Orthopedics: Knees and Hips

Presented By Jennifer McNamara
CPC,CCS,CRC,CPMA,CDEO,COSC,CGSC,COPC

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Meet the Speaker

Jennifer McNamara

CPC, CCS, CRC, CPMA, CDEO, COSC, CGSC, COPC

As CEO of Healthcare Inspired LLC and a Compliance Consultant, Jennifer is a nationally recognized expert in healthcare management and compliance. With a dynamic presence as a speaker, podcaster, and auditor, Jennifer inspires positive change in the healthcare industry.

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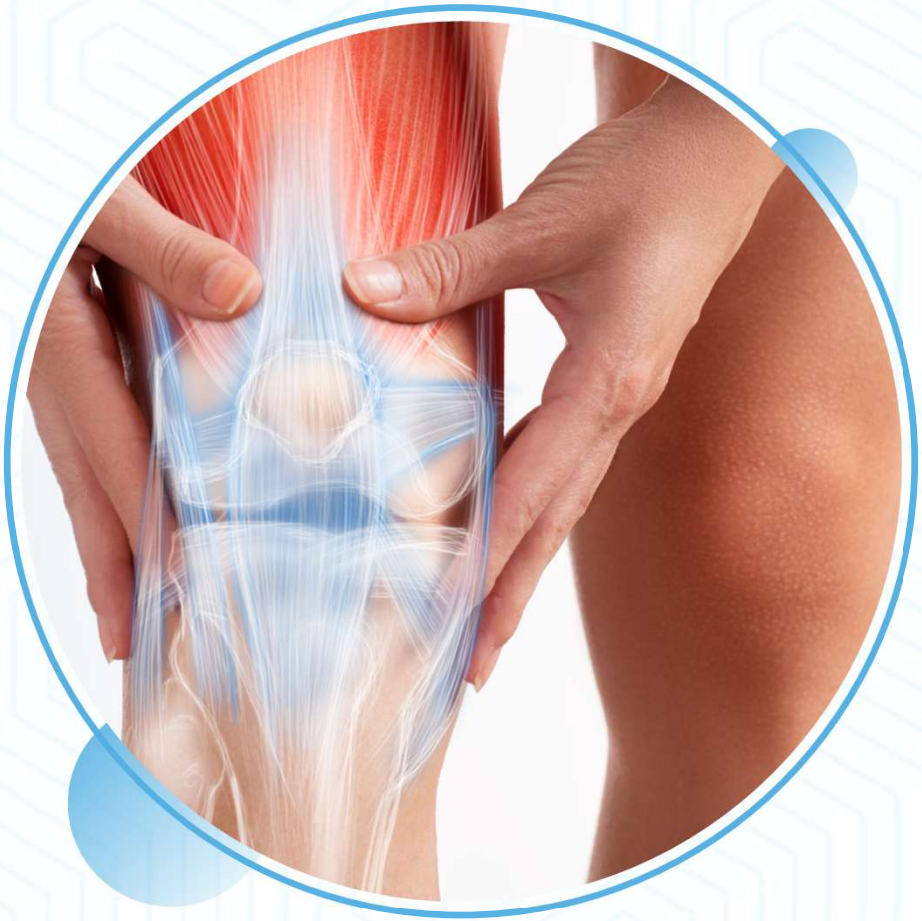
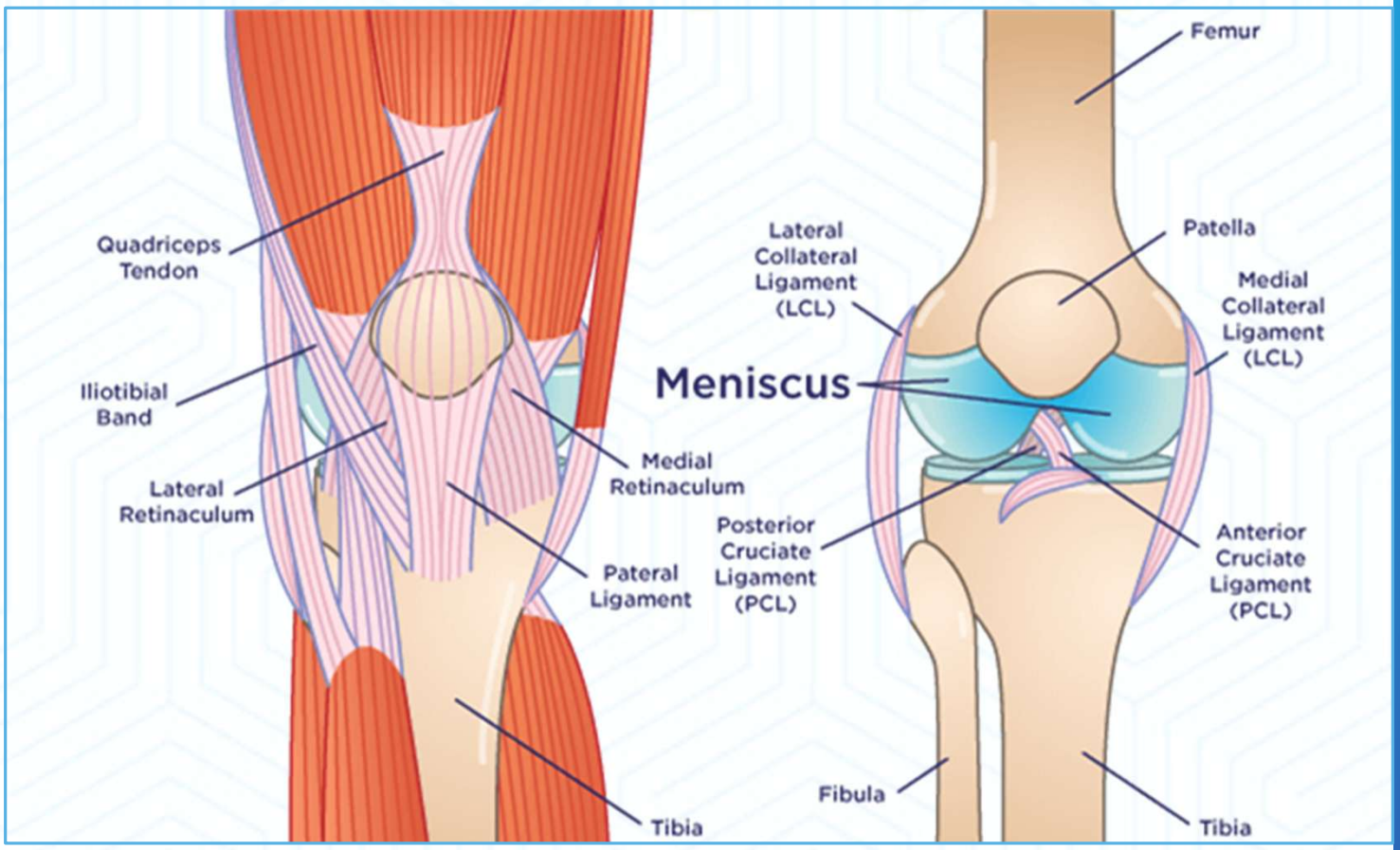


