip resurfacing (n=304 hips) versus THA (n=308 hips) from 6 RCTs.¹⁵ Follow-up period of the studies ranged from 5 to 14 years. There was a lower overall complication rate in the total hip resurfacing group compared to THA (odds ratio [OR], 2.17; 95% confidence interval [CI], 1.21 to 3.88; p=.009). There was no significant difference in terms of revision rates found between the 2 groups (OR, 1.06; 95% CI, 0.57 to 1.99; p=.85). The overall risk of bias for included studies was deemed moderate.

A systematic review by Davey et al (2023) evaluated long-term outcomes for Birmingham hip resurfacing from 12 studies (N=7132 hips).¹⁶ The minimum follow-up period was 10 years, with a mean follow-up of 11.5 years (range, 10 to 15.3 years). The overall surgical revision rate was 4.7% at final follow-up (n=334 hips); the most commonly reported complication following the hip resurfacing procedure was peri-prosthetic fracture (0.9%; n=65).

Cohort Studies

Zuke et al (2025) evaluated the long-term outcomes of the Birmingham hip resurfacing implant in a cohort of 224 male patients under 60 years of age with osteoarthritis, following them for an average of 14 years.¹⁷ Survivorship analysis revealed excellent long-term durability, with 96.0% of implants remaining free from any revision and 97.4% free from aseptic revision at 15 years. Eight patients required revision surgery, primarily due to infection (n=3), pseudotumor formation with elevated metal ions (n=2), and femoral component loosening (n=2). Median serum cobalt and chromium levels were 1.4 ppb and 1.5 ppb, respectively, with only 2 cases of late-onset elevated metal ions requiring revision. Patient-reported outcomes were similar between the cohort of patients who received Birmingham hip resurfacing and a matched cohort of patients who received THA, with no significant differences in the modified Harris Hip Score (92.65 vs. 93.56; p=0.44) or long-term activity levels.

Azam et al (2016) published a study that evaluated long-term (minimum, 10-year follow-up) survivorship and functional outcomes of Birmingham total hip resurfacing performed by a single surgeon between 1999 and 2004 in patients with hip osteoarthritis.¹⁸ In this retrospective cohort study, revision surgery was considered the endpoint of survivorship. A total of 222 patients (244 hips) included 153 men and 69 women. At a mean follow-up of 12 years, 94% of implants were intact. In males, implant survival was 95% while in females, it was 90%. Failure was seen in 14 patients (16 hips), which included 7 (10%) female and 7 (5%) male patients. Femoral components failed due to aseptic loosening and varus collapse in 8 patients after a mean of 9.6 years. Metal allergy was reported in 3 patients (5 hips), all of whom were female; 2 of the latter had bilateral resurfacing. Other complications included femoral neck stress fractures in 2 patients and acetabular component loosening in 1 patient. The failure rate was higher in patients who received a total hip resurfacing femoral component size of 46 mm or less (10/16 hips revised).

Daniel et al (2014) reported results of a prospective cohort study on long-term implant survival from a single-surgeon series of Birmingham total hip resurfacing.¹⁹ The earliest 1000 consecutive total hip resurfacing implants comprised 335 hips (288 women) and 665 hips (598 men) of all ages and diagnoses without exclusions, who were prospectively followed with mailed questionnaires; the first 402 hips (350 patients) also had a clinical and radiologic review. The mean follow-up was nearly 14 years (range, 12 to 15 years). In total, 59 patients (68 hips) died 0.7 to 12.6 years postsurgery from unrelated causes. Thirty-eight revisions were required at 0.1 to 14 years (median, 9 years) following the operation. These included 17 femoral failures (2%) and 7 each due to infections, soft-tissue reactions, and other causes. With revision for any reason as the endpoint, Kaplan-Meier survival analysis showed 97% (95% CI, 97% to 98%) and 96% (95% CI, 95% to 96%) survival rates at 10 and 15 years, respectively. Radiologic assessment showed 11 (4%) femoral and 13 (4%) acetabular radiolucencies, and 1 (0.3%) radiologic femoral failure. Men appeared to have better implant survival rates (98%; 95% CI, 97% to 99%) at 15 years than women (92%; 95% CI, 90% to 93%); women younger than 60 years had the poorest implant survival rate (90%; 95% CI, 88% to 93%). Patients younger than 50 years with osteoarthritis had the best results (99% survival at 15 years; 95% CI, 99% to 100%), with no failures in men in this group.

