Total Hip Replacement

PRIMARY AND REVISION SURGERY | Coverage, costs, recovery and financial protection
United States | Reviewed November 13, 2026

Total hip replacement replaces the damaged ball and socket. Revision can involve the socket, femoral component, both, or selected modular parts. Bone loss, fractures and infection may change the operation, recovery setting and total financial exposure.

You deserve to understand the financial plan before surgery. Use this guide to prepare questions and compare written estimates; your own benefits and clinical plan determine the final bill.

What the cost tables mean

The ranges are editorial planning scenarios, not measured national averages, current fee schedules, or quotes. They describe plausible budgets across different settings. Revision prices are especially uncertain. Actual costs may be lower or substantially higher.

Allowed total: the estimated negotiated price paid jointly by an in-network insurer and patient. Insured share: 20% of that amount only after the deductible is met and before the applicable annual limit. Self-pay: a negotiated cash estimate before charity care, not the hospital's undiscounted sticker price.

An 80/20 PPO has no single standard deductible or annual limit. The tables assume covered, authorized, in-network services, no remaining deductible, and no prior progress toward the maximum. Therapy copays and other benefit designs may produce different results. [1]

A realistic insurance calculation

Example: $35,000 allowed total, $2,000 remaining deductible and $7,000 remaining out-of-pocket maximum. The preliminary share is $2,000 + 20% of $33,000 = $8,600. The applicable limit reduces covered in-network responsibility to $7,000. Premiums, excluded care, and ordinary out-of-network costs generally do not count toward that limit. [1]

Scope: adult U.S. care. Medicare, Medicaid, Medicare Advantage, employer plans and individual policies have different payment rules. Original Medicare is not the PPO illustrated here. CPT descriptions are paraphrased; the provider must verify current coding and bundling.

Ask whether home therapy, outpatient PT and follow-up X-rays are included. Some primary patients need little formal therapy; revision may involve a longer period of support and supervised rehabilitation.

Billing & Necessity Basics

Common procedure codes

CPT	Typical use - paraphrased
27130	Primary total hip replacement
27132	Conversion of previous hip surgery to total replacement
27134	Revision of both major components
27137 / 27138	Revision of socket / femoral component

The main primary-surgery estimate is for 27130 on one hip. Coding for removal, spacer placement, debridement and reimplantation depends on exactly what is done. A limited exchange is not necessarily coded or priced like replacement of all components. The coding team must verify current edits, diagnosis codes, laterality and modifiers. [8]

Primary surgery: what insurers commonly need

For arthritis, expect imaging evidence of advanced disease, pain or disability affecting daily activities, examination findings and documentation of appropriate nonsurgical care. Record dates and responses to medication, exercise or therapy, activity changes, assistive devices and injections when appropriate. Explain contraindications or why further conservative care would not help. Local Medicare and commercial policies differ. [9,10]

Revision: document the reason for failure

The record may document loosening, recurrent dislocation or instability, component wear or failure, fracture, bone loss or infection. Imaging and, when appropriate, laboratory testing, aspiration and cultures help establish the problem. Pain alone requires investigation; it does not automatically establish that revision will help or be covered. [9,10]

A revision request should address the actual failure rather than simply repeat the primary-arthritis checklist. Do not assume every patient must repeat months of PT before treatment for infection, fracture or mechanical failure. Ask for the policy that applies to the documented indication. [9]

Obtain authorization for the correct side, actual operation and setting. Conversion surgery, bilateral surgery and staged infection treatment need their own estimates. Readiness requirements and recent injection timing should be checked with the team; they are not identical across plans. [10]

Insurance vs. Uninsured Landscape

Insured: the setting and recovery benefits matter

Verify the surgeon and exact facility, then check anesthesia, imaging, DME, therapy and home health. Authorization for surgery is not automatic approval for inpatient admission, home infusion or facility rehabilitation. The insurer may ask why a hospital stay is necessary when outpatient treatment is proposed as an alternative.

Self-pay: compare the full package

One provider publishes anterior hip-replacement prices of $21,300 at an ASC and $25,495 at a hospital, with implants among the listed inclusions. These are examples from one provider, not national averages, and do not establish revision pricing. Confirm current eligibility, inclusions and exclusions directly. [11]

A different center advertises $17,579 for hip replacement while stating that the device costs extra. Compare implant-inclusive quotes rather than headline prices. [14] Cash bundles may exclude major complications and further operations. Ask what happens if the planned primary operation becomes a more complex procedure.

