Instructions for use
The following coverage policy applies to health benefit plans administered by Cigna. Coverage policies are intended to provide guidance in interpreting certain standard Cigna benefit plans and are used by medical directors and other health care professionals in making medical necessity and other coverage determinations. Please note the terms of a customer’s particular benefit plan document may differ significantly from the standard benefit plans upon which these coverage policies are based. For example, a customer’s benefit plan document may contain a specific exclusion related to a topic addressed in a coverage policy.

In the event of a conflict, a customer’s benefit plan document always supersedes the information in the coverage policy. In the absence of federal or state coverage mandates, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of:
1. The terms of the applicable benefit plan document in effect on the date of service
2. Any applicable laws and regulations
3. Any relevant collateral source materials including coverage policies
4. The specific facts of the particular situation

Coverage policies relate exclusively to the administration of health benefit plans. Coverage policies are not recommendations for treatment and should never be used as treatment guidelines.

This evidence-based medical coverage policy has been developed by eviCore, Inc. Some information in this coverage policy may not apply to all benefit plans administered by Cigna.

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CMM-314.1: Definitions

- **Femoroacetabular Impingement (FAI)** is an anatomical mismatch between the head of the femur and the acetabulum resulting in compression of the labrum or articular cartilage during flexion. The mismatch can arise from subtle morphologic alterations in the anatomy or orientation of the ball-and-socket components (for example, a bony prominence at the head-neck junction or acetabular over coverage) with articular cartilage damage initially occurring from abutment of the femoral neck against the acetabular rim, typically at the anterosuperior aspect of the acetabulum. Although hip joints can possess the morphologic features of FAI without symptoms, FAI may become pathologic with repetitive movement and/or increased force on the hip joint. High-demand activities may also result in pathologic impingement in hips with normal morphology.

- It has been proposed that impingement with damage to the labrum and/or acetabulum is a causative factor in the development of hip osteoarthritis, and that as many as half of cases currently categorized as primary osteoarthritis may have an etiology of FAI.

- There are two types of FAI that may occur alone or more frequently together: CAM impingement and pincer impingement.
  - **CAM impingement** is associated with an asymmetric or non-spherical contour of the head or neck of the femur jamming against the acetabulum, resulting in cartilage damage, delamination (detachment from the subchondral bone), and secondary damage to the labrum. Deformity of the head/neck junction that looks like a pistol grip on radiographs is associated with damage to the anterosuperior area of the acetabulum. Symptomatic CAM impingement is found most frequently in young male athletes.
  - **Pincer impingement** is associated with over-coverage of the acetabulum and is most typically found in women of middle age. In cases of isolated pincer impingement, the labrum is affected primarily and cartilage damage may be limited to a narrow strip of the acetabular cartilage.

- **Non-surgical management**, with regard to the treatment of hip pain, is defined as any provider-directed non-surgical treatment, which has been demonstrated in the scientific literature as efficacious and/or is considered reasonable care in the treatment of hip pain. The types of treatment involved can include, but are not limited to, relative rest/activity modification, weight loss, supervised physiotherapy modalities an therapeutic exercises, oral prescription and non-prescription medications, assistive devices (e.g., care, crutches, walker, wheelchair, and/or intra-articular injection [i.e., steroid]).

CMM-314.2: General Guidelines

- The determination of medical necessity for the performance of arthroscopy or open hip surgery is always made on a case-by-case basis.

- Hip arthroscopic or open procedures may be considered medically necessary for individuals when surgery is being performed for fracture, tumor, infection, or foreign body that has led to or will likely lead to progressive destruction.
CMM-314.3: Indications

Arthroscopic or open hip surgery is considered medically necessary for ANY of the following clinical situations:

- Acute fracture of the hip (femoral or acetabular)
- Malunion of a previous fracture
- Acute or post-traumatic injury in which there is a correlation between examination and diagnostic imaging findings confirming a condition which is reasonably suspected of producing the individual’s severe pain and limitation in function
- Tumor, infection, foreign body, or other deformity, (e.g., in conjunction with a periacetabular osteotomy for hip dysplasia) that has led to or will likely lead to progressive destruction
- Synovial biopsy
- Irrigation and debridement of an intra-articular joint space infection
- Removal of a radiographically-confirmed ossific or osteochondral loose body
- Labral repair or reconstruction to address labral pathology when an individual has ALL of the following criteria:
  - Mechanical symptoms of the hip (e.g., catching, locking, or giving way) associated with groin-dominant hip pain that significantly limits activities
  - ANY of the following positive provocative tests for intra-articular hip pathology on physical examination:
    - Anterior impingement sign (i.e., hip or groin pain with forced hip flexion, adduction, and internal rotation)
    - FABER test (i.e., hip or groin pain with forced flexion, abduction, and external rotation)
    - Fitzgerald test (i.e., hip or groin pain with extension, internal rotation, and adduction from forced hip flexion, abduction, and external rotation or with extension, external rotation, and abduction from forced hip flexion, adduction, and internal rotation)
  - Unresponsive to at least 3 months of provider-directed non-surgical treatment which must include an image-guided diagnostic/therapeutic intra-articular hip injection to which there was not a negative response
  - An advanced diagnostic imaging study confirming labral pathology amenable to surgical management (Refer to MS-24: Hip for advanced imaging indications for labral tear)
- Femoroacetabular Impingement (FAI) when an individual has ALL of the following criteria:
  - Groin-dominant hip pain that is worsened by flexion (e.g., squatting or prolonged sitting) and significantly limits activities
  - Positive anterior impingement sign (i.e., groin-dominant hip pain with forced hip flexion, adduction, and internal rotation) on physical examination
  - Limited passive hip internal rotation on physical examination
Unresponsive to at least 3 months of provider-directed non-surgical treatment which must include an image-guided diagnostic/therapeutic intra-articular hip injection to which there was not a negative response

