

7.01.142 Surgery for Groin Pain in Athletes			
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Section:	7.0 Surgery	Page:	Page 1 of 9

## Policy Statement

Surgical treatment of groin pain in athletes (also known as athletic pubalgia, Gilmore groin, osteitis pubis, pubic inguinal pain syndrome, inguinal disruption, slap shot gut, sportsmen groin, footballers groin injury complex, hockey groin syndrome, athletic hernia, sports hernia, or core muscle injury) is considered **investigational**.

## Policy Guidelines

There is no specific code for surgical treatment of groin pain in athletes. The following unlisted CPT codes may be used:

- **27299:** Unlisted procedure, pelvis or hip joint
- **49659:** Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy
- **49999:** Unlisted procedure, abdomen, peritoneum and omentum

## Description

Sports-related groin pain, commonly known as athletic pubalgia or sports hernia, is characterized by disabling activity-dependent lower abdominal and groin pain not attributable to any other cause. Athletic pubalgia is most frequently diagnosed in high-performance male athletes, particularly those who participate in sports that involve rapid twisting and turning such as soccer, hockey, and football. For patients who fail conservative therapy, surgical repair of any defects identified in the muscles, tendons, or nerves has been proposed.

## Related Policies

- Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non-Orthopedic Conditions
- Orthopedic Applications of Platelet-Rich Plasma
- Surgical Treatment of Femoroacetabular Impingement

## Benefit Application

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal mandates (e.g., Federal Employee Program [FEP]) prohibits plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

## Regulatory Status

Treatment of sports-related groin pain is a surgical procedure and, as such, is not subject to regulation by the U.S. Food and Drug Administration.

## Rationale

### Background

#### Groin Pain in Athletes

Groin pain in athletes is a poorly defined condition for which there is no consensus on cause and/or treatment.<sup>1</sup> Alternative names include Gilmore groin, osteitis pubis, pubic inguinal pain syndrome, inguinal disruption, slap shot gut, sportsmen groin, footballers groin injury complex, hockey groin syndrome, athletic hernia, sports hernia, and core muscle injury.

Some believe the groin pain is an occult hernia process, a prehernia condition, or an incipient hernia, with the major abnormality being a defect in the transversalis fascia, which forms the posterior wall of the inguinal canal. Another theory is that injury to soft tissues that attach to or cross the pubic symphysis is the primary abnormality. The most common of these injuries are thought to be at the insertion of the rectus abdominis onto the pubis, with either primary or secondary pain arising from the adductor insertion sites onto the pubis. It has been proposed that muscle injury leads to failure of the transversalis fascia, with a resultant formation of a bulge in the posterior wall of the inguinal canal.<sup>1</sup> Osteitis pubis (inflammation of the pubic tubercle) and nerve irritation/entrapment of the ilioinguinal, iliohypogastric, and genitofemoral nerves are also believed to be sources of chronic groin pain. A 2015 consensus agreement has recommended the more general term *groin pain in athletes*, with specific diagnoses of adductor-related, iliopsoas-related, inguinal-related, and pubic-related groin pain.<sup>2</sup>

An association between femoroacetabular impingement (FAI) and groin pain in athletes has been proposed (see Blue Shield of California Medical Policy: Surgical Treatment of Femoroacetabular Impingement). It is believed that if FAI presents with limitations in hip range of motion, compensatory patterns during athletic activity may lead to increased stresses involving the abdominal obliques, distal rectus abdominis, pubic symphysis, and adductor musculature. A 2015 systematic review of 24 studies that examined the co-occurrence of FAI and groin pain in athletes found an overlap of the 2 conditions that ranged from 27% of hockey players to 90% of collegiate football players who presented with hip and groin pain.<sup>3</sup> Surgery for sports-related groin pain has been performed concurrently with treatment of FAI or following FAI surgery if symptoms did not resolve.

