Hip Arthroscopy - Single Service

Clinical Guidelines for Medical Necessity Review

Version: 3
Effective Date: September 20, 2024

Important Notices

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Guideline Information:

Specialty Area: Diseases & Disorders of the Musculoskeletal System (M00-M99)
Guideline Name: Hip Arthroscopy - Single Service

Literature review current through: 9/20/2024
Document last updated: 9/20/2024
Type: [**X**] Adult (18+ yo) | [_] Pediatric (0-17 yo)

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Medical Necessity Criteria

Service: Hip Arthroscopy

General Guidelines

- **Units, Frequency, & Duration:** None.
- **Criteria for Subsequent Requests:** None.
- **Recommended Clinical Approach:** Diagnostic hip arthroscopy is a minimally invasive procedure that provides visualization for diagnostically challenging cases or minimally invasive biopsy for synovial disease.[1] Labral repair techniques have demonstrated superior results compared with debridement however, both have demonstrated similar clinical results. Labral repair may be beneficial for patients with recurrent hip instability, particularly after trauma. The torn labrum can be reattached to the acetabulum using suture anchors or other techniques. Osteochondroplasty of the hip removes bone and overlying cartilage from the acetabulum and femoral neck that contribute to femoroacetabular Impingement (FAI). This procedure can be performed arthroscopically or in an open procedure.
- **Exclusions:** None.

Medical Necessity Criteria

Indications

➔ **Hip arthroscopy procedures** are considered appropriate when **ALL** of the following are **TRUE**:

◆ **ANY** of the following is **TRUE**:

- **Diagnostic hip arthroscopy** is considered appropriate if the patient has a source of hip pain without a clear diagnosis with **ANY** of the following[2]:
  - Loose bodies; **OR**
  - Chondral injuries; **OR**
  - Synovial disease; **OR**
  - Adhesive capsulitis; **OR**
  - Joint sepsis; **OR**

- **Arthroscopic labral debridement** is considered appropriate when labral degeneration is visible on advanced imaging; **OR**
- **Arthroscopic osteochondroplasty** is considered appropriate when **ALL** of the following are **TRUE**:
    - Positive impingement sign with pain (hip is flexed to 90 degrees, adducted, and internally rotated); **AND**
    - Moderate to severe persistent hip or groin pain that limits activity and is worse with hip flexion; **AND**
    - Advanced imaging shows **ANY** of the following:
        - FAI impingement with evidence of CAM impingement (alpha angle greater than 50 degrees); **OR**
        - Pincer impingement (coxa profunda or acetabular retroversion)[3]; **OR**
- **Arthroscopic labral repair** is considered appropriate if a labral tear can be repaired based on advanced imaging findings[4]; **AND**

◆ Failure of conservative management for greater than 3 months, including **ALL** of the following:

- Oral steroid or anti-inflammatory medication, or analgesics; **AND**
- Physical therapy; **AND**
- **ANY** of the following:
    - Corticosteroid injection if medically appropriate; **OR**
    - Corticosteroid injection is contraindicated; **AND**
- **ANY** of the following:
    - Weight reduction if BMI is greater than 40; **OR**
    - Documentation of attempted weight loss if BMI is greater than 40; **OR**
    - Weight loss is not applicable (BMI less than 40).

Non-Indications

➔ **Hip arthroscopy procedures** are not considered appropriate when **ANY** of the following is **TRUE**[1,5]:

◆ Ankylosis of the hip; **OR**
◆ Advanced hip osteoarthritis (Tonnis grade 2 or 3); **OR**
◆ Local nerve pathology/disorders (e.g., pudendal neuralgia, peroneal nerve palsy); **OR**
◆ Capsular laxity.