Multiple other studies have found similar conclusions in large patient cohorts. For example, 10-year or greater implant survival rate was greater in male hips than in female hips, across multiple age groups.^{20,21,22,23,24} Additionally, decreasing femoral head size was significantly associated with an increased risk of revision in multiple studies.^{22,25} Another study (Kim et al [2008]) found that most failures were related to early acetabular loosening.²⁶

Gross et al (2012) reported that in 373 hips from the first multicenter FDA regulated trial on hip resurfacing with the Cormet prosthesis, the learning curve was at least 200 cases, with survival at 11 years of 93% for the first 100 cases, 93% for the second 100 cases, and 98% for the last 73 cases.^{27,28} Nunley et al (2010) suggested that, for experienced hip surgeons, the learning curve for avoiding early complications (e.g., early femoral fracture) is 25 or fewer cases, but the learning curve for achieving the desired component positioning is 75 to 100 or more cases.²⁹

Total Hip Resurfacing to Total Hip Arthroplasty Conversion Systematic Reviews

Marker et al (2009) published a systematic review that included 2 studies comparing the outcomes of hip resurfacing versus conventional THA.⁸ McGrath et al (2009) published 1 of the studies, which compared outcomes of 39 patients whose resurfacing was converted to THA with a group of primary THA patients matched by sex, age, BMI, and preoperative Harris Hip Score; all procedures had been performed by the same surgeon.³⁰ Perioperative measures were similar except for the mean operating time, which was 19 minutes longer for the revision group. At an average of 45 months of follow-up, the mean Harris Hip Scores were similar for both groups (92 for conversion to THA vs. 94 for primary THA).

Cohort Studies

De Steiger et al (2010) reported on outcomes for revised total hip resurfacing from the Australian Joint Replacement Registry.³¹ A total of 437 revisions were reported (of 12,093 primary total hip resurfacing; ~4%) between 1999 and 2008. After excluding 39 revisions for infection, the major reason for revision of primary total hip resurfacing was fracture of the femoral neck (43%), followed by loosening/lysis (32%), metal sensitivity (7%), and pain (6%). A femoral-only revision, which converts the joint to a conventional total hip resurfacing, was performed in 247 (62%) of the 397 revisions undertaken for reasons other than infection. At 3 years, the rate of re-revised total hip resurfacing THA was 7%, compared with 2.8% of primary conventional THA. Reasons for re-revision included loosening/lysis (n=6), infection (n=4), dislocation of prosthesis (n=1), and fracture (n=2). At 5 years, femoral-only re-revision (7%) was similar to re-revision of both the acetabular and femoral components (5%) but the rate of acetabular-only re-revision was 20%. A more relevant outcome for

this evidence review, one that the investigators did not assess, would be a comparison of the revision rates for total hip resurfacing versus conventional THA.

Stoney et al (2020) reported on outcomes for revised total hip resurfacing from the same Australian Joint Replacement Registry between 1999 and 2018.³² This study specifically looked at male patients younger than 65 years old and compared Birmingham hip resurfacing (n=4790 procedures) to 3 conventional THA prostheses (n=2696 procedures). Birmingham hip resurfacing prostheses had a higher statistically significant rate of all-cause revision at 17 years than THA prostheses (hazard ratio [HR] 2.77; 95% CI, 1.78 to 4.32; p<.001); revisions occurred in 4.5% of primary Birmingham hip resurfacing procedures and all revisions were major revisions (e.g., removal or exchange of femoral or acetabular components). The study authors concluded that the design and bearing surface of the Birmingham hip resurfacing prostheses could impact the increase in revision rate compared to THA prostheses since the Birmingham hip resurfacing prostheses had a higher rate of septic loosening, fracture, lysis, and metal-related pathology.