Knee

Knee Anatomy



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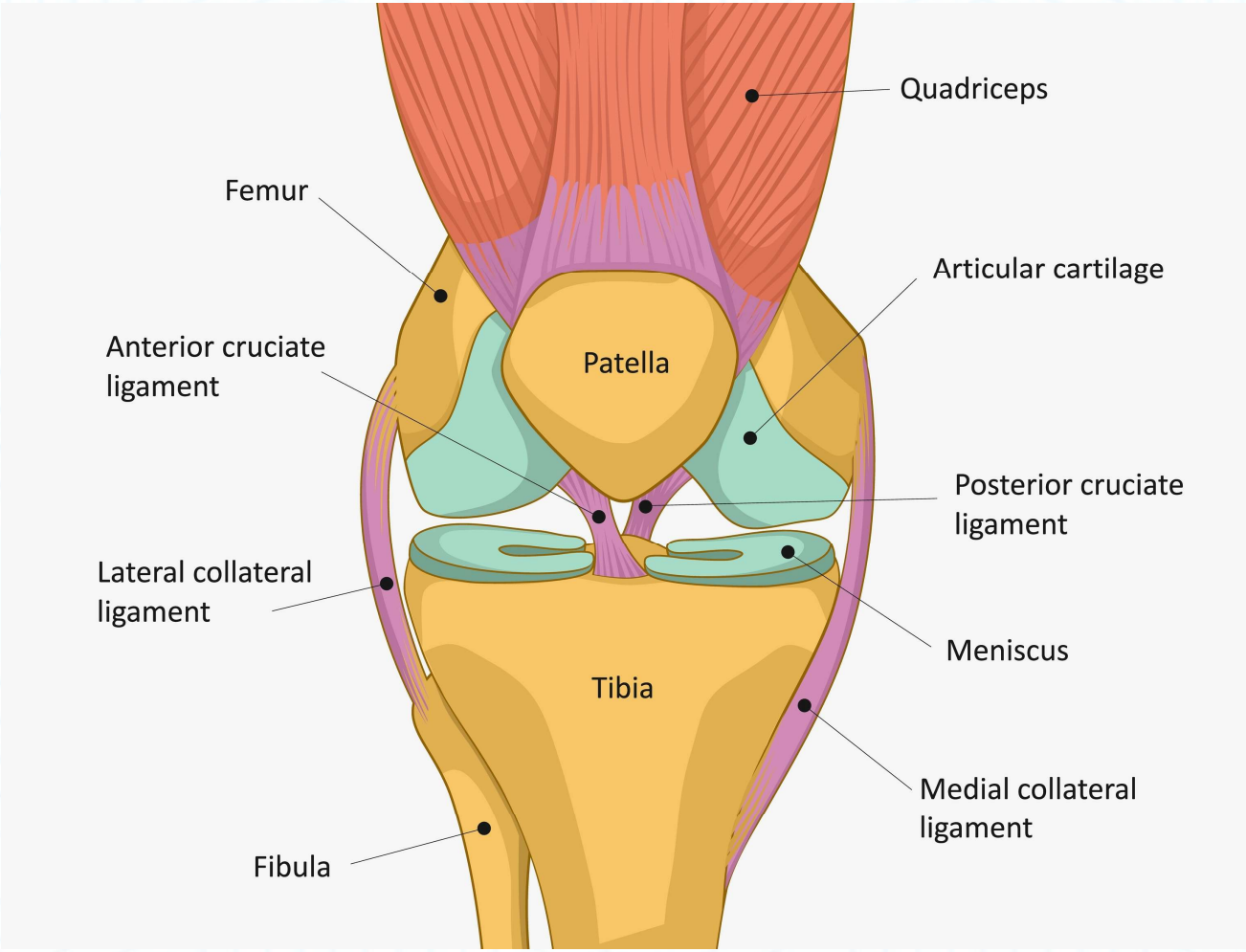
Knee Anatomy



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Common Knee Diseases

Osteoarthritis of Knee (M17.-)

- **Primary OA (M17.0, M17.1, M17.10–M17.12, etc.)**
  - Caused by age-related wear and tear, no underlying condition.
  - Cartilage wears down gradually → bone-on-bone pain, stiffness, reduced mobility.
- **Secondary OA (M17.2-, M17.3-, etc.)**
  - Due to trauma, prior surgery, obesity, congenital deformity, or other conditions.
- **Key ICD-10 notes:** Laterality is required (right, left, bilateral, unspecified).