### Diagnosis

A diagnosis of groin pain in athletes is based primarily on history, physical exam, and imaging. The clinical presentation will generally be a gradual onset of progressive groin pain associated with the activity. A physical exam will not reveal any evidence for a standard inguinal hernia or groin muscle strain. Imaging with magnetic resonance imaging or ultrasound is generally done as part of the workup. In addition to the exclusion of other sources of lower abdominal and groin pain (e.g., stress fractures, FAI, labral tears), imaging may identify injury to the soft tissues of the groin and abdominal wall.<sup>4</sup>

### Treatment

#### Conservative

Many injuries will heal with conservative treatment, which includes rest, icing, nonsteroidal anti-inflammatory drugs, and rehabilitation exercises. A physical therapy (PT) program that focuses on strength and coordination of core muscles acting on the pelvis may improve recovery. In a 1999 study, 68 athletes with chronic adductor-related groin pain were randomized to 8 to 12 weeks of an active training PT program that focused on strength and coordination of core muscles, particularly adductors, or to standard PT without active training.<sup>5</sup> At 4 months posttreatment, 68% of patients in the active training group had returned to sports without groin pain compared with 12% in the standard PT group. At 8- to 12- year follow-up, 50% of athletes in the active training group rated their outcomes as excellent compared with 22% in the standard PT group.<sup>6</sup> For in-season professional athletes, injections of corticosteroid or platelet-rich plasma (see Blue Shield of California Medical Policy: Autologous Platelet-Derived Growth Factors for

Wound Healing and Other Non–Orthopedic Conditions), or a short corticosteroid burst with taper have also been used.

### **Surgical**

Surgical treatment is typically reserved for patients who have failed at least 3 months of conservative treatment. One approach consists of open or laparoscopic sutured hernia repair with mesh reinforcement of the posterior wall of the inguinal canal. Laparoscopic procedures may use either a transabdominal preperitoneal or an extraperitoneal approach. A variety of musculotendinous defects, nerve entrapments, and inflammatory conditions have been observed with surgical exploration. Meyers et al (2008) have proposed that any of the 17 soft tissues that attach or cross the pubic symphysis can be involved, leading to as many as 26 surgical procedures and 121 different combinations of procedures that address the various core muscle injuries.<sup>7</sup> The objective is to stabilize the pubic joint by tightening or broadening the attachments of various structures to the pubic symphysis and/or by loosening the attachments or other supporting structures via epimysiotomy or detachment.

Because various surgical procedures used to treat sports-related groin pain have reported success, it has been proposed that general fibrosis from any surgery may act to stabilize the anterior pelvis and thus play a role in improved surgical outcomes.

### **Literature Review**

Evidence reviews assess the clinical evidence to determine whether the use of a technology improves the net health outcome. Broadly defined, health outcomes are length of life, quality of life, and ability to function- including benefits and harms. Every clinical condition has specific outcomes that are important to patients and to managing the course of that condition. Validated outcome measures are necessary to ascertain whether a condition improves or worsens; and whether the magnitude of that change is clinically significant. The net health outcome is a balance of benefits and harms.

To assess whether the evidence is sufficient to draw conclusions about the net health outcome of a technology, 2 domains are examined: the relevance and the quality and credibility. To be relevant, studies must represent one or more intended clinical use of the technology in the intended population and compare an effective and appropriate alternative at a comparable intensity. For some conditions, the alternative will be supportive care or surveillance. The quality and credibility of the evidence depend on study design and conduct, minimizing bias and confounding that can generate incorrect findings. The randomized controlled trial (RCT) is preferred to assess efficacy; however, in some circumstances, nonrandomized studies may be adequate. RCTs are rarely large enough or long enough to capture less common adverse events and long-term effects. Other types of studies can be used for these purposes and to assess generalizability to broader clinical populations and settings of clinical practice.

Sports-related groin pain has a variable natural history, with an uncertain time course of the disorder. Also, pain and functional ability are subjective outcomes and, thus, may be particularly susceptible to placebo effects. Because of these factors, controlled trials are essential to demonstrate the clinical effectiveness of surgical treatment of athletic pubalgia compared with alternatives such as continued medical management.

In 2015, a consensus report call the Doha agreement recommended the use of specific diagnoses of adductor-related, iliopsoas-related, inguinal-related, or pubic-related groin pain in place of athletic pubalgia or sportsman's hernia.<sup>2</sup> However, these terms have yet to be routinely used in the published literature. Because it is not possible to determine which patient subgroups were studied, the terminology from the published reports is used. The only validated patient-reported outcome measure for pain and dysfunction in the groin area in young and middle-aged patients that were identified in the Doha report is the Copenhagen Hip and Groin Outcome Score.<sup>8</sup>