ANY of the following radiographic findings to confirm FAI (Refer to MS-24: Hip for advanced imaging indications for FAI)
- Alpha angle greater than 55 degrees
- Pistol-grip deformity
- Decrease of femoral head-neck offset
- Acetabular retroversion (i.e., crossover sign, ischial spine sign)
- Coxa profunda

Documented presence of EITHER of the following:
- Tönnis grade 0 osteoarthritis (i.e., no signs of osteoarthritis)
- Tönnis grade 1 osteoarthritis (i.e., sclerosis of the joint with slight joint space narrowing and osteophyte formation, and no or slight loss of femoral head sphericity)

Documented absence of BOTH of the following:
- Tönnis grade 2 osteoarthritis (i.e., small cysts in femoral head or acetabulum, with moderate joint space narrowing [i.e., < 2mm wide on plain radiographs of the pelvis] and moderate loss of femoral head sphericity)
- Tönnis grade 3 osteoarthritis (i.e., large cysts in the femoral head or acetabulum, severe joint space narrowing [e.g., bone-on-bone] or obliteration of the joint space, and severe deformity and loss of sphericity of the femoral head)

Avascular necrosis of the femoral head when and individual has ALL of the following criteria:
- One of the following hip procedures is planned:
  - Core decompression
  - Varus rotational osteotomy
  - Valgus flexion osteotomy
  - Curettage and bone grafting through the Mont trapdoor technique or the Merel D’Aubigne light bulb technique
  - Free vascularized fibular graft (FVFG)
- ANY of the following symptoms or exam findings of avascular necrosis of the femoral head:
  - Deep pain in groin
  - Pain associated with movement or weight-bearing
  - Limited rotation of hip in both extension and flexion
  - Antalgic gait
  - Mechanical symptoms of the hip (e.g., catching, locking, or giving way) associated with groin-dominant hip pain that significantly limits activities
- Imaging shows ONE of the following (Refer to MS-4: Avascular Necrosis (AVN)/Osteonecrosis and MS-24: Hip for advanced imaging indications for avascular necrosis of the femoral head):
  - For core decompression (EITHER of the following):
    - MRI or x-ray findings of cystic or sclerotic changes without subchondral fracture of the femoral head (i.e., Ficat and Arlet stage II or less)
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- MRI findings of less than 30% involvement of femoral head
- For varus rotational osteotomy:
  - MRI findings of small lesion (less than 15% involvement of the femoral head) in which the lesion can be rotated away from a weight bearing surface
- For valgus flexion osteotomy:
  - MRI findings of anterolateral disease
- For curettage and bone grafting through the Mont trapdoor technique or the Merel D’Aubigne light bulb technique:
  - MRI findings of pre-collapse
- For free vascularized fibular graft (FVFG):
  - MRI findings of either pre-collapse or collapsed avascular necrosis of the femoral head in young individuals with a reversible etiology

Synovectomy is considered medically necessary when ALL of the following criteria have been met:
- Function-limiting pain (e.g., loss of hip function which interferes with the ability to carry out age appropriate activities of daily living and/or demands of employment)
- Any ONE of the following physical examination findings:
  - Limited range of motion
  - Evidence of joint swelling/effusion
- Failure of provider-directed non-surgical management for at least three (3) months in duration
- MRI or CT arthrogram demonstrates evidence of synovitis
- Presence of any ONE of the following:
  - Inflammatory arthritis (i.e., rheumatoid arthritis, gout, pseudogout, psoriatic arthritis)
  - Pigmented villonodular synovitis (PVNS)
  - Synovial chondromatosis
  - Lyme synovitis
  - Hemochromatosis
  - Recurrent hemarthrosis (i.e., secondary to sickle cell anemia, bleeding diathesis, hemophilia)

Synovectomy is considered not medically necessary for any other indication or condition.