Su et al (2021) evaluated the 10-year survivorship of Birmingham total hip resurfacing to assess the safety and efficacy of this device.³³ Between 2006 to 2009, there were 280 hip procedures performed at 5 different sites. Outcome measures assessed were Kaplan-Meier survivorship, Harris hip scores, radiographic component stability and osteolysis, reasons for revision, and metal levels including cobalt and chromium. At 10-year follow-up, using all-cause component revision as an endpoint, the 10-year survivorship for all-cause component revisions for all hips was 92.9% (95% CI, 89.8% to 96.1%). Male patients had significantly better survivorship (95.6%; 95% CI, 92.7% to 98.6%) compared to females (85.5%; 95% CI, 77.1% to 93.8%). Younger males (less than 65 years old at the time of procedure) had a slightly better survivorship of 96.0% (95% CI, 93.1% to 98.9%). Twenty hips (out of the 280 included) underwent revision; reasons for revision were for femoral loosening (n=5), femoral neck fracture (n=3), pseudotumor (n=3), osteolysis (n=2), acetabular loosening (n=1), and a combination of pain, noise, or metal levels (n=6); mean time to revision was 5.4 years. Among patients with unrevised hips, the Harris hip score improved from the preoperative phase to 1 year postoperatively and continued to remain stable 10 years postoperatively.

Adverse Events

Molloy et al (2024) analyzed long-term outcomes of Birmingham hip resurfacing by evaluating 11 independent cohort studies with a minimum follow-up of 10 years.³⁴ A total of 3,129 hip resurfacing arthroplasties were included, with a mean follow-up of 11.7 years. The pooled 10-year survival rate was 95.5% (95% CI, 93.4% to 97.1%), with 149 revisions occurring (4.8% of procedures). The primary causes of revision were aseptic loosening (20.1%) and adverse reactions to metal debris (20.1%).

Reito et al (2014) intended to evaluate 10-year survivorship of Birmingham total hip resurfacing, to investigate whole blood metal ion levels, to assess the prevalence of adverse events to metal debris, and to assess the relationship between blood metal ion levels plus symptoms of adverse events and metal debris among patients who underwent total hip resurfacing at a single institution.³⁵ Between 2001 and 2004, 219 patients received 261 total hip resurfacing implants. All patients with intact devices underwent systematic screening comprising clinical examination, whole blood cobalt and chromium measurements, and targeted cross-sectional imaging; any implant revision was the key study endpoint. At 10 year follow-up, device survival for the entire cohort was 91%, with revision required in 10 (6%) men and 13 (20%) women. The prevalence of adverse events to metal debris was 7% in male and 9% in female patients; it was associated with revision in 3 (2%) men and 8 (9%) women. Pseudotumors were observed most commonly in symptomatic patients who had elevated metal ion levels (63%) than in asymptomatic patients who had elevated metal ion levels (42%) and symptomatic patients who had nonelevated metal ions (11%).

Williams et al (2011) assessed the prevalence of pseudotumor formation by ultrasound in asymptomatic patients with metal-on-metal THA (n=31) or metal-on-metal total hip resurfacing (n=21).³⁶ Results were compared with 24 asymptomatic patients with a metal-on-polyethylene THA.

At a minimum of 2 years after surgery (mean, not reported), 10 (32%) patients in the metal-on-metal THA group had a solid (n=7) or cystic mass (n=3), 5 (25%) patients in the total hip resurfacing group had a solid (n=3) or cystic mass (n=2), and 1 (4%) patient in the metal-on-polyethylene THA group had a cystic mass. Isolated fluid collection was similar across the 3 groups (10%, 5%, and 8%, respectively). Serum chromium and cobalt ion levels in patients with metal-on-metal prostheses ranged from 2 to 720 times the upper limit of normal. There was no correlation between the serum metal ion levels and the size of pseudotumor abnormality and no significant difference in serum metal ion levels in patients with pseudotumor formation than in patients without pseudotumors in this small study. The high percentage of patients diagnosed with a pseudotumor in this study is due in part to a definition of pseudotumor that included cystic without solid mass.

Kwon et al (2011) determined the prevalence of asymptomatic pseudotumors after metal-on-metal total hip resurfacing in 201 hips.³⁷ All patients who had surgery at least 3 years previously (N=228) were invited to participate. The 158 patients who agreed to participate underwent evaluation by ultrasound, followed by biopsy and magnetic resonance imaging (MRI) if a tumor was identified on ultrasound. Mean follow-up was 61 months (range, 36 to 88 months). Pseudotumors that contained both cystic and solid components were identified in 4.4% of patients (6 female, 1 male) and 6.5% of resurfaced hips. Histologic examination of the pseudotumors showed extensive necrosis of connective tissue and scattered aggregates of metal particles within necrotic macrophages in extracellular tissue. The pseudotumors were associated with significantly higher cobalt and chromium levels from serum and hip aspirate.