## Mesh Reinforcement

### Randomized Controlled Trials

Paajanen et al (2011) reported on a multicenter RCT comparing surgical treatment with conservative therapy in 60 athletes who had suspected sports hernia.<sup>9</sup> Of the 60 (including 31 national-level soccer players), 36 (60%) were totally disabled from their sport and 24 (40%) had a marked limitation in training and competing. For inclusion in the trial, the location of pain had to be rostral to the inguinal ligament in the deep inguinal ring at palpation or the insertion point of the adductor tendons. Exclusion criteria were isolated tendonitis of the adductor muscles or tendons without groin pain rostral to the inguinal ligament, obvious inguinal hernias, or suspicion of inguinal nerve entrapment. Participants had to have the desire to continue sports at the same level as before the groin injury. Pubic bone marrow edema was identified by magnetic resonance imaging (MRI) in 58% of patients. For participants (38%) who had a normal MRI in the pubic area, the pain was attributed to the insufficiency of the posterior wall of the inguinal canal. After at least 3 months of groin symptoms, patients were randomized to surgical or conservative treatment groups. Conservative treatment included at least 2 months of active physical therapy that focused on improving coordination and strength of core muscles, along with corticosteroid injections and oral anti-inflammatory analgesics. Surgical treatment consisted of laparoscopic total extraperitoneal repair with mesh placed behind the pubic bone and/or posterior wall of the inguinal canal. Ten percent of the patients also underwent open tenotomy of the adductor magnus or longus. Of the 30 surgically treated athletes, 27 (90%) returned to sports activities by 3 months compared with 8 (27%) of the nonoperative group. At 1, 3, 6, and 12 months after treatment, visual analog scale (VAS) scores for pain were significantly lower in the surgically treated group ( $p < 0.001$ ). At 12 months, mean VAS scores for pain were less than 2 in both groups. However, among the 30 patients assigned to the conservative treatment group, 7 (23%) crossed over to surgery after 6 months with successful return to sport, 4 (13%) discontinued their sport of choice, and 16 (53%) were left with disabling symptoms after 12 months but chose not to undergo surgery.

A RCT by Ekstrand and Ringborg (2001) randomized 66 male soccer players to hernioplasty plus neurotomy ( $n=17$ ), physical therapy ( $n=14$ ), strength training of abdominal muscles ( $n=18$ ), or a no treatment control ( $n=17$ ).<sup>10</sup> All patients had an incipient hernia determined by herniography and/or positive nerve block test of the ilioinguinal or iliohypogastric nerves. VAS scores for pain were assessed at 3 and 6 months during coughing, sit-ups, jogging, kicking, and sprinting. VAS scores for pain in the control, physical therapy, and training groups were generally unchanged at 3 and 6 months, although results were analyzed using nonparametric tests instead of the more appropriate repeated-measures or mixed-effects analysis. VAS scores improved significantly more for the surgery group than for the 3 other groups ( $p < 0.01$ ). Strengths of this study included the active comparison groups and careful selection of patients. However, results are difficult to interpret due to the combined surgical procedure of hernioplasty plus neurotomy.

### Observational Studies

Nonrandomized comparative and uncontrolled studies can sometimes provide useful information on health outcomes but are prone to biases such as noncomparability of treatment groups, the placebo effect, and variable natural history of the condition. A number of observational series have reported on surgical outcomes.<sup>7,11,12,13,14,15</sup> However, these studies enrolled variable patient populations and used different surgical techniques. All studies reported that a high percentage of patients returned to full sports activities, but there were no control groups for comparison.

Kopelman et al (2016) reported on a prospective series of 246 male patients with chronic groin pain.<sup>16</sup> All patients underwent an ultrasound, and 98 also underwent an MRI. Of the 246 patients, 209 underwent conservative treatment with rest and nonsteroidal anti-inflammatory drugs, after which 51 (21%) of 246 underwent inguinal surgery. Another 37 (15%) patients were diagnosed by imaging with noninguinal pathologies such as inflammation of the pubic bone and symphysis pubis, rectus abdominis muscles, and hip joint pathologies. Of the 51 who underwent surgery

(mesh repair, oblique aponeurosis release, neurolysis), a direct or an indirect hernia was observed in 18 (35%) patients. In the remainder (65%), no abnormalities were found. There were 2 surgical failures, and all other patients returned to full sports activity within 4.3 weeks. In this series, most patients did not require surgery, and the authors commented that pubic and suprapubic symptomatology should be differentiated from inguinal and adductor complaints.

### **Section Summary: Mesh Reinforcement**

The evidence on mesh reinforcement for inguinal-related groin pain includes 2 RCTs and a large prospective series. Results of the RCTs have suggested that, in carefully selected patients, mesh reinforcement results in an earlier return to play. However, a 2016 large prospective series indicated that only about 20% of patients with chronic groin pain benefit from inguinal surgery. Selection of patients in this series excluded patients with noninguinal pathology and failure of a conservative treatment trial of complete rest and nonsteroidal anti-inflammatory drugs. Further study is needed to corroborate these results and to define the patient population that would benefit from this treatment approach.