Refer to CMM 313: Hip Replacement/Arthroplasty regarding salvage procedures.

CMM-314.4: Experimental, Investigational, or Unproven

- Arthroscopic or open hip surgery is considered experimental, investigational, or unproven for any other indication or condition, including:
  - Capsular plication
  - Anterior inferior iliac spine/subspinous decompression
  - In-office diagnostic arthroscopy (e.g., Mi-Eye™, VisionScope®)
## CMM-314.5: Procedure (CPT®) Codes

This guideline relates to the CPT® code set below. Codes are displayed for informational purposes only. Any given code’s inclusion on this list does not necessarily indicate prior authorization is required.

<table>
<thead>
<tr>
<th>CPT®</th>
<th>Code Description/Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>26990</td>
<td>Incision and drainage, pelvis or hip joint area; deep abscess or hematoma</td>
</tr>
<tr>
<td>26991</td>
<td>Incision and drainage, pelvis or hip joint area; infected bursa</td>
</tr>
<tr>
<td>26992</td>
<td>Incision, bone cortex, pelvis and/or hip joint (e.g. osteomyelitis or bone abscess)</td>
</tr>
<tr>
<td>27000</td>
<td>Tenotomy, adductor of hip, percutaneous (separate procedure)</td>
</tr>
<tr>
<td>27001</td>
<td>Tenotomy, adductor of hip, open</td>
</tr>
<tr>
<td>27003</td>
<td>Tenotomy, adductor, subcutaneous, open, with obturator neurectomy</td>
</tr>
<tr>
<td>27005</td>
<td>Tenotomy, hip flexor(s), open (separate procedure)</td>
</tr>
<tr>
<td>27006</td>
<td>Tenotomy, abductors and/or extensor(s) of hip, open (separate procedure)</td>
</tr>
<tr>
<td>27025</td>
<td>Fasciotomy, hip or thigh, any type</td>
</tr>
<tr>
<td>27027</td>
<td>Decompression fasciotomy(ies), pelvic (buttock) compartment(s) (eg. glutaeus medius- minimus, glutaeus maximus, iliopsoas, and/or tensor fascia lata muscle), unilateral</td>
</tr>
<tr>
<td>27030</td>
<td>Arthroscopy, hip, with drainage (e.g. infection)</td>
</tr>
<tr>
<td>27033</td>
<td>Arthroscopy, hip, including exploration or removal of loose or foreign body</td>
</tr>
<tr>
<td>27034</td>
<td>Denervation, hip joint, intrapelvic or extrapelvic intra-articular branches of sciatic, femoral, or obturator nerves</td>
</tr>
<tr>
<td>27036</td>
<td>Capsulectomy or capsulotomy, hip, with or without excision of heterotrophic bone, with release of hip flexor muscles (i.e. glutaeus medius, glutaeus minimus, tensor fascia latae, rectus femoris, Sartorius, iliopsoas).</td>
</tr>
<tr>
<td>27040</td>
<td>Biopsy, soft tissue of pelvis and hip area; superficial</td>
</tr>
<tr>
<td>27041</td>
<td>Biopsy, soft tissue of pelvis and hip area; deep, subfascial or intramuscular</td>
</tr>
<tr>
<td>27043</td>
<td>Excision, tumor, soft tissue of pelvis and hip area, subcutaneous; 3 cm or greater</td>
</tr>
<tr>
<td>27044</td>
<td>Excision, tumor, soft tissue of pelvis and hip area, subcutaneous (e.g. intramuscular); 5 cm or greater</td>
</tr>
<tr>
<td>27047</td>
<td>Excision, tumor, soft tissue of pelvis and hip area, subcutaneous; less than 3 cm</td>
</tr>
<tr>
<td>27048</td>
<td>Excision, tumor, soft tissue of pelvis and hip area, subfascial (e.g. intramuscular); less than 5 cm</td>
</tr>
<tr>
<td>27049</td>
<td>Radical resection of tumor (e.g. sarcoma), soft tissue of pelvis and hip area; less than 5 cm</td>
</tr>
<tr>
<td>27050</td>
<td>Arthroscopy, with biopsy; sacroiliac joint</td>
</tr>
<tr>
<td>27052</td>
<td>Arthroscopy, with biopsy; hip joint</td>
</tr>
<tr>
<td>27054</td>
<td>Arthroscopy, with synovectomy, hip joint</td>
</tr>
<tr>
<td>27057</td>
<td>Decompression fasciotomy(ies), pelvic(buttock) compartment(s) (e.g. glutaeus medius- minimus, glutaeus maximus, iliopsoas, and/or tensor fascia lata muscle) with debridement of nonviable muscle, unilateral</td>
</tr>
<tr>
<td>27059</td>
<td>Radical resection of tumor (e.g. sarcoma), soft tissue of pelvis and hip area; 5 cm or greater</td>
</tr>
<tr>
<td>27060</td>
<td>Excision; ischial bursa</td>
</tr>
<tr>
<td>27062</td>
<td>Excision; trochanteric bursa or calcification</td>
</tr>
<tr>
<td>27065</td>
<td>Excision of bone cyst or benign tumor, wing of ilium, symphysis pubis, or greater trochanter of femur; superficial, includes autograft, when performed</td>
</tr>
<tr>
<td>27066</td>
<td>Excision of bone cyst or benign tumor, wing of ilium, symphysis pubis, or greater trochanter of femur; deep (subfascial), includes autograft, when performed</td>
</tr>
</tbody>
</table>
27067  Excision of bone cyst or benign tumor, wing of ilium, symphysis pubis, or greater trochanter of femur; with autograft requiring separate incision