Level of Care Criteria

Outpatient

Procedure Codes (CPT/HCPCS)

CPT/HCPCS Code	Code Description/Definition
27299	Unlisted procedure, pelvis or hip joint
29860	Diagnostic arthroscopy of hip joint; Diagnostic arthroscopy of hip joint with synovial biopsy
29861	Surgical arthroscopy of hip with removal of foreign body; Surgical arthroscopy of hip with removal of loose body
29862	Surgical arthroscopy of hip with debridement of articular cartilage; Surgical arthroscopy of hip with debridement of articular cartilage, abrasion arthroplasty, and resection of labrum; Surgical arthroscopy of hip with debridement of articular cartilage, and abrasion arthroplasty; Surgical arthroscopy of hip with shaving of articular cartilage, abrasion arthroplasty, and resection of labrum
29863	Surgical arthroscopy of hip with synovectomy
29914	Surgical arthroscopy of hip with femoroplasty; Surgical arthroscopy of hip with femoroplasty for cam lesion
29915	Surgical arthroscopy of hip with acetabuloplasty; Surgical arthroscopy of hip with acetabuloplasty for pincer lesion
29916	Surgical arthroscopy of hip with labral repair
29999	Unlisted arthroscopic procedure

Medical Evidence

Woyski and Mather (2019) analyze the significant increase in labral repair procedures from 19% in 2009 to 81% in 2017. Diagnostic intraarticular injection is a standard approach when the source of hip pain is unknown. Injections are sensitive and allow the clinician to differentiate hip pain from extraarticular, intra-articular, and spinal etiologies. Techniques for partial or complete labral reconstruction or augmentation have developed in recent years that have improved long-term outcomes. Support is published in multiple randomized control trials.[4]

Ross et al. (2017) performed a clinical review on the increased utilization of hip arthroscopy and available techniques. The authors review hip arthroscopy with respect to four pathologies: the central, peripheral, peritrochanteric, and subgluteal compartments. Compared to traditional open procedures, hip arthroscopy is minimally invasive and results in a decreased risk of neurovascular injury, morbidity, and recovery time.[1]

Groh et al. (2009) note that arthroscopy is the gold standard treatment. Magnetic resonance arthrography (MRA) is the preferred diagnostic test compared to magnetic resonance imaging (MRI) and computed tomography (CT) as they are ineffective in determining a diagnosis. The use of arthroscopy allows the clinician to visualize related intraarticular structures (e.g., articular cartilage, ligamentum teres). Overall, complication rates vary (1.4% to 25%). Complications include deep venous thrombosis (DVT), articular damage, and neurovascular injury. There is an increased risk to the superior gluteal neurovascular bundle, lateral femoral cutaneous nerve, and the femoral neurovascular bundle. This is related to portal placement and the sciatic and pudendal nerves because of traction. Nerve palsies can resolve within two hours to three weeks.[2]

References

1. Ross JR, Larson CM, Bedi A. Indications for hip arthroscopy. *Sports Health*. 2017 Sep/Oct;9(5):402-413. doi: 10.1177/1941738117712675. PMID: 28678628; PMCID: PMC5582699.
2. Groh MM, Herrera J. A comprehensive review of hip labral tears. *Curr Rev Musculoskelet Med*. 2009 Jun;2(2):105-17. doi: 10.1007/s12178-009-9052-9. PMID: 19468871; PMCID: PMC2697339.
3. Wilson AS, Cui Q. Current concepts in management of femoroacetabular impingement. *World J Orthop*. 2012 Dec 18;3(12):204-11. doi: 10.5312/wjo.v3.i12.204. PMID: 23362464; PMCID: PMC3557322.
4. Woyski D, Mather RC. Surgical treatment of labral tears: Debridement, repair, reconstruction. *Curr Rev Musculoskelet Med*. 2019 Sep;12(3):291-299. doi: 10.1007/s12178-019-09575-1. PMID: 31346980; PMCID: PMC6684681.
5. National Institute for Health and Care Excellence (NICE). Osteoarthritis in over 16s: Diagnosis and management [NG226]. Published October 19, 2022. Accessed July 1, 2024. www.nice.org.uk/guidance/ng226.

Clinical Guideline Revision History/Information

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Review History		
Version 2	12/29/2023	
Version 3	9/20/2024	Updated language regarding conservative treatment