Steffen et al (2008) published a retrospective study of 610 consecutive hip resurfacings (120 with >5-year follow-up) that attributed failure to metal debris in 0.5% of total hip resurfacings.³⁸ Olliviere et al (2009), however, examined histologic samples taken at the time of revision and concluded that the rate of metallosis-related revision in their series of 463 consecutive patients was 3% at 5 years.³⁹ All patients in this series had been recruited into the local arthroplasty follow-up program at the time of the primary surgery; 437 (94%) returned for clinical and radiologic follow-up at a mean follow-up of 43 months (range, 6 to 90 months). Case notes, radiographs, and MRI scans were available for the 13 revisions (2.8%, 12 patients). Histologic findings were available for 12 cases and were re-reviewed by a histopathologist with experience in metal wear and debris. In 7 cases, the histologic findings were consistent with a response to metal wear debris. Survivorship analysis gave an overall survival rate of 95.8% at 5 years, with an endpoint survival of 96.9% at 5 years for metallosis requiring revision. The relative risk for female sex in the metallosis group was 4.94. Also associated with metallosis were a smaller femoral component, greater abduction angle, and a higher BMI.

Mont et al (2007) described the results of the FDA-regulated investigational device exemption prospective, multicenter trial of the Conserve Plus hip resurfacing system in 2007.⁴⁰ The investigators identified a number of risk factors for complications after the first 292 procedures; they included the presence of cysts, poor bone quality, leaving reamed bone uncovered, minimizing the size of the femoral component to conserve acetabular bone, and malpositioning of the acetabular shell. Modification of inclusion criteria and surgical technique in the next 906 patients (1016 hips) resulted in a decreased rate of femoral neck fracture (from 7% to <1%). A trend was reported suggesting a reduction in other types of complications (e.g., nerve palsy was reduced from 4.1% to 2.2%, loosening of the acetabular cup from 3.4% to 1.9%). No differences between the 2 cohorts were observed in the Harris Hip Score (93 vs. 93) or the 12-Item Short-Form Health Survey (e.g., Physical Component Summary score, 50 vs. 50).

Section Summary: Total Hip Resurfacing

The evidence on total hip resurfacing includes RCTs, numerous large observational studies, large registry studies, and systematic reviews. The efficacy of total hip resurfacing performed with current techniques is similar to that for THA over the short-to-medium term, and total hip resurfacing may permit easier conversion to a THA for younger patients expected to outlive their prosthesis. Based on the potential ease of revision of total hip resurfacing compared with THA, current evidence supports

conclusions that hip resurfacing presents a reasonable alternative for active patients who are considered too young for THA. The literature on adverse events (e.g., metallosis, pseudotumor formation, implant failure) is evolving as longer follow-up becomes available.

Partial Hip Resurfacing

Clinical Context and Therapy Purpose

The purpose of partial hip resurfacing is to provide a treatment option that is an alternative to or an improvement on existing therapies, such as conventional surgical methods, in individuals with avascular necrosis with collapse of the femoral head who are undergoing THA and would potentially outlive the prosthesis.

The following PICO was used to select literature to inform this review.

Populations

The relevant population of interest is individuals with avascular necrosis of the femoral head with no greater than 50% involvement of the femoral head. Younger, physically active individuals are the most suitable candidates for partial hip resurfacing.

Interventions

The therapy being considered is partial hip resurfacing.

Comparators

Comparators of interest include conventional THA.

Outcomes

The general outcomes of interest are symptoms, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related morbidity.

Based upon what little literature exists about partial hip resurfacing, follow-up of a minimum of 10 years would be appropriate.

Study Selection Criteria

Methodologically credible studies were selected using the following principles:

1. To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs.
2. In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
3. To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
4. Studies with duplicative or overlapping populations were excluded.