Meniscal Tears (S83.2-, M23.2-)

- **Acute tear (S83.2-)**
  - Happens suddenly (sports injury, twisting).
  - Often medial meniscus; causes locking, swelling, pain.
- **Old or degenerative tear (M23.2-)**
  - Chronic tear from wear over time.
  - Common in older adults with OA.
- **Documentation must say:** acute vs chronic, medial vs lateral, and whether both menisci involved.

Ligament Injuries

- **Anterior Cruciate Ligament (ACL) — S83.51-**
  - Classic sports injury; twisting or pivoting.
  - Instability, "giving out" sensation.
- **Posterior Cruciate Ligament (PCL) — S83.52-**
  - Often from trauma (car accident, fall).
  - Less common than ACL tears.
- **Collateral ligaments (MCL, LCL) — S83.41-, S83.42-**
  - Injuries from impact to side of knee.
- **Key ICD-10 notes:** Requires laterality and encounter (initial, subsequent, sequela).

Common Knee Diseases

Chondromalacia Patellae (M22.4-)

- Softening and breakdown of cartilage under the kneecap.
- Causes anterior knee pain, worsens with stairs, sitting long periods.
- Common in young athletes, runners, and women.

Patellar Instability / Dislocation (S83.0-, M22.0-)

- **Acute dislocation (S83.0-)**
  - Sudden trauma, kneecap shifts laterally.
- **Recurrent/patellar instability (M22.0-)**
  - Knee "gives way," repeated dislocations.
  - Requires surgery sometimes (MPFL reconstruction).

Bursitis of Knee (M70.4-)

- Inflammation of bursae (small fluid sacs) around knee.
- "Housemaid's knee" = prepatellar bursitis.
- Pain, swelling in front of kneecap; often occupational or overuse-related.

Internal Derangement of Knee (M23.-)

- Catch-all group for chronic meniscus/ligament issues.
- Includes old tears, loose bodies, chronic instability.
- Used when pathology is not acute but sequela of old injury.

Other Common Diagnoses

- **Synovitis (M65.9-)** – Inflammation of synovial membrane, swelling, pain.
- **Loose Body (M23.4-)** – Cartilage/bone fragment floating in joint.
- **Post-traumatic OA (M17.3-)** – OA after fracture, ligament rupture, or surgery.

Common Knee Diseases

Coding reminders:

- Always grab **laterality** (RT, LT, bilateral).
- Document **acute vs chronic**.
- Use **seventh characters** (A = initial, D = subsequent, S = sequela) for injuries.
- Link **imaging + conservative care** to show medical necessity for surgery.

Common Knee Diseases

Coding reminders:

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- Link **imaging + conservative care** to show medical necessity for surgery.

Arthroscopic Codes – Knee

CPT	DESCRIPTION	NOTES
29871	Arthroscopy, knee, surgical; for infection, lavage and drainage (washout)	
29873	Arthroscopy knee; with lateral release	
29875	Arthroscopy, knee, surgical; synovectomy, limited (eg, plica or shelf resection) (separate procedure)	NCCI EDITS – CHAPTER IV – SECTION I – SUBSECTION 26 CMS does not allow separate reporting of a procedure designated as a "separate procedure" when it is performed at the same patient encounter as another procedure in an anatomically related area through the same skin incision, orifice, or surgical approach
29876	synovectomy major 2+comparments (eg medial or lateral)	
29879	Arthroscopy, knee, surgical; abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture	
29874	Arthroscopy, knee, surgical; for removal of loose body or foreign body (eg, osteochondritis dissecans fragmentation, chondral fragmentation) (1cm = 10mm)	***see NCCI edits for billing scenarios***
29877	Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty)	***see NCCI edits for billing scenarios*** (notchplasty)
G0289	Arthroscopy, knee, surgical, for removal of loose body, foreign body, debridement/shaving of articular cartilage (chondroplasty) at the time of other surgical knee arthroscopy in a different compartment of the same knee	

Chondroplasty – Points to note:

•29877 nor G0289 should be used to report chondroplasty with meniscectomy 29880 or 29881 since chondroplasty is included in their definitions. – no exceptions

•29877 or G0289 **MAY BE** separately reported with meniscal repair codes 29882 and 29883 when performed in a **SEPARATE COMPARTMENT**, as long as another reportable service is not performed there.

•Modifier 59 is not used for Medicare claims.

•Medicare assumes that G0289 represents the arthroscopic removal of a loose body or foreign body in a different compartment.

•Modifier 59 or XS may be applied when reporting 29877 to private payers to indicate the separate compartment rule is met.

****ALWAYS CHECK YOUR PAYORS MEDICAL AND PAYOR POLICIES****

https://www.cms.gov/files/document/medicare-ncci-policy-manual-2024-chapter-4.pdf

Arthroscopic Codes – Knee – con't

CPT	DESCRIPTION	NOTES
29881	Arthroscopy, knee, surgical; with meniscectomy (medial **OR** lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed	•Includes any **chondroplasty** done in that same or other compartment. • ⚠️ Don't bill 29877 with this (bundled).
29880	Medial **AND** Lateral…	•Both compartments treated in the **same knee, same session**. •More extensive than 29881. Documentation must clearly state **both medial & lateral work**.
29882	Arthroscopy, knee, surgical; with meniscus repair (medial **OR** lateral)	•For repair (suturing/anchoring) of **one meniscus**. •Different from meniscectomy — saving the meniscus vs removing it. Document **tear type, repair technique, fixation used**.
29883	Medial **AND** Lateral	•Both menisci repaired in same session. •Requires clear operative detail for **both compartments**.
29884	Arthroscopy, knee, surgical; with lysis of adhesions, with or without manipulation (separate procedure)	** scar tissue / cyclops lesion
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction	•Arthroscopically assisted repair/reconstruction of **anterior cruciate ligament**. •Requires documentation of **graft type, tunnels, fixation method**.