### **Surgical Repair or Release of Soft Tissue**

#### **Observational Studies**

There is more limited literature on the repair or release of soft tissue. An example of a large case series is a retrospective review by Meyers et al (2008) that reported on the surgical treatment of 5218 patients diagnosed with athletic pubalgia over the prior 2 decades.<sup>7</sup> Initially, diagnoses were made by history and physical examination, with MRI used in the more recent years. Referrals increased from 3 per week in 1987 to 25 per week in 2008. Patients treated with surgery ranged from 11 to 71 years of age; women comprised about 8% of the group. The surgeries involved 26 different procedures of reattachments and/or releases of soft tissues that normally attach or cross the pubic symphysis. The authors reported that 95.3% of the patients returned to full play within 3 months of surgery. For a subgroup of athletes treated in-season, 90% were able to return to full play within 3 weeks. Adverse surgery-related events included dysesthesias (0.3%), significant hematomas (0.3%), and vein thrombosis (0.1%), all of which resolved within 1 year.

### **Section Summary: Surgical Repair or Release of Soft Tissue**

An alternative approach to the treatment of groin pain in athletes has been reported in a large series. This retrospective study included a review of medical records spanning 2 decades and over 5000 cases. There was no information on prior conservative treatments. More recent reports on these procedures from other institutions are lacking.

### **Summary of Evidence**

For individuals who have sports-related groin pain who receive mesh reinforcement or who receive surgical repair and release of soft tissue, the evidence includes 2 RCTs and a number of case series. Relevant outcomes are symptoms, functional outcomes, and treatment-related morbidity. The evidence on mesh reinforcement for inguinal-related groin pain includes 2 RCTs and a large prospective series. Results of the RCTs have suggested that, in carefully selected patients, mesh reinforcement results in an earlier return to play. However, a large prospective series from 2016 indicated that only about 20% of patients with chronic groin pain benefit from inguinal surgery. Further study is needed to define the patient population that would benefit from this treatment approach. An alternative approach to the treatment of groin pain in athletes involves repair or release of soft tissue. This approach has been reported in a large series. It included a 2008 review of medical records spanning 2 decades and over 5000 cases. More recent reports on these procedures from other institutions are needed. The evidence is insufficient to determine the effects of the technology on health outcomes.

### **Supplemental Information**

#### **Practice Guidelines and Position Statements**

The American Academy of Orthopaedic Surgeons has an online educational website, last reviewed in 2017, on sports hernia (athletic pubalgia).<sup>17</sup> The Academy indicated that a sports hernia is a painful soft tissue injury that occurs in the groin area. The Academy advised

that “In many cases, 4 to 6 weeks of physical therapy will resolve any pain and allow an athlete to return to sports. If, however, the pain comes back when you resume sports activities, you may need to consider surgery to repair the torn tissues.”

### British Hernia Society

The British Hernia Society published a 2014 position statement on the treatment of sportsman's groin.<sup>18</sup> Based on a consensus conference, the term *inguinal disruption* was agreed to be the preferred nomenclature because no true hernia exists. Participants agreed that there was abnormal tension in the groin, particularly around the inguinal ligament attachment and that other findings may include the possibility of external oblique disruption with consequent small tears. It was noted that other pathologies also account for symptoms of groin pain, including adductor muscle tendonitis, osteitis pubis, and pubic symphysisitis. A multidisciplinary approach with tailored physical therapy was recommended as an initial treatment, with surgery involving releasing the tension in the inguinal canal and reinforcing it with a mesh or suture repair.

### U.S. Preventive Services Task Force Recommendations

Not applicable.

### Medicare National Coverage

There is no national coverage determination. In the absence of a national coverage determination, coverage decisions are left to the discretion of local Medicare carriers.

### Ongoing and Unpublished Clinical Trials

Some currently unpublished trials that might influence this review are listed in Table 1.

