Medical Coverage Policy | Surgery for Groin Pain in Athletes

EFFECTIVE DATE: 04|07|2015
POLICY LAST UPDATED: 11|20|2018

OVERVIEW
Sports-related groin pain, commonly known as athletic pubalgia or sports hernia, is characterized by disabling activity-dependent lower abdominal and groin pain that is 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.

MEDICAL CRITERIA
Not applicable

PRIOR AUTHORIZATION
Not applicable

POLICY STATEMENT
BlueCHiP for Medicare
Surgical treatment of athletic pubalgia 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 not covered as the body of evidence is insufficient to determine the effects of the technology on health outcomes.

Commercial Products
Surgical treatment of athletic pubalgia 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 not medically necessary as the body of evidence is insufficient to determine the effects of the technology on health outcomes.

COVERAGE
Benefits may vary between groups and contracts. Please refer to the appropriate Benefit Booklet, Evidence of Coverage or Subscriber Agreement for applicable not medically necessary/not covered benefits/coverage.

BACKGROUND
Groin pain in athletes is a poorly defined condition for which there is no consensus on the cause and/or treatment. 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 to be 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 is 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.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 recommended the more general term groin pain in athletes, with specific diagnoses of adductor-related, iliopsoas-related, inguinal-related, and pubic-related groin pain.

An association between femoroacetabular impingement (FAI) and athletic pubalgia has also been proposed. 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. Surgery for athletic pubalgia has been performed concurrently with treatment of FAI, or following FAI surgery if symptoms did not resolve.

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

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.

CODING

BlueCHiP for Medicare and Commercial Products

There is not a specific code for the surgical treatment of groin pain in athletes, use the unlisted codes below following the unlisted process

27299 Unlisted procedure, pelvis or hip joint
49659 Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy
49999 Unlisted procedure, abdomen, peritoneium and omentum

RELATED POLICIES

None

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