Cohere Medical Policy - Hip Arthroscopy

Clinical Policy for Medical Necessity Review

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This policy was reviewed by the American Association of Orthopaedic Surgeons (AAOS) prior to publication.

Important Notices

Notices & Disclaimers:

GUIDELINES ARE SOLELY FOR COHERE'S USE IN PERFORMING MEDICAL NECESSITY REVIEWS AND ARE NOT INTENDED TO INFORM OR ALTER CLINICAL DECISION-MAKING OF END USERS.

Cohere Health, Inc. ("**Cohere**") has published these clinical guidelines to determine the medical necessity of services (the "**Guidelines**") for informational purposes only, and solely for use by Cohere's authorized "**End Users**". These Guidelines (and any attachments or linked third-party content) are not intended to be a substitute for medical advice, diagnosis, or treatment directed by an appropriately licensed healthcare professional. These Guidelines are not in any way intended to support clinical decision-making of any kind; their sole purpose and intended use is to summarize certain criteria Cohere may use when reviewing the medical necessity of any service requests submitted to Cohere by End Users. Always seek the advice of a qualified healthcare professional regarding any medical questions, treatment decisions, or other clinical guidance. The Guidelines, including any attachments or linked content, are subject to change at any time without notice.

Other Notices:

Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

Policy Information:

Specialty Area: Musculoskeletal Care
Policy Name: Cohere Medical Policy- Hip Arthroscopy
Type: [**X**] Adult (18+ yo) | [**X**] Pediatric (0-17 yo)

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Medical Necessity Criteria

Service: Hip Arthroscopy

Cohere Health takes an evidence-based approach to reviewing imaging and procedure requests, meaning that sufficient clinical information must be provided at the time of submission to determine medical necessity. Documentation must include a recent and detailed history, physical examination related to the onset or change in symptoms, relevant lab results, prior imaging, and details of previous treatments. Advanced imaging or procedures should be requested after a clinical evaluation by the treating provider, which may include referral to a specialist.

- When a specific clinical indication is not explicitly addressed in the Cohere Health medical policy, medical necessity will be determined based on established clinical best practices, as supported by evidence-based literature, peer-reviewed sources, professional society guidelines, and state or national recommendations, unless otherwise directed by the health plan.
- Requests submitted without clinical documentation, or those that do not align with the provided clinical information—such as mismatched procedure, laterality, body part, or CPT code—may be denied for lack of medical necessity due to insufficient or inconsistent clinical information.
- When there are multiple diagnostic or therapeutic procedures requested simultaneously or within the past three months, each will be reviewed independently. Clinical documentation must clearly justify all of the following:
    - The medical necessity of each individual request
    - Why prior imaging or procedures were inconclusive, or why additional/follow-up studies are needed
    - How the results will impact patient management or treatment decisions
- Requests involving adjacent or contiguous body parts may be considered not medically necessary if the documentation demonstrates that the patient's primary symptoms can be adequately assessed with a single study or procedure.

Description

Hip arthroscopy is a minimally invasive procedure that offers visualization of the hip joint through an instrument known as an arthroscope. Hip arthroscopy is useful for clinically complex cases with an unclear diagnosis and can also be used to collect biopsies to assess for synovial disease. Injuries to the hip may also be repaired during arthroscopy, including labral tears and acute trauma resulting in loose bodies within the hip joint. The torn labrum may be repaired by removing labral pieces and then suturing the tear.

Femoroacetabular impingement (FAI) is another common indication for hip arthroscopy. It causes pain and limits activity because of the abnormal shape of the bones of the hip, which developed improperly during childhood skeletal growth. In general, arthroscopy is well-tolerated, safe, and leads to improved function and quality of life.[1]

Medical Necessity Criteria

Indications

Hip arthroscopy is considered appropriate if **ANY** of the following is **TRUE**[1]:

- **Diagnostic hip arthroscopy** is considered appropriate if the patient has **ALL** of the following[1,2]:
  - A source of hip pain with an unclear diagnosis; **AND**
  - **ANY** of the following is **TRUE**:
    - Loose bodies; **OR**
    - Chondral lesion; **OR**
    - Synovial disease; **OR**
    - Adhesive capsulitis; **AND**
  - **ANY** of the following:
    - Acute pathology or acute injury (infection, trauma, gluteal tear) which is exempt from conservative care; **OR**
    - Failure of conservative management for greater than 3 months, including **ALL** of the following[1,2]:
      - Anti-inflammatory medications, non-opioid analgesics, or prescription medications (e.g., oral steroids, neuropathic pain medications) if not contraindicated; **AND**
      - Physical therapy or physician-directed exercise program; **AND**
      - **ANY** of the following:
        - Corticosteroid injection if medically appropriate; **OR**