MENISCUS REPAIRS AND MENISCECTOMIES ARE NOT BUNDLED WITH AN ACL RECONSTRUCTION!!!!

Aetna – Knee Scope

Let's break it down!!
Policy

Aetna considers arthroscopic debridement (with or without partial meniscectomy) medically necessary for persons presenting with mild-to-moderate (Outerbridge classification I and II, not III or IV) osteoarthritis (OA) with knee pain plus mechanical symptoms due to loose bodies and/or meniscal tears.

Aetna considers arthroscopic partial meniscectomy medically necessary for traumatic meniscal tears unless there is moderate or severe osteoarthritis present (Outerbridge classification III or IV).

Aetna considers arthroscopic partial meniscectomy experimental and investigational for **degenerative meniscal tears.**

Arthroscopic partial meniscectomy:	
CPT codes covered if selection criteria are met:	
29880	Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed
29881	with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed
ICD-10 codes covered if selection criteria are met:	
S83.200A - S83.289S	Tear of meniscus, current injury
ICD-10 codes not covered for indications listed in the CPB:	
M23.200 - M23.269	Derangement of meniscus due to old tear or injury
M25.561 - M25.569	Pain in knee
M25.661 - M25.669	Stiffness of knee, not elsewhere classified

What does this mean -
if you do a partial meniscectomy for a degenerative meniscal tear it will NOT be paid

https://www.aetna.com/cpb/medical/data/600_699/0673.html

Premera Blue - Knee Scope

Indication Medical Necessity Meniscal tear Knee arthroscopy for repair of a meniscal tear may be considered medically necessary when ALL of the following criteria are met:

Clinical documentation confirms the presence of ONE of the following:
Positive McMurray test; or
Positive Apley test; or
Joint line tenderness with palpation; or
Diagnostic imaging (MRI, CT, etc.) done within the 12 months prior to surgery demonstrates a torn or displaced meniscus (e.g., bucket handle tear, radial tear, posterior horn tear); or
Meniscus tear coincident with ACL injury, discovered during arthroscopy for ACL

AND

Repair is indicated by ONE of the following:
Functional impairment (e.g., knee locking, giving way or decreased range of motion [ROM]) is present; or
A medically necessary ACL repair or reconstruction has been approved; or
Symptoms have not responded to 8 weeks of conservative care (e.g., PT, activity modification, oral analgesics)

AND

If age 50 and older, imaging shows the absence of severe arthritis (i.e., large osteophytes, marked narrowing of joint space, severe sclerosis, and definite deformity of bone contour

Knee arthroscopic partial meniscectomy is considered not medically necessary for a degenerative tear(s) (e.g., horizontal cleavage tear on imaging) with no associated mechanical symptoms (e.g., knee locking, giving way, or decreased range of motion)

https://www.premera.com/medicalpolicies/7.01.549.pdf

Precertification Lists

Precertification information

Precertification applies to all benefits plans that include a precertification requirement. Participating providers are required to pursue precertification for procedures and services on the lists below.

2024 Participating Provider Precertification List – Effective date: July 1, 2024 (PDF)

https://www.aetna.com/health-care-professionals/precertification/precertification-lists.html

Search by CPT code

Use our search tool to see if precertification is required. Enter one or more 5-digit CPT codes. This tool also helps to determine if a special program applies.

Code 1 29888

CPT code: 29888

The procedure code you entered was not found on the Aetna Participating Provider Medical Precertification List. If you're a participating provider, no precertification is required when this service is performed as an outpatient procedure for a medical or surgical diagnosis. This procedure code may require precertification for behavioral health diagnoses.

See the Aetna Behavioral Health precertification list (PDF)

Review our clinical policy bulletins to determine if limitations apply.

See our clinical policy bulletins

Precertification lists

Time-Saving Resources: Code Check and Prior Auth Tools
Sometimes you need to quickly check a code or see if prior authorization is needed for a member. Save time and a phone call with these two quick resources.

Code check tool
Our code check tool gives you a quick way to see if procedure codes are covered. The tool includes all dental, medical, eviCore, and AIM codes, as well as unlisted codes. Note that this tool gives you general information; it's **not member or plan specific**.

Prior authorization tool
If you need more than just a quick code check, sign in and use our secure prior authorization tool for **member-specific** benefit information. You can check codes and find out if you need authorization or referral. The prior auth tool also confirms if the service is covered in- or out-of-network and displays related medical policies.

https://www.premera.com/wa/provider/news/online-tools-resources/time-saving-resource/

Precertification lists

1. Enter a 5-character code (CPT, ADA, or HCPCS)

This tool doesn't accept modifiers.

Prior authorization

Code check

29827

Check

Review Requirement	Documentation required
No Prior Authorization Required	N/A

This code does not require review. However, inpatient stays require notification. Fax notification to 800-843-1114.

Description

ARTHROSCOPY, SHOULDER, SURGICAL; WITH ROTATOR CUFF REPAIR

Reviewed for

N/A

1. Enter a 5-character code (CPT, ADA, or HCPCS)

This tool doesn't accept modifiers.

Prior authorization

Code check

29888

Review Requirement	Documentation required
Prior Authorization Required	Submit site of service, history and physical, documentation of medical necessity including procedure report. No review needed for member age 18 and under.