Hospital versus ambulatory surgery center

A freestanding ASC provides outpatient surgery for selected patients; a hospital outpatient department is a different setting and may allow overnight observation. Formal inpatient admission is another arrangement. A hospital quote is not automatically an inpatient quote. Clinical suitability and current code-specific payer rules determine what is available.

Some revisions can be performed as outpatient care, but complex revision, infection treatment, major bone loss, fracture or medical risk may call for hospital resources. Ask about blood availability, monitoring, safe discharge and transfer costs. Do not assume every revision is automatically inpatient or every outpatient revision belongs in a freestanding ASC. [12]

Infection changes the financial pathway

The plan may involve washout with retention of fixed components, a one-stage exchange, or staged removal with an antibiotic spacer and later reimplantation. Antibiotics and monitoring can continue between operations. Ask for the full sequence and separate authorizations, including what happens if reimplantation is delayed. Recovery is often more demanding than primary replacement. [12]

A primary-replacement package is not a quote for infected revision. Request separate estimates for each operation, interval infection treatment, imaging, laboratory work, rehabilitation and equipment.

Cost Breakdown: primary and revision

Illustrative U.S. planning budgets, not measured national averages or provider quotes. Each table includes one operation, routine facility care and outpatient rehabilitation. Facility allowances include the implant. Prolonged institutional rehabilitation and separate infection treatment are excluded.

Primary replacement: one hip, discharge home

Expense	Allowed total	Your 20% share*	Self-pay total
Surgical professionals	$2,000-$5,000	$400-$1,000	$2,500-$6,000
Facility / implant	$15,000-$35,000	$3,000-$7,000	$12,000-$35,000
Anesthesiology	$800-$2,000	$160-$400	$1,000-$2,500
Pre-op / imaging	$300-$1,000	$60-$200	$300-$1,200
Outpatient rehab	$500-$2,000	$100-$400	$500-$2,000
TOTAL	$18,600-$45,000	$3,720-$9,000*	$16,300-$46,700

Revision: one noninfected corrective operation

Expense	Allowed total	Your 20% share*	Self-pay total
Surgical professionals	$3,000-$9,000	$600-$1,800	$3,500-$11,000
Facility / implant	$25,000-$75,000	$5,000-$15,000	$22,000-$85,000
Anesthesiology	$1,200-$3,500	$240-$700	$1,200-$4,000
Workup / imaging	$600-$2,500	$120-$500	$600-$3,000
Outpatient rehab	$1,000-$5,000	$200-$1,000	$1,000-$5,000
TOTAL	$30,800-$95,000	$6,160-$19,000*	$28,300-$108,000

*The 20% share assumes the deductible is met and applies only before the annual maximum. Actual benefits may use copays. The revision model represents more substantial component exchange, not a simple isolated liner exchange or the whole course of a two-stage infected revision.

These component allowances are editorial assumptions and do not decompose the published bundles. Never add fees again when included. Staged infection, fracture fixation, major grafting, prolonged stay and additional procedures require individual quotes. No defensible universal two-stage cash total is promised here.

Hidden Expenses & Recovery Logistics

Budget for the services around the operation

Equipment: walker, crutches, shower chair, raised toilet seat, reacher or sock aid may help. Ask the therapist which items fit your precautions before buying. A $100-$400 basic equipment allowance is a retail planning figure; complex equipment costs more.

Home and travel: assess stairs, rugs, lighting, furniture and bathroom access. Price rides, parking, companion lodging, meals, childcare and help with shopping. Ordinary household assistance is different from skilled home-health care and may be self-funded.

Prescriptions and revision extras: confirm clot-prevention and pain-drug costs. If infected, separately price infusion drugs, nursing, supplies, line care, laboratory monitoring and infectious-disease visits. Ask about braces, weight-bearing restrictions, grafts and other special revision resources before agreeing to a cash package.