Review of Evidence

Comparative Study

A search of the literature on resurfacing for osteonecrosis identified a number of articles. Grecula (2005)⁴¹ and Stulberg et al (2009)⁴² both discussed comparisons of partial hip resurfacing to total hip resurfacing, referencing a single comparative study by Beaule et al (2004).⁴³ This literature showed that total resurfacing/replacement provided more consistent and better initial pain relief than partial resurfacing.

Section Summary: Partial Hip Resurfacing

The literature on partial hip surfacing for osteonecrosis includes a comparative study. There is an increase in poor outcomes with partial hip resurfacing compared with total hip resurfacing, which is believed to be related to continued abrasion and possible misfit of the femoral component against the native acetabular cartilage. Therefore, for younger patients who do not have contraindications

for the metal-on-metal prosthesis, total hip resurfacing (femoral and acetabular implant) would be preferred over a femoral component alone. Partial hip resurfacing would be appropriate in patients with osteonecrosis who have contraindications for a metal-on-metal prosthesis.

Supplemental Information

The purpose of the following information is to provide reference material. Inclusion does not imply endorsement or alignment with the evidence review conclusions.

Clinical Input From Physician Specialty Societies and Academic Medical Centers

While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

2013 Input

In response to requests, input was received from 1 physician specialty society and 1 academic medical center while this policy was under review in 2013. Input was mixed, although both reviewers agreed that evidence is not sufficient to conclude that the potential for harm with metal-on-metal hip resurfacing outweighs the benefit for all patients. One reviewer noted that current cross-linked polyethylene total hip components may last 20 to 30 years, limiting the number of patients who would outlive a total hip prosthesis and be considered an appropriate candidate for total hip resurfacing.

Practice Guidelines and Position Statements

Guidelines or position statements will be considered for inclusion in 'Supplemental Information' if they were issued by, or jointly by, a U.S. professional society, an international society with U.S. representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

American Academy of Orthopaedic Surgeons

In 2010, the American Academy of Orthopaedic Surgeons published a technology overview on metal-on-metal hip resurfacing.⁴⁴ To compare revision rates between metal-on-metal hip resurfacing and total hip arthroplasty (THA), the Academy analyzed 3 joint registries, which indicated that patients who received total hip resurfacing were at greater risk for revision than patients who received THA. One registry suggested that younger men may have a lower revision rate after total hip resurfacing than THA, although the available data were not found to clearly establish an advantage for this subgroup. There was no conclusive evidence on predictors of successful or unsuccessful outcomes.

Hip Society

In 2012, the Hip Society published an algorithmic approach to the diagnosis and management of metal-on-metal arthroplasty.⁴⁵ The review indicated that adverse local tissue reactions to metal debris are escalating and that all arthroplasty patients returning for follow-up should be queried for pain, discomfort, or compromise of function. Symptomatic patients should be evaluated for all intra-articular and extra-articular causes of pain, including aseptic loosening, sepsis, component malposition, or fluid collections and/or masses about the hip. The Hip Society stated that there is still a role for metal-on-metal resurfacing arthroplasty in select patient groups. The ideal candidate is a man younger than age 55 with osteoarthritis and a femoral head size larger than 50 mm. Another relative indication is the need or desire to return to a very high activity level at work or in recreation. Contraindications to metal-on-metal resurfacing include known or suspected metal sensitivity; moderate or worse renal function; women who may become pregnant; osteoporosis; large cysts; and avascular necrosis of more than 50%.

National Institute for Health and Care Excellence

In 2014, NICE updated its guidance on THA and total hip resurfacing for end-stage arthritis of the hip.⁴⁶ NICE concluded that both THA and total hip resurfacing were options for treating end-stage arthritis of the hip, although clinicians may be more likely to offer resurfacing arthroplasty to men than to women because of higher revision rates observed in women. NICE concluded that THA was more effective and less costly than total hip resurfacing in all analyses, that the revision rate was the most important key driver of costs and quality-adjusted life years, and that because the predicted revision rate of THA was less than 5% at 10 years in the population for whom both THA and total hip resurfacing were suitable, the revision rate standard for total hip resurfacing should be the same as that for THA. NICE recommended specific prostheses for THA and total hip resurfacing only if the prostheses have revision rates of 5% or less at 10 years.

U.S. Preventive Services Task Force Recommendations

Not applicable.