**Table 1. Summary of Key Trials**

NCT No.	Trial Name	Planned Enrollment	Completion Date
<b>Ongoing</b>			
NCT01876342	Total ExtraPeritoneal (TEP) Versus Open Minimal Suture Repair for Treatment of Sportsman's Hernia/Athletic Pubalgia: A Randomized Multi-center Trial	60	Dec 2018
<b>Unpublished</b>			
NCT02297711	Total ExtraPeritoneal (TEP) Versus Open Minimal Suture Repair for Treatment of Sportsman's Hernia/Athletic Pubalgia: A Randomized Multi-center Trial	100	Oct 2015 (unknown)
NCT00934388	A Randomised, Blinded Study on Laparoscopic Mesh Reinforcement for Chronic Groin Pain	80	Dec 2015 (unknown)

NCT: national clinical trial.

## References

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3. Munegato D, Bigoni M, Gridavilla G, et al. Sports hernia and femoroacetabular impingement in athletes: A systematic review. World J Clin Cases. Sep 16 2015;3(9):823-830. PMID 26380829
4. Khan W, Zoga AC, Meyers WC. Magnetic resonance imaging of athletic pubalgia and the sports hernia: current understanding and practice. Magn Reson Imaging Clin N Am. Feb 2013;21(1):97-110. PMID 23168185
5. Holmich P, Uhrskou P, Ulnits L, et al. Effectiveness of active physical training as treatment for long-standing adductor-related groin pain in athletes: randomised trial. Lancet. Feb 6 1999;353(9151):439-443. PMID 9989713

6. Holmich P, Nyvold P, Larsen K. Continued significant effect of physical training as treatment for overuse injury: 8- to 12-year outcome of a randomized clinical trial. *Am J Sports Med.* Nov 2011;39(11):2447-2451. PMID 21813441
7. Meyers WC, McKechnie A, Philippon MJ, et al. Experience with "sports hernia" spanning two decades. *Ann Surg.* Oct 2008;248(4):656-665. PMID 18936579
8. Thorborg K, Holmich P, Christensen R, et al. The Copenhagen Hip and Groin Outcome Score (HAGOS): development and validation according to the COSMIN checklist. *Br J Sports Med.* May 2011;45(6):478-491. PMID 21478502
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10. Ekstrand J, Ringborg S. Surgery versus conservative treatment in soccer players with chronic groin pain: A prospective randomised study in soccer players. *Eur J Sports Traumatol Rel Res.* 2001;23:141-145.
11. Ahumada LA, Ashruf S, Espinosa-de-los-Monteros A, et al. Athletic pubalgia: definition and surgical treatment. *Ann Plast Surg.* Oct 2005;55(4):393-396. PMID 16186706
12. Steele P, Annear P, Grove JR. Surgery for posterior inguinal wall deficiency in athletes. *J Sci Med Sport.* Dec 2004;7(4):415-421; discussion 422-413. PMID 15712496
13. Paajanen H, Syvahuoko I, Airo I. Totally extraperitoneal endoscopic (TEP) treatment of sportsman's hernia. *Surg Laparosc Endosc Percutan Tech.* Aug 2004;14(4):215-218. PMID 15472551
14. Kumar A, Doran J, Batt ME, et al. Results of inguinal canal repair in athletes with sports hernia. *J R Coll Surg Edinb.* Jun 2002;47(3):561-565. PMID 12109611
15. Irshad K, Feldman LS, Lavoie C, et al. Operative management of "hockey groin syndrome": 12 years of experience in National Hockey League players. *Surgery.* Oct 2001;130(4):759-764; discussion 764-756. PMID 11602909
16. Kopelman D, Kaplan U, Hatoum OA, et al. The management of sportsman's groin hernia in professional and amateur soccer players: a revised concept. *Hernia.* Feb 2016;20(1):69-75. PMID 25380561
17. American Academy of Orthopaedic Surgeons, Wilkerson R. OrthoInfo: Sports Hernia (Athletic Pubalgia). 2017; <http://orthoinfo.aaos.org/topic.cfm?topic=A00573>. Accessed January 18, 2018.
18. Sheen AJ, Stephenson BM, Lloyd DM, et al. 'Treatment of the sportsman's groin': British Hernia Society's 2014 position statement based on the Manchester Consensus Conference. *Br J Sports Med.* Jul 2014;48(14):1079-1087. PMID 24149096
19. Blue Cross Blue Shield Association. Medical Policy Reference Manual, No. 7.01.142 (February 2019).

## Documentation for Clinical Review

- No records required

## Coding

*This Policy relates only to the services or supplies described herein. Benefits may vary according to product design; therefore, contract language should be reviewed before applying the terms of the Policy. Inclusion or exclusion of codes does not constitute or imply member coverage or provider reimbursement.*

### IE

The following services may be considered investigational.