Time off work: allowances for financial planning

Work / activity	Primary replacement	Revision planning allowance
Flexible desk work	Often 2-6 weeks	Often 6-12+ weeks
Desk work with commute	Often 4-6 weeks	Often 8-12+ weeks
Prolonged standing / travel	Often 6-12 weeks	Often 3-4+ months
Heavy lifting / climbing	Often 3+ months	Often 4-6+ months; may need modified duties

These are practical leave-budget allowances, not universal return-to-work standards. Revision timing is particularly variable; bone healing, weight-bearing limits, infection and additional operations can extend leave by months. Obtain job-specific clearance. [12,13]

Hip revision may require several days in hospital, slower rehabilitation and temporary weight-bearing limits. Arrange help at home, transportation and written work restrictions. Driving requires safe braking and movement without impairing medication. Ask HR about gradual return, disability benefits, leave and continued insurance. [12,13]

Patient Playbook: the traps

Approval, networks and separate bills

"Approved" does not mean every expense is paid. Authorization, benefit eligibility, provider participation and patient cost-sharing are separate questions. A revision can need a new authorization even if the first operation was approved. A complication is not automatically excluded just because it followed elective surgery.

An in-network hospital may use independent anesthesiologists, radiologists and assistant surgeons. Under the No Surprises Act, most privately insured patients have protections for covered out-of-network ancillary care at an in-network hospital, hospital outpatient department or ASC. Anesthesia protections generally cannot be waived through notice and consent. A separate bill can be valid; prohibited balance billing is the problem. [2]

The law does not erase deductibles or coinsurance. Choosing an out-of-network facility can leave substantial exposure. Ground-ambulance balance bills generally fall outside federal protections; state rules may add protection. [2]

A hospital bed does not establish inpatient status

Observation is outpatient care, even overnight. Ask the care team each day about your status and request written notices of changes. Original Medicare generally requires three qualifying inpatient days for skilled-nursing coverage; observation does not count. Exceptions and Medicare Advantage rules can differ. A qualifying stay alone does not guarantee skilled-nursing eligibility. [5,6]

Bundles, warranties and plan-year resets

"All-inclusive" may exclude the implant, pre-op imaging, prescriptions, therapy or complications. Routine surgical follow-up may be included in the surgeon's global fee while imaging or treatment by another clinician is separate. Ask which services are bundled rather than assuming every extra bill is wrong.

A manufacturer warranty is not comprehensive revision insurance. Ask exactly which device or services, if any, it covers; it may not pay the hospital, surgeon, anesthesia or rehabilitation. Do not assume a product failure makes medical care free.

Two-stage treatment can cross two plan years. If each year has a fresh $2,000 deductible and $7,000 applicable maximum, $40,000 allowed care in year one and $60,000 in year two could produce $7,000 + $7,000 = $14,000 of covered in-network responsibility. This is an example, not a prediction.

A cash price paid outside insurance may not count toward your deductible or maximum. Hospital charity care may exclude independent clinicians. Verify both before paying. [7]

Patient Playbook: before surgery

1. Build one accurate description of the episode

Request the procedure and diagnosis codes, operated side where relevant, surgeon and facility names, billing identifiers, proposed implant, expected admission status, and anticipated rehabilitation. For revision, identify what will be removed, retained or replaced and whether treatment is one-stage or staged.

2. Verify your benefits directly

Call the insurer with that information. Ask: "Are these providers and this location in my exact network? What remains on my deductible and individual/family maximum? What are the surgery, therapy, equipment, home-health and prescription rules?" Save the reference number and request a portal response. Check the plan-year reset date.

3. Resolve authorization and appeal gaps

Get the authorization number, covered dates, codes and approved setting. Ask whether each revision stage, admission, infusion service and rehabilitation placement needs separate approval. For a denial, obtain the written reason and policy; ask the surgeon to provide missing evidence, pursue peer-to-peer review when available, and meet appeal deadlines. Request expedited review when medically warranted.

4. Get comparable written estimates

Using insurance: request a patient-specific estimate using current benefits. Self-pay: request a Good Faith Estimate from each billing entity, including the facility, surgeon and anesthesiology group. One entity's estimate may not include others. Request separately scheduled testing and therapy estimates too. [3]

Federal Good Faith Estimate rights generally apply when uninsured or choosing not to use insurance. Scheduling at least three business days ahead or requesting an estimate triggers applicable timing rules. Keep the estimate in writing; emergency care is different. [3]

5. Clarify the bundle and deposit

Ask whether implants, hardware removal, anesthesia, assistant surgeons, diagnostic work, overnight care, follow-up and rehabilitation are included. Obtain transfer, complication, cancellation and refund terms. For a custom device, ask who pays if manufacture begins but surgery is canceled.