27070  Partial excision, wing of ilium, symphysis pubis, or greater trochanter of femur, (craterization, saucerization) (e.g. osteomyelitis or bone abscess); superficial

27071  Partial excision, wing of ilium, symphysis pubis, or greater trochanter of femur, (craterization, saucerization) (e.g. osteomyelitis or bone abscess); deep

27075  Radical resection of tumor; wing of ilium, 1 pubic or ischial ramus or symphysis pubis

27076  Radical resection of tumor; ilium, including acetabulum, both pubic rami, or ischium and acetabulum.

27077  Radical resection of tumor; innominate bone, total

27078  Radical resection of tumor; ischial tuberosity and greater trochanter of femur

27080  Coccygectomy, primary

27086  Removal of foreign body, pelvis or hip; subcutaneous tissue

27087  Removal of foreign body, pelvis or hip; deep (subfascial or intramuscular)

27097  Release or recession, hamstring, proximal

27098  Transfer, adductor to ischium

27100  Transfer external oblique muscle to greater trochanter including fascial or tendon extension (graft)

27105  Transfer paraspinous muscle to hip (includes fascial or tendon extension graft)

27110  Transfer iliopsoas; to greater trochanter of femur

27111  Transfer iliopsoas; to femoral neck

27140  Osteotomy and transfer of greater trochanter of femur (separate procedure)

27146  Osteotomy, iliac, acetabular or innominate bone;

27147  Osteotomy, iliac, acetabular or innominate bone; with open reduction of hip

27151  Osteotomy, iliac, acetabular or innominate bone; with femoral osteotomy

27156  Osteotomy, iliac, acetabular or innominate bone; with femoral osteotomy and with open reduction of hip

27158  Osteotomy, pelvis, bilateral (eg, congenital malformation)

27161  Osteotomy, femoral neck (separate procedure)

27165  Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cast

27170  Bone graft, femoral head, neck, intertrochanteric or subtrochanteric area (includes obtaining bone graft)

27175  Treatment of slipped femoral epiphysis; by traction, without reduction

27176  Treatment of slipped femoral epiphysis; by single or multiple pinning, in situ

27177  Open treatment of slipped femoral epiphysis; single or multiple pinning or bone graft (includes obtaining graft)

27178  Open treatment of slipped femoral epiphysis; closed manipulation with single or multiple pinning

27179  Open treatment of slipped femoral epiphysis; osteoplasty of femoral neck (Heyman type procedure)

27181  Open treatment of slipped femoral epiphysis; osteotomy and internal fixation

27185  Epiphyseal arrest by epiphysiodesis or stapling, greater trochanter of femur

27187  Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate, femoral neck and proximal femur

29860  Arthroscopy, hip, diagnostic with or without synovial biopsy (separate procedure)

29861  Arthroscopy, hip, surgical; with removal of loose body or foreign body
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<table>
<thead>
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<th>Code</th>
<th>Description</th>
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<tr>
<td>29862</td>
<td>Arthroscopy, hip, surgical; with debridement/shaving of articular cartilage (chondroplasty), abrasion Arthroplasty, and/or resection of labrum</td>
</tr>
<tr>
<td>29863</td>
<td>Arthroscopy, hip, surgical; with synovectomy</td>
</tr>
<tr>
<td>29914</td>
<td>Arthroscopy, hip, surgical; with femoroplasty (i.e. treatment of cam lesion)</td>
</tr>
<tr>
<td>29915</td>
<td>Arthroscopy, hip, surgical; with acetabuloplasty (i.e. treatment of pincer lesion)</td>
</tr>
<tr>
<td>29916</td>
<td>Arthroscopy, hip, surgical; with labral repair</td>
</tr>
</tbody>
</table>

This list may not be all inclusive and is not intended to be used for coding/billing purposes. The final determination of reimbursement for services is the decision of the health plan and is based on the individual’s policy or benefit entitlement structure as well as claims processing rules.

CMM-314.6: References