Type	Code	Description
CPT®	27299	Unlisted procedure, pelvis or hip joint

Type	Code	Description
	49659	Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy
	49999	Unlisted procedure, abdomen, peritoneum and omentum
<b>HCPCS</b>	None	
<b>ICD-10 Procedure</b>	0LUH0JZ	Supplement Perineum Tendon with Synthetic Substitute, Open Approach
	0LUH4JZ	Supplement Perineum Tendon with Synthetic Substitute, Percutaneous Endoscopic Approach
	0LUJ0JZ	Supplement Right Hip Tendon with Synthetic Substitute, Open Approach
	0LUJ4JZ	Supplement Right Hip Tendon with Synthetic Substitute, Percutaneous Endoscopic Approach
	0LUK0JZ	Supplement Left Hip Tendon with Synthetic Substitute, Open Approach
	0LUK4JZ	Supplement Left Hip Tendon with Synthetic Substitute, Percutaneous Endoscopic Approach
	0WQM0ZZ	Repair Male Perineum, Open Approach
	0WQM3ZZ	Repair Male Perineum, Percutaneous Approach
	0WQM4ZZ	Repair Male Perineum, Percutaneous Endoscopic Approach
	0WQN0ZZ	Repair Female Perineum, Open Approach
	0WQN3ZZ	Repair Female Perineum, Percutaneous Approach
	0WQN4ZZ	Repair Female Perineum, Percutaneous Endoscopic Approach
	0WUM0JZ	Supplement Male Perineum with Synthetic Substitute, Open Approach
	0WUM4JZ	Supplement Male Perineum with Synthetic Substitute, Percutaneous Endoscopic Approach
	0WUN0JZ	Supplement Female Perineum with Synthetic Substitute, Open Approach
	0WUN4JZ	Supplement Female Perineum with Synthetic Substitute, Percutaneous Endoscopic Approach
	0YQ50ZZ	Repair Right Inguinal Region, Open Approach
	0YQ53ZZ	Repair Right Inguinal Region, Open Approach
	0YQ54ZZ	Repair Right Inguinal Region, Percutaneous Endoscopic Approach
	0YQ60ZZ	Repair Left Inguinal Region, Open Approach
	0YQ63ZZ	Repair Left Inguinal Region, Percutaneous Approach
	0YQ64ZZ	Repair Left Inguinal Region, Percutaneous Endoscopic Approach
	0YQA0ZZ	Repair Bilateral Inguinal Region, Open Approach
	0YQA3ZZ	Repair Bilateral Inguinal Region, Percutaneous Approach
	0YQA4ZZ	Repair Bilateral Inguinal Region, Percutaneous Endoscopic Approach
	0YU50JZ	Supplement Right Inguinal Region with Synthetic Substitute, Open Approach
	0YU54JZ	Supplement Right Inguinal Region with Synthetic Substitute, Percutaneous Endoscopic Approach
	0YU60JZ	Supplement Left Inguinal Region with Synthetic Substitute, Open Approach
	0YU64JZ	Supplement Left Inguinal Region with Synthetic Substitute, Percutaneous Endoscopic Approach
	0YUA0JZ	Supplement Bilateral Inguinal Region with Synthetic Substitute, Open Approach
	0YUA4JZ	Supplement Bilateral Inguinal Region with Synthetic Substitute, Percutaneous Endoscopic Approach



## Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

Effective Date	Action	Reason
09/30/2014	BCBSA Medical Policy Adoption	Medical Policy Committee
04/01/2016	Policy revision without position change	Medical Policy Committee
04/01/2017	Policy title change from Surgery for Athletic Pubalgia Policy revision without position change	Medical Policy Committee
04/01/2018	Policy revision without position change	Medical Policy Committee
04/01/2019	Policy revision without position change	Medical Policy Committee

## Definitions of Decision Determinations

**Medically Necessary:** A treatment, procedure, or drug is medically necessary only when it has been established as safe and effective for the particular symptoms or diagnosis, is not investigational or experimental, is not being provided primarily for the convenience of the patient or the provider, and is provided at the most appropriate level to treat the condition.

**Investigational/Experimental:** A treatment, procedure, or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

**Split Evaluation:** Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a split evaluation, where a treatment, procedure, or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

## Prior Authorization Requirements (as applicable to your plan)

Within five days before the actual date of service, the provider must confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department. Please call (800) 541-6652 or visit the provider portal at [www.blueshieldca.com/provider](http://www.blueshieldca.com/provider).

*Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.*