Description

Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction

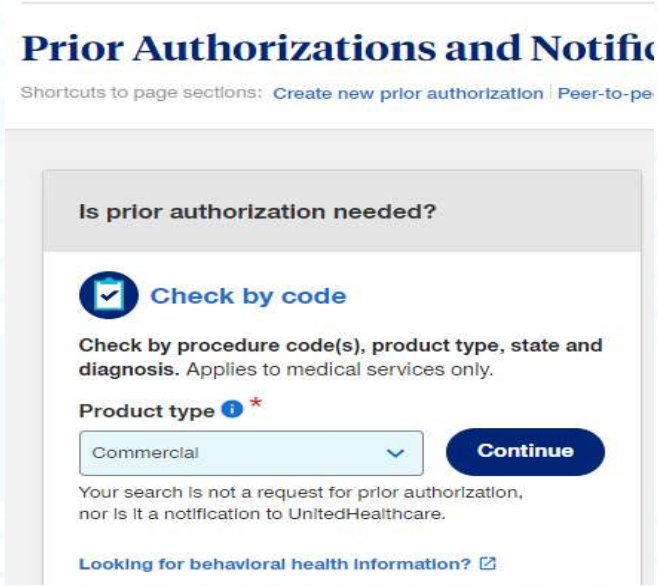
Reviewed for

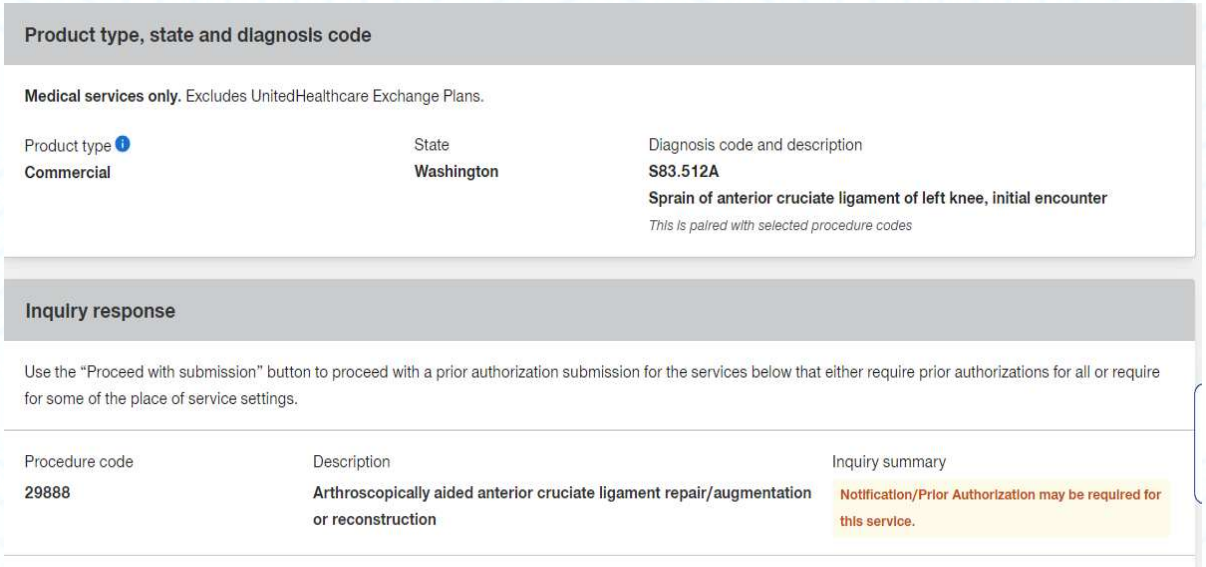
Medical necessity including site of service

https://www.premera.com/wa/provider/news/online-tools-resources/time-saving-resource/

Precertification lists

Next screen – you'll enter:
1. Product type
2. State
3. Diagnosis code
4. Procedure code (up to 5 codes at a time)





https://www.uhcprovider.com/en/prior-auth-advance-notification.html

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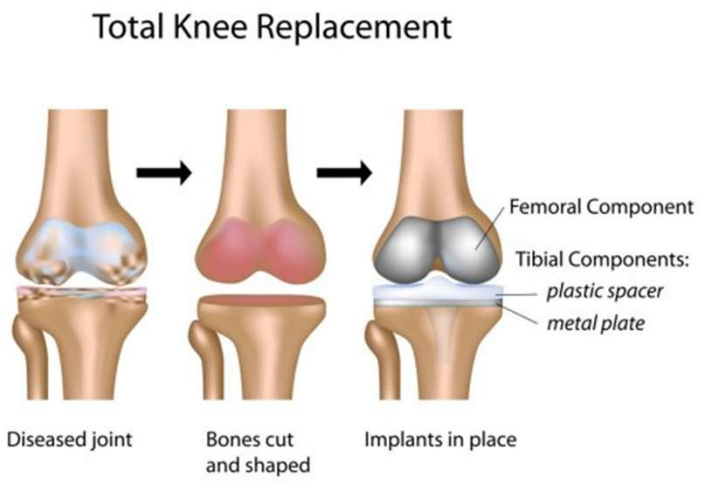
Total Knee Arthroscopy

Total Knee Replacement (Total Knee Arthroplasty):

- **Designed to**: replace the damaged or worn surfaces of the knee joint with artificial components, creating a new knee joint.
- **What Occurs**? The damaged cartilage and bone in the knee joint are removed, and metal components are placed on the ends of the femur and tibia bones. A plastic ***spacer*** is inserted between the metal components to create a smooth gliding surface.
- **Why**? Patients suffering from severe knee pain and limited knee function due to conditions such as osteoarthritis, rheumatoid arthritis, or post-traumatic arthritis.