6. Negotiate access before going out of network

If no suitable in-network specialist is reasonably available, request a network-gap exception and a single-case agreement. Obtain written terms from insurer and provider stating covered services, payment terms, in-network patient cost-sharing, and no balance billing beyond that share. An insurer's exception alone may not settle the provider's charges.

Patient Playbook: paying and disputing

7. Seek assistance before taking on debt

Ask the hospital financial counselor for charity-care and hardship screening, uninsured discounts and payment-plan terms. Apply even if insured; eligibility varies. Ask which independent clinicians participate in the hospital's assistance policy and contact others separately. Tax-exempt charitable hospitals must maintain financial-assistance policies. [7]

Before using a credit card or medical financing, obtain the corrected balance and compare interest, fees and deferred-interest terms. If negotiating a cash payment, request the agreed full settlement and any remaining exclusions in writing.

8. Price the discharge plan

Confirm the exact pharmacy, DME supplier, therapy clinic, home-health agency and any infusion provider. Check participation and authorization before service. Ask who will teach transfers, stairs and medication use. Arrange transport and caregiving; ask the discharge planner to address an unsafe or unaffordable plan.

9. Audit the EOB against the itemized bill

An Explanation of Benefits is not a bill. Match patient, date, procedure, side, network status, allowed amount, insurer payment, contractual adjustment and patient share. Check duplicate services, denied claims, missing deposits and amounts above the EOB responsibility. Request explanations of unfamiliar charges, not automatic deletion of all separate charges.

If disputed, ask billing for an itemized statement and the insurer for claim review. Request a written hold on the disputed amount while it is reviewed; do not assume collections stop automatically. Pay or arrange undisputed amounts as appropriate and keep receipts.

10. Use the right protection

For a potentially prohibited surprise bill, contact the provider and insurer, identify the No Surprises Act issue, and request proper in-network cost-sharing. Submit an unresolved complaint through cms.gov/medical-bill-rights or the No Surprises Help Desk, 1-800-985-3059. [2]

For uninsured/self-pay care, a bill from one provider at least $400 above that provider's Good Faith Estimate may qualify for federal patient-provider dispute resolution. Initiate it within 120 calendar days of the initial bill, subject to eligibility rules. This is different from an insured claim appeal. [4]

11. Keep a record and verify the final balance

Save estimates, authorizations, policy pages, assistance decisions, EOBs, receipts and call notes in one place. Before final payment, confirm insurance processing is complete, discounts and deposits are applied, and disputes resolved. For staged revision, repeat the review for each episode and each plan year.

Sources and appointment worksheet

Sources support coverage rules, coding, clinical pathways and published examples. They do not validate the editorial cost ranges as national market data. Blue source titles are clickable. Reviewed November 13, 2026.

[1] HealthCare.gov: Out-of-pocket maximum and exclusions | Open source

[2] CMS: Medical-bill rights when using insurance | Open source

[3] CMS: Good Faith Estimate rights without insurance | Open source

[4] CMS: Disputing a bill above a Good Faith Estimate | Open source

[5] Medicare: Inpatient versus outpatient status | Open source

[6] Medicare: Skilled nursing facility coverage | Open source

[7] IRS: Hospital financial-assistance policies | Open source

[8] CMS: Billing and coding, Total Joint Arthroplasty A59811 | Open source

[9] CMS: Local coverage, Total Joint Arthroplasty L39911 | Open source

[10] Aetna: Hip arthroplasty medical policy | Open source

[11] Published example: Dr. Wickline self-pay joint packages | Open source

[12] AAOS: Revision total hip replacement | Open source

[13] AAHKS: Total hip replacement and recovery | Open source

[14] Published example: Surgery Center of Oklahoma hip package | Open source

Bring these questions to your next appointment

Which components will be retained, exchanged or removed, and is infection suspected?

What are my weight-bearing restrictions and expected support needs between stages?

Record: insurer contact/reference _____ Authorization _____
Remaining deductible _____ Remaining maximum _____
Written episode estimate _____ Plan-year reset _____

Educational information, not an individual coverage decision or medical clearance. Obtain a written plan from your clinical team and insurer. Recheck policies, prices and codes before scheduling.