        - Documentation that corticosteroid injection is contraindicated; **OR**
- **Arthroscopic labral debridement/repair** is considered appropriate with **ALL** of the following:
    - Labral tearing is visible on advanced imaging[1-4]; **AND**
    - **ANY** of the following:
        - Acute traumatic tear; **OR**
        - Failure of conservative management for greater than 3 months, including **ALL** of the following:
            - Anti-inflammatory medications, non-opioid analgesics, or prescription medications (e.g., oral steroids, neuropathic pain medications) if not contraindicated; **AND**
            - Physical therapy or physician-directed exercise program; **AND**
            - **ANY** of the following:
                - Corticosteroid injection if medically appropriate; **OR**
                - Documentation that corticosteroid injection is contraindicated; **OR**
- **Trochanteric bursectomy** is considered appropriate when the patient has **ALL** of the following[1,2]:
    - **ANY** of the following:
        - Trochanteric bursitis (greater trochanteric pain syndrome); **OR**
        - Greater trochanteric pain syndrome; **OR**
        - Gluteal tendinopathy; **AND**
    - Failure of conservative management for greater than 3 months, including **ALL** of the following:
        - Anti-inflammatory medications, non-opioid analgesics, or prescription medications (e.g., oral steroids, neuropathic pain medications) if not contraindicated; **AND**
        - Physical therapy or physician-directed exercise program; **AND**
        - **ANY** of the following:
            - Corticosteroid injection if medically appropriate; **OR**
            - Documentation that corticosteroid injection is contraindicated; **OR**
- **Gluteal repair**, whether arthroscopic or open, is considered appropriate when the patient has imaging findings of **ANY** of the following[1,2]:
    - Gluteal tear; **OR**
    - **ALL** of the following:
        - Gluteal tendinopathy; **AND**

        - Failure of conservative management for greater than 3 months, including **ALL** of the following:
            - Anti-inflammatory medications, non-opioid analgesics, or prescription medications (e.g., oral steroids, neuropathic pain medications) if not contraindicated; **AND**
            - Physical therapy or physician-directed exercise program; **AND**
            - **ANY** of the following:
                - Corticosteroid injection if medically appropriate; **OR**
                - Documentation that corticosteroid injection is contraindicated; **OR**
- **Arthroscopic osteochondroplasty** is considered appropriate with **ALL** of the following[1,2,5]:
    - 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 demonstrates **ANY** of the following:
        - Femoroacetabular impingement (FAI) impingement with evidence of CAM impingement (alpha angle greater than 50 degrees); **OR**
        - Pincer impingement (coxa profunda or acetabular retroversion)/subspine impingement[6]; **OR**
        - Ischiofemoral impingement[6,7]; **OR**
        - Residual impingement remains after first arthroscopy[1,8]; **AND**
    - Failure of conservative management for greater than 3 months, including **ALL** of the following:
        - Anti-inflammatory medications, non-opioid analgesics, or prescription medications (e.g., oral steroids, neuropathic pain medications) if not contraindicated; **AND**
        - Physical therapy or physician-directed exercise program; **AND**
        - **ANY** of the following:
            - Corticosteroid injection if medically appropriate; **OR**
            - Documentation that corticosteroid injection is contraindicated; **OR**
- **Other intervention of the hip** is considered appropriate for **ANY** of the following[1,2]:
    - Ligamentum teres disorder[9]; **OR**
    - Proximal hamstring injury indicated by **ANY** of the following[9-11]:
        - 2-tendon injury with greater than 2 centimeters of retraction; **OR**

        - 3-tendon injury; **OR**
    - Acute infection/joint sepsis[1]; **OR**
    - Acute trauma with associated findings on imaging (e.g. loose body noted after hip dislocation); **OR**
    - Acute gluteal tear (partial or full-thickness) within three months of injury[12]; **OR**
    - **ALL** of the following:
        - **ANY** of the following:
            - Sciatic nerve entrapment[13]; **OR**
            - Psoas tendon disorder; **OR**
            - Atraumatic instability that is felt to be resolvable with arthroscopic capsular plication[14,15]; **AND**
        - Failure of conservative management for greater than 3 months, including **ALL** of the following:
            - Anti-inflammatory medications, non-opioid analgesics, or prescription medications (e.g., oral steroids, neuropathic pain medications) if not contraindicated; **AND**
            - Physical therapy or physician-directed exercise program; **AND**
            - **ANY** of the following:
                - Corticosteroid injection if medically appropriate; **OR**
                - Documentation that corticosteroid injection is contraindicated.

Non-Indications

Hip arthroscopy is not considered appropriate when **ANY** of the following is **TRUE**:[1,2]

- Ankylosis of the hip; **OR**
- Advanced hip osteoarthritis (Tönnis grade 2 or 3).