Coding

CPT Code: 27447 - Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)

CPT Code: 27446 - Arthroplasty, knee, condyle and plateau; medial OR lateral compartment

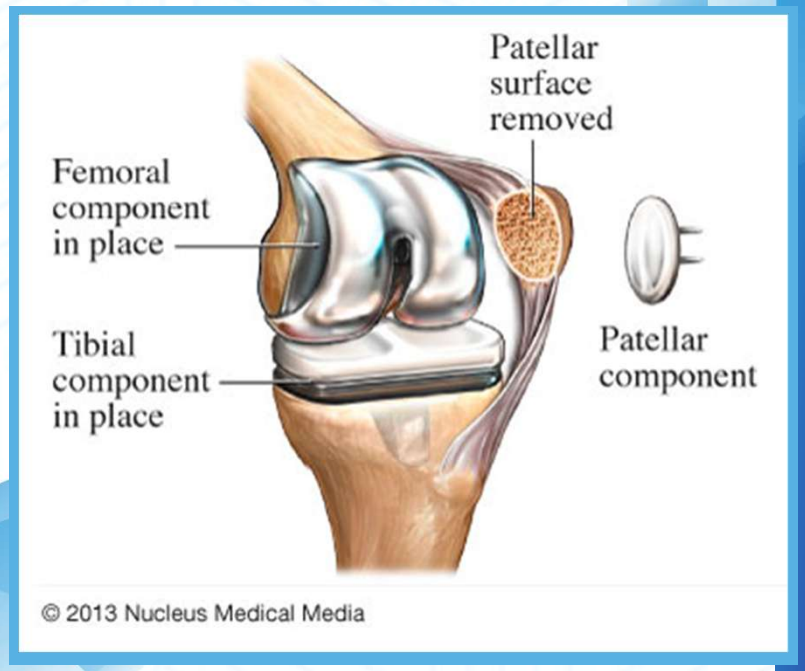
CPT Code: 27486 - Revision of total knee arthroplasty, with or without allograft; 1 component

CPT Code: 27487 - Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component

CPT Code: 27488 - Removal of prosthesis, including total knee prosthesis, methylmethacrylate with or without insertion of spacer, knee

Knee Revision

- For a TKA revision (27486 *Revision of total knee arthroplasty, with or without allograft; 1 component)*
- 27487 *Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component*)
  - Look for "polyetheline liner" removal or replacement
  - Poly Exchange
  - 27486 with a 52 Modifier
  - CPT Assistant (July 2013)



Drug Delivery Implants

20700 ***Manual*** preparation and insertion of drug-delivery device(s); deep(eg, subfascial) (List separately in addition to primary procedure) (usually polymethylmethacrylate beads on a wire with Tobramycin or Vancomycin)

20702… ***Manual*** preparation and insertion of drug-delivery device(s), intramedullary (List separately in addition to primary procedure)

20704… Manual preparation and insertion of drug-delivery device(s), intra-articular (List separately in addition to primary procedure)

20701 **Removal** of drug-delivery device(s); **deep**(e.g., subfascial) (List separately in addition to primary procedure)

20703 **Removal** of drug-delivery device(s), **intramedullary** (List separately in addition to primary procedure)

20705 **Removal** of drug-delivery device(s), **intra-articular** (List separately in addition to primary procedure)

Drug Delivery Implants

Musculoskeletal Drug - Delivery Devices

20700 - 20705

20700, 20702, 20704

- Manually prepared drug-delivery

Do not report 20702 in conjunction with 11981, 27091, 27488)

Stand Alone Removal

- Intramedullary infection of the femur
- 20680 - Removal of implant; deep (e.g., buried wire, pin, screw, metal band, nail, rod or plate), would be reported.

20703, 20704, 20705

- Removal Same time as main procedure

(Use 20703 in conjunction with 23485, 24430, 24435, 25400, 25405, 25415, 25420, 25425, 27470, 27472, 27720, 27722, 27724, 27725)

Example

- Complete Removal of an infected TKA (Resection Arthroplasty) with placement of an intra-articular drug - delivery device as a planned staged procedure.
- Manual fashions of an antibiotic-laden cement spacer is completed intraoperatively and inserted into the joint defect to preserve the joint space.
- Knee (27488) Total joint prosthesis removal and space placement.
- 20704 may NOT BE reported for the spacer or beads.
- Infected TJA; revision arthroplasty with placement of modular articular components.
- Removal of components and replacement (revision) 27487-52
- Existing intra-articular drug delivery devices removed are included
- Resorbable antibiotic - eluting beads manually prepared separately at the time of surgery and inserted USE code 20704

Documentation Tips

- Diagnosis(es) and indication(s) for surgery
- Intraoperative work performed
- Findings that led to the specific procedure being performed SUCH AS: Revision Arthroplasty.
- Say that the surgeon fabricated the drug- delivery device.
- For articulating spacer with a joint revision is reported, document the bone resections and balancing of the joint and ligaments needed for the use of the revision code.
- If only modular parts replaced, use modifier 52 for reduced services on the TKA

Removal and Replacement Same Day or Staged

- 27486 Revision 1 Component
- 27487 Revision Femoral and Full Tibial
- Know what is being replaced
- Multi Day Staged:
  - 27488 Removal of Prosthesis
  - Use 78 if it's a complication and 70-80 % of allowable fee
  - 58 Modifier Staged within 90 days-100% global starts over
  - 27447 for second stage
  - Do not report 20705 in conjunction with 11982, 27130, 27447, 27486
  - 27310 Infection remains and 20704 new spacer
  - 20700-20705 designed for deep in Musculoskeletal, Not subcutaneous

Example

Stage 1:

- Removal of prosthesis with or without spacer 27488

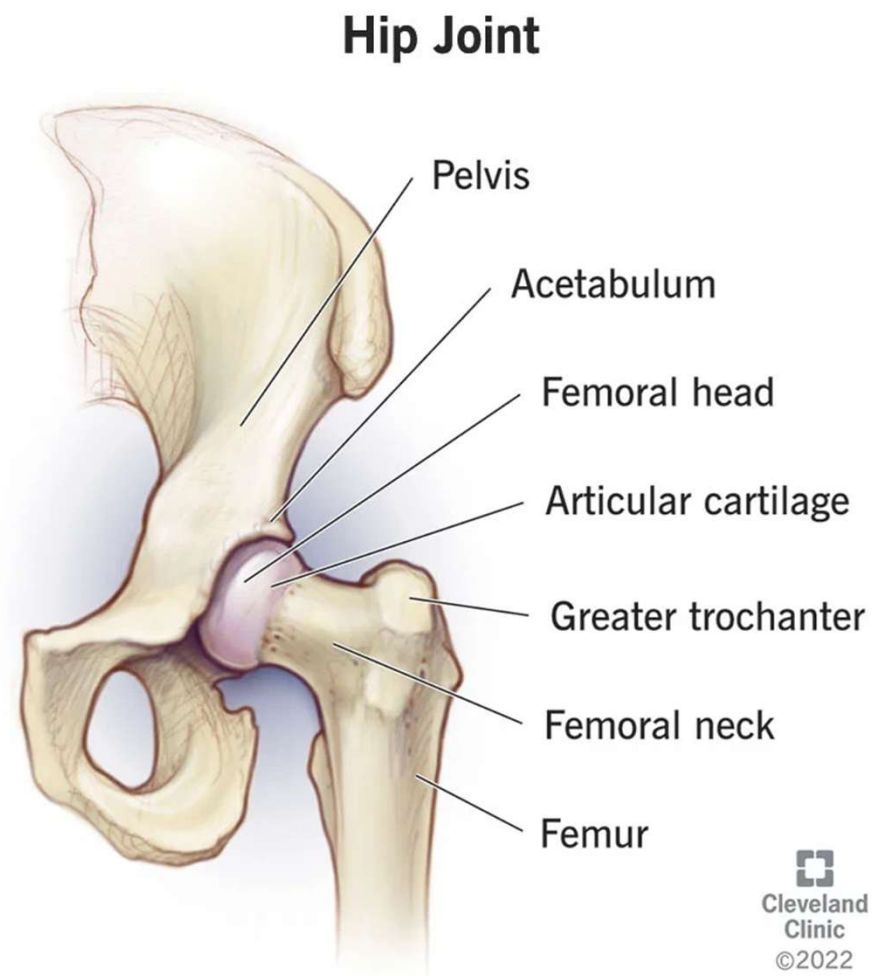
Stage 2:

- Total Knee Replacement- All components 27447,58,22
- 22 with documentation supporting the alteration of the surgical field and is more difficult
- Use 58 if within 90 days
- Do not use 58 if it's a complication

https://www.aaos.org/AAOSNow/2007/Sep/managing/managing1/

Hips

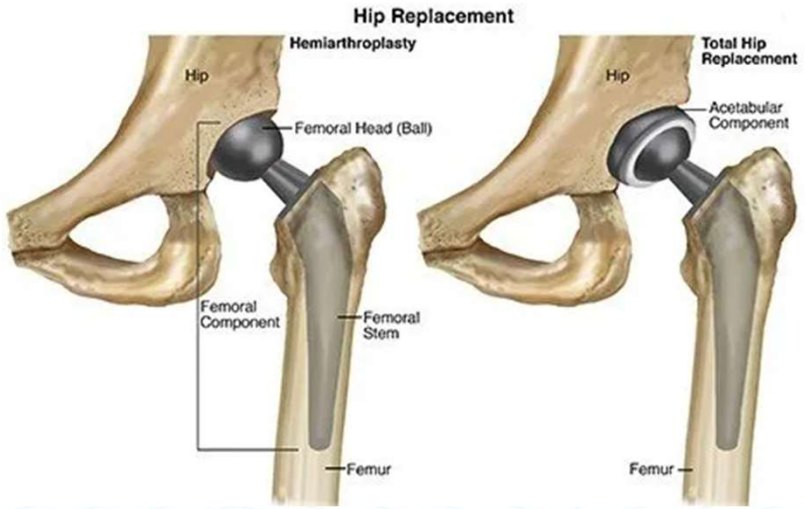
Hip Anatomy



Hip Arthroplasty

Total Hip Replacement (Total Hip Arthroplasty):

- **Designed to**: replace the damaged or arthritic hip joint with an artificial joint, known as a prosthesis or implant.
- **What Occurs**? Removal of the damaged bone and cartilage from the hip joint and replacing it with a metal or ceramic ball attached to a metal stem that fits into the **femur** (thigh bone), and a socket (**acetabulum**) is replaced with a metal or plastic cup.
- **Why**? relieve severe hip pain, improve joint function, and enhance mobility in patients with conditions like osteoarthritis, rheumatoid arthritis, avascular necrosis, and hip fractures.



Hip Arthroscopy

29860 – Arthroscopy, hip, diagnostic

- *Diagnostic only* (no surgical work performed).
- Used when scope is performed to evaluate pathology, not treated.

29861 – Arthroscopy, hip, surgical; with removal of loose body or foreign body

- For removal of **loose fragments** of cartilage, bone, or other material.
- Must be intra-articular and documented as **loose body/foreign body**.
- Not for routine debridement (that falls under 29862).

29862 – Arthroscopy, hip, surgical; with debridement/shaving of articular cartilage (chondroplasty), abrasion arthroplasty, and/or resection of labrum

Used for **debridement-type procedures**:

- Chondroplasty
- Labral debridement (NOT re pair)
- Partial synovectomy
- Don't use if labrum is **repaired** — that's 29916.

29863 – Arthroscopy, hip, surgical; with synovectomy, complete

- For **complete synovectomy** of hip joint.
- Must be clearly documented as **complete**, not partial (partial = 29862).

Hip Arthroscopy

29914 – Arthroscopy, hip, with femoroplasty (i.e., treatment of CAM lesion)

- Used when surgeon reshapes the **femoral head-neck junction** to correct CAM impingement.
- Requires documentation of **amount of bone resected** and rationale (impingement, limited ROM, labral pathology).
- Not for simple debridement — must be reshaping/osteoplasty.