Medicare National Coverage

There is no national coverage determination. In the absence of a national coverage determination, coverage decisions are left to the discretion of local Medicare carriers.

Ongoing and Unpublished Clinical Trials

Some currently ongoing and unpublished trials that might influence this review are listed in Table 1.

Table 1. Summary of Key Trials

NCT No.	Trial Name	Planned Enrollment	Completion Date
<i>Ongoing</i>			
NCT00611585 ^a	Birmingham Hip Resurfacing System (BHR) Post Approval Study: A Prospective, Multi-Centered Study of the Birmingham Hip Resurfacing System	360	Mar 2025

NCT: national clinical trial.

^aDenotes an industry-sponsored or cosponsored study

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Documentation for Clinical Review

Please provide the following documentation:

- History and physical and/or consultation report including:
 - Radiological findings including involvement of femoral head and acetabulum including cartilage changes (if applicable)
 - Specific procedure requested (total or partial hip) and reason requested
 - Whether patient is likely to outlive a traditional prosthesis
 - Any known or suspected metal sensitivity
 - Any other known contraindications (e.g., osteopenia, osteonecrosis, bone cysts, skeletal immaturity, vascular, muscular or renal insufficiency, morbid obesity, immunosuppressed state, etc.)
- Applicable radiology or lab report(s)

Post Service (in addition to the above, please include the following):

- Operative report(s)

Coding

The list of codes in this Medical Policy is intended as a general reference and may not cover all codes. Inclusion or exclusion of a code(s) does not constitute or imply member coverage or provider reimbursement policy.

Type	Code	Description
CPT®	27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft
	27299	Unlisted procedure, pelvis or hip joint
HCPCS	S2118	Metal-on-metal total hip resurfacing, including acetabular and femoral components

Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

Effective Date	Action
12/01/2025	New policy.

Definitions of Decision Determinations

Healthcare Services: For the purpose of this Medical Policy, Healthcare Services means procedures, treatments, supplies, devices, and equipment.

Medically Necessary or Medical Necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I section 14059.5(a) and 22 CCR section 51303(a). Medically Necessary services must include services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.

For Members less than 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) standard of Medical Necessity set forth in 42

USC section 1396d(r)(5), as required by W&I sections 14059.5(b) and 14132(v). Without limitation, Medically Necessary services for Members less than 21 years of age include all services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support, or maintain the Member's current health condition. Contractor must determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the Child.

Criteria Determining Experimental/Investigational Status

In making a determination that any procedure, treatment, therapy, drug, biological product, facility, equipment, device, or supply is "experimental or investigational" by the Plan, the Plan shall refer to evidence from the national medical community, which may include one or more of the following sources:

1. Evidence from national medical organizations, such as the National Centers of Health Service Research.
2. Peer-reviewed medical and scientific literature.
3. Publications from organizations, such as the American Medical Association (AMA).
4. Professionals, specialists, and experts.
5. Written protocols and consent forms used by the proposed treating facility or other facility administering substantially the same drug, device, or medical treatment.
6. An expert physician panel selected by one of two organizations, the Managed Care Ombudsman Program of the Medical Care Management Corporation or the Department of Managed Health Care.

Feedback

Blue Shield of California Promise Health Plan is interested in receiving feedback relative to developing, adopting, and reviewing criteria for medical policy. Any licensed practitioner who is contracted with Blue Shield of California Promise Health Plan is welcome to provide comments, suggestions, or concerns. Our internal policy committees will receive and take your comments into consideration. Our medical policies are available to view or download at www.blueshieldca.com/en/bsp/providers.

For medical policy feedback, please send comments to: MedPolicy@blueshieldca.com

Questions regarding the applicability of this policy should be directed to the Blue Shield of California Promise Health Plan Prior Authorization Department at (800) 468-9935, or the Complex Case Management Department at (855) 699-5557 (TTY 711) for San Diego County and (800) 605-2556 (TTY 711) for Los Angeles County or visit the provider portal at www.blueshieldca.com/en/bsp/providers.

Disclaimer: Blue Shield of California Promise Health Plan may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as member health services contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member health services contracts may differ in their benefits. Blue Shield of California Promise Health Plan reserves the right to review and update policies as appropriate.