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

As compared to traditional open procedures, hip arthroscopy is minimally invasive, decreases the risk of neurovascular injury, and requires a shorter recovery time. A 2023 systematic review of patients aged 50 years and older saw these benefits persist among an older population, albeit alongside a pronounced risk for revision surgery and subsequent total hip arthroplasty (THA). The systematic review consisted of 6,696 patients across 17 studies who underwent primary hip arthroscopy between 2015 and 2021. Up to 10.8% of patients underwent surgical revision, while up to 34% experienced ultimate conversion to THA. The authors concluded that, although postoperative patient-reported outcomes were significantly improved as compared to baseline, careful patient selection is particularly important for patients of advanced age in order to appropriately weigh the very real risk of eventual revision or conversion to THA.[16]

Conducted in 2018, the UK FASHIoN study was an assessor-blinded, randomized controlled trial involving 348 patients with femoroacetabular hip impingement syndrome (FAI), 171 of whom underwent hip arthroscopy, while the other 177 were treated with conservative care alone. The authors found that hip arthroscopy conferred a significant improvement in quality of life at one year after surgical intervention. They noted that these results solidified the use of arthroscopy to treat FAI, which has grown in clinical popularity in recent years.[17]

A 2021 systematic review addressed the role of hip arthroscopy in the management of gluteal tendinopathy. The authors evaluated 27 studies, including 6 randomized controlled trials, with an aggregate of 1103 patients. Bursectomy was felt to be a valuable treatment option for patients who failed conservative measures. Surgical repair of partial-thickness and full-thickness gluteal tears was encouraged to be considered early in the course of injury due to the lack of data regarding nonoperative treatment of grade 3 and grade 4 (partial; full) tendinopathy.[12]

The American Association of Orthopaedic Surgeons (AAOS) has issued position statements pertaining to hip arthroscopy. Information statement

1047, published in 2016, acknowledges the increased patient safety risks conferred by tobacco use - including increased ventilatory support, myocardial infarction, cardiac arrest, cerebrovascular accident, sepsis, and death.[18] The AAOS states that patients who are active smokers may reduce these risks through cessation of smoking prior to surgery; they also note the special role orthopaedic surgeons play in counseling patients on the benefits of reduced or eliminated tobacco use before surgery. Importantly, unconfirmed cessation is not endorsed as a hard stop to surgery; rather, the surgeon's unique role as an advocate for preoperative smoking cessation is emphasized. Statements 1040 and 1184 discuss the impact of obesity on musculoskeletal conditions.[19,20] Patients with morbid obesity (BMI of 40 or above) are encouraged to participate in a weight loss program, obtain weight reduction resources through their physician, rectify nutritional deficiencies, and consider a delay in surgical treatment if it would facilitate participation in weight loss interventions that may improve surgical outcomes. Statement 1040 notes that individuals with obesity face an increased risk for sports injuries, and that when such injuries are treated arthroscopically, the procedure may be more technically difficult because of the loss of superficial landmarks. Questions remain as to whether functional results are affected by obesity. Further, the authors note the risks associated with general anesthesia for patients with obesity and emphasize the importance of adequate patient positioning and padding to avoid pressure ulcers, nerve palsies, and compartment syndromes, which are more common among obese patients. In general, obesity is associated with greater risk of premature complications and mortality during the perioperative period. The AAOS endorses compassionate, risk-informed patient counseling for obese patients who are considering surgery. Careful screening and appropriate referral to nutrition or endocrine care is also endorsed. Statement 1184 reinforces the risks associated with obesity in the setting of orthopaedic care and similarly encourages adequate patient counseling prior to surgery.

Social determinants of health remain an important area of ongoing orthopaedic surgery research, with recent literature raising questions regarding the healthcare disparities that may be potentiated by care limitations based on obesity and smoking status/nicotine dependence.[21-23] Other ongoing research interrogates the impacts that biological sex, race, and socioeconomic status have on hip arthroscopy utilization and outcomes.[24-33]

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Policy Revision History/Information

Original Date: May 22, 2020		
Review History		
Version 2	12/29/2023	Annual review.
Version 3	09/20/2024	Updated language regarding conservative treatment
Version 4	04/17/2025	Annual policy review & restructure: Adjusted Recommended Clinical Approach to current format Added indications for gluteal repair and hip bursectomy based on physician feedback Removed weight reduction requirement in accordance with professional society guidelines Added indications: Acute infection/joint sepsis; acute trauma with findings documented on imaging (e.g. loose body noted after hip dislocation); acute gluteal tear within 3 months of injury; proximal hamstring injury; extra-articular impingement; sciatic nerve entrapment; ligamentum teres disorder; capsular plication Updated references Updated medical evidence section Conservative care language modified to reflect non-opioid pain control.

		Modified steroid injection language for clarity.
Version 5	09/11/2025	Specified that gluteal repair may be arthroscopic or open (indications did not change) Combined indication for pincer impingement and subspine impingement to reflect the current classification of these clinical entities