29915 – Arthroscopy, hip, with acetabuloplasty (i.e., treatment of Pincer lesion)

- Used when surgeon reshapes the **acetabular rim** to correct pincer impingement.
- May include **labral takedown and re-fixation** as part of the rim trimming.
- Documentation should note **rim trimming in mm and location**.

29916 – Arthroscopy, hip, with labral repair

- For **labral repair** (suturing, anchoring), not just trimming.
- Must document **tear type** (radial, flap, etc.), **repair technique**, and fixation devices.
- Don't use if labrum is only debrided → that's 29862.

Hip Arthroplasty

Total Hip Arthroplasty (THA):

- CPT Code: 27130 - Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft.
- 27132- Previous Surgery
- 27134- Revision Both components
- 27137- Acetabular Only
- 27138- Femoral Only

Partial Hip Arthroplasty or Hemiarthroplasty:

- CPT Code: 27125 - Hemiarthroplasty, hip, partial (e.g., femoral stem prosthesis, bipolar arthroplasty).

For Fracture:

- CPT Code 27236: Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement

Complex Scenarios

- Partial Replacement Liner:
  - 27137-52
  - Claim Note
  - Clear Documentation
- 27030 describes an arthrotomy of the hip joint with drainage, typically performed in cases of infection. However, if the surgeon performs debridement of tissue and/or muscle during the procedure but not bone, you should refer to debridement codes 11040-11043.
- A patient had a hip arthroscopy as a teenager and years later presents for a total hip replacement surgery due to severe osteoarthritis.
  - 27132

Two Stage

First Stage Surgery:

- CPT Code: 27091 - Removal of hip prosthesis; complicated, including total hip prosthesis, methylmethacrylate with or without insertion of spacer.

Second Stage Surgery:

- CPT Code: 27132 - Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft.
- *It's important to note that CPT code 27134 should not be reported unless both the removal and exchange of the hip replacement component(s) occur during the same operative session.*
- *In the two-stage procedure, where the removal and re-implantation of the hip replacement components happen in separat sessions, CPT code 27132 is used for the second stage.*

Aetna – Hip Scope

The policy starts like this:

Medical Necessity

1.Aetna considers femoro-acetabular surgery, open or arthroscopic, for the treatment of hip impingement syndrome medically necessary for persons who fulfill ***ALL*** the following criteria:

Aetna considers hip arthroscopy to repair a labral tear medically necessary for:

1.traumatic labral tears causing mechanical symptoms; *or*

2.an adjunct to FAI surgery.

1.Medically Necessary Procedures

2.Medically necessary procedures, when above criteria are met, include:

1.Femoro-acetabular surgery, open or arthroscopic, for the treatment of hip impingement syndrome;

2.Hip arthroscopy to repair a labral tear for traumatic labral tears causing mechanical symptoms or an adjunct to FAI surgery;

3.Repair of *complete* gluteus medius tears;

4.Hip arthroscopy for removal of foreign bodies;

5.Hip arthroscopy for the removal of loose bodies when no significant osteoarthritis is present (Tonnis 0 or 1);

6.Hip arthroscopy for synovectomy in limited instances of inflammatory arthritis, when no significant osteoarthritis is present (Tonnis 0 or 1).

3.Aetna considers surgery for FAI impingement experimental and investigational for all other indications.

Experimental and Investigational

1.Hip arthroscopy to **repair degenerative labral tears** (e.g., due to early osteoarthritis)

2.Labrum reconstruction for the treatment of FAI **Note:** Labral reconstruction uses a graft to reconstruct the native labrum. This is distinct from a labral repair, which is to repair the torn tissue by sewing it back together and/ or to its attachment site.

https://www.aetna.com/cpb/medical/data/700_799/0736.html

Regence Blue – Hip Scope

I. Open or arthroscopic surgical treatment of femoroacetabular impingement (FAI) may be medically necessary in skeletally mature patients when **ALL** of the following criteria (A-E) are met:

A. Moderate-to-severe hip pain that is worsened by flexion activities (e.g., squatting or prolonged sitting) that significantly limits activities

B. Unresponsive to conservative therapy for at least 3 months or clinical documentation that conservative therapy is contraindicated (e.g., history of falls due to mechanical instability of hip joint).

C. Positive impingement sign on clinical examination (i.e., pain elicited with 90 degrees of flexion and internal rotation and adduction of the femur)

D. ALL of the following criteria must be met:

1. Imaging (conventional x-rays, MRI, MRI arthrogram) documents morphology indicative of cam-type or pincer-type FAI (See List of Information Needed for Review); and

2. No evidence of advanced osteoarthritis, defined as Tonnis grade II or III, or joint space of less than 2 mm, except when there is mechanical instability.

E. Requested procedures must be consistent with the anatomical abnormalities documented.

II. Open or arthroscopic treatment of FAI is considered not medically necessary when Criterion I. is not met.

Note that capsular plication, capsular repair, acetabular or femoral chondroplasty, acetabular or femoral microfracture, labral reconstruction, iliotibial band windowing, trochanteric bursectomy, abductor muscle repair, and/or iliopsoas tenotomy, when performed at the time of any FAI surgery, would be considered a component of and incidental to the FAI procedure.

https://blue.regence.com/trgmedpol/surgery/sur160.pdf

References and Resources

AMA: Code and Guideline Changes | AMA (ama-assn.org)

SELECT CODER: SelectCoder | Application Landing (decisionhealth.com)

AAOS: AAOS Code-X

AAOS NOW: AAOS Now

AAPC / CODIFY: Codify by AAPC

AETNA: https://www.aetna.com/cpb/medical/data/600_699/0673.html

CMS: NCCI Policy Manual for Medicare | CMS

ORTHO INFO: https://www.orthoinfo.org/

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