

<b>MEDICAL POLICY</b>		<b>Hip Arthroscopy</b>	
<b>Effective Date: 9/1/2019</b>		Section: SUR	Policy No.: 246
 9/1/19		Medical Policy Committee Approved Date: 11/12; 1/14; 1/15; 4/15; 1/16; 3/17; 3/18; 8/19	
Medical Officer	Date		

**See Policy CPT CODE section below for any prior authorization requirements**

**SCOPE:**

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayn Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

**APPLIES TO:**

All lines of business

**BENEFIT APPLICATION**

Medicaid Members

*Oregon:* Services requested for Oregon Health Plan (OHP) members follow the OHP Prioritized List and Oregon Administrative Rules (OARs) as the primary resource for coverage determinations. Medical policy criteria below may be applied when there are no criteria available in the OARs and the OHP Prioritized List.

**POLICY CRITERIA**

This policy is based upon McKesson InterQual® (2017.3) medical necessity criteria regarding hip arthroscopy:<sup>1</sup>

- I. In patients 18 years of age or older, arthroscopy of the hip joint may be considered **medically necessary and covered** when performed for **any one or more** of the following:
  - A. Joint exploration post penetrating joint injury (urgent).
  - B. Lavage of joint with joint aspirate diagnostic for infection (urgent).
  - C. Removal or stabilization of intra-articular osteochondral lesion or loose body.
  - D. Acetabuloplasty when **all** (1-3) of the following criteria are met:
    1. Documentation of **two or more** of the following symptoms:

- a. Pain increased with initiation of activity; **or**
  - b. Pain increased with weight bearing; **or**
  - c. Pain interferes with activities of daily living (ADL); **or**
  - d. Pain at night; **or**
  - e. Limited range of motion (ROM); **and**
2. Imaging documents arthritis **and** any **two or more** of the following:
    - a. Subchondral cyst; **or**
    - b. Subchondral sclerosis; **or**
    - c. Periarticular osteophytes; **or**
    - d. Periarticular osteopenia; **or**
    - e. Marginal erosion; **or**
    - f. Joint subluxation; **or**
    - g. Joint space narrowing; **and**
  3. **All** of the following conservative treatments (a-d) have been attempted within the last year and did not result in a resolution of symptoms:
    - a. Non-steroidal anti-inflammatory (NSAIDs) or acetaminophen for  $\geq 3$  weeks; **and**
    - b. Disease modifying antirheumatic drugs (DMARDs)  $\geq 12$  weeks; **and**
    - c. Physical therapy (PT) or home exercise  $\geq 12$  weeks; **and**
    - d. Activity modification  $\geq 12$  weeks.
- E. Debridement or repair of acetabular labral tear when **all** (1-3) of the following criteria are met:
1. Documentation of **two or more** of the following symptoms:
    - a. Hip or groin pain; **or**
    - b. Locking or catching; **or**
    - c. Giving way by history; **or**
    - d. Clicking; **or**
    - e. Pain with range of motion (ROM); **or**
    - f. Limited ROM; **and**
  2. Imaging documents a labral tear; **and**
  3. **All** of the following conservative treatments (a-c) have been attempted within the last year and did not result in a resolution of symptoms:
    - a. Non-steroidal anti-inflammatory (NSAIDs) or acetaminophen for  $\geq 3$  weeks; **and**
    - b. Physical therapy (PT) or home exercise  $\geq 6$  weeks; **and**
    - c. Activity modification  $\geq 6$  weeks.
- F. Repair of femoroacetabular impingement (FAI) when **all** (1-3) of the following criteria are met:
1. Documentation of **two or more** of the following symptoms:
    - a. Hip or groin pain; **or**
    - b. Locking or catching; **or**
    - c. Giving way by history; **or**
    - d. Clicking; **or**
    - e. Pain with range of motion (ROM); **or**

- f. Limited ROM; **or**
  - g. Positive impingement test; **and**
  - 2. Imaging documents FAI; **and**
  - 3. **All** of the following conservative treatments (a-c) have been attempted within the last year and did not result in a resolution of symptoms:
    - a. Non-steroidal anti-inflammatory (NSAIDS) or acetaminophen for  $\geq 3$  weeks; **and**
    - b. Physical therapy (PT) or home exercise  $\geq 6$  weeks; **and**
    - c. Activity modification  $\geq 6$  weeks.
- G. Synovectomy when **all** (1-3) of the following criteria are met:
- 1. **All** of the following symptoms (a-c) are present:
    - a. Joint pain; **and**
    - b. Pain with range of motion (ROM); **and**
    - c. Limited ROM; **and**
  - 2. Imaging documents an absence of or minimal degenerative changes in bone or cartilage; **and**
  - 3. Symptoms are refractory to  $\geq 12$  weeks of conservative disease-specific treatment within the last year.
- II. In patients 18 years of age or older, arthroscopy of the hip joint is considered **not medically necessary** when criteria I. above is not met.

## BILLING GUIDELINES

### Inpatient/Outpatient Setting

- Lavage of joint with joint aspirate diagnostic for infection should be performed in the inpatient setting.
- All other procedures should be performed in the outpatient setting.

## CPT CODES

All Lines of Business	
No Prior Authorization Required	
29861	Arthroscopy, hip, surgical; with removal of loose body or foreign body
29862	Arthroscopy, hip, surgical; with debridement/shaving of articular cartilage (chondroplasty), abrasion arthroplasty, and/or resection of labrum
29863	Arthroscopy, hip, surgical; with synovectomy
29914	Arthroscopy, hip, surgical; with femoroplasty (ie, treatment of cam lesion)
29915	Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion)
29916	Arthroscopy, hip, surgical; with labral repair

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29999	Unlisted procedure, arthroscopy
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## DESCRIPTION

Arthroscopy is the direct joint visualization through an arthroscope and involves the insertion of a small scope with a camera on the end through a small incision into the hip joint. Visualization of the hip joint permits diagnosis and in some cases treatment, without involving open surgery.<sup>2</sup>

## CENTERS FOR MEDICARE & MEDICAID

As of March 2018, no Centers for Medicare & Medicaid (CMS) coverage guidance was identified which addresses the use of hip arthroscopy for any condition.

## INSTRUCTIONS FOR USE

Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days' notice of policy changes that are restrictive in nature.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement.

## REGULATORY STATUS

### Mental Health Parity Statement

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case.

## REFERENCES

1. McKesson, InterQual Procedures Criteria (2016.3); Arthroscopy, Surgical, Hip; Accessed on 3/17/2018.
2. Hayes, Arthroscopic Repair of Labral Tear of the Hip; Published 6/2/2016; Accessed 3/14/2017; [link](#).