

Hip Arthroscopy

ORG: S-572 (ISC)

[Link to Codes](#)

MCG Health

Inpatient & Surgical Care
30th Edition

- Care Planning - Inpatient Admission and Alternatives
 - Clinical Indications for Procedure
 - Alternatives to Procedure
 - Operative Status Criteria
- Hospitalization
 - Optimal Recovery Course
 - Goal Length of Stay - **Ambulatory**
 - Extended Stay
- Discharge
 - Discharge Planning
 - Discharge Destination
- Evidence Summary
 - Criteria
 - Length of Stay
 - Rationale
 - Related CMS Coverage Guidance
- References
- Footnotes
- Definitions
- Codes

Care Planning - Inpatient Admission and Alternatives

Clinical Indications for Procedure

- Procedure is indicated for **1 or more** of the following(1)(2)(3): **NNNNNNNN**
 - ☐ Identified structural hip disorder and **ALL** of the following:
 - ☐ Positive MRI or other imaging finding, including **1 or more** of the following(1):
 - Loose bodies(1)(3)
 - Labral tears or cysts(1)(13)
 - Femoroacetabular impingement^[A](12)(14)(16)(17)
 - Chondral injury(1)
 - Synovial disease unresponsive to systemic therapy(1)

- Ligamentum teres tear or rupture(1)(18)
- Posttraumatic periacetabular osteophytes
- Capsular instability(19)(20)
- Iliopsoas or anterior inferior iliac spine impingement(6)(21)(22)
- Extra-articular impingement (eg, subspine, ischiofemoral)(6)(23)(24)(25)
- Sciatic nerve entrapment (eg, piriformis syndrome)(1)(6)(21)
- Greater trochanteric pain syndrome (eg, gluteal tendon tear)(6)(21)(26)
- Partial proximal hamstring tendon avulsion(1)(7)(27)
- Symptomatic os acetabuli[B](4)
- Treatment needed because of **1 or more** of the following:
 - Chronic pain
 - Clinically significant functional impairment
 - Nonoperative therapy has been tried and failed (eg, analgesics, rest, physical therapy, anti-inflammatory agents).
- Hip dysplasia, borderline (lateral center-edge angle (LCEA) between 18 to 25 degrees)(1)(2)(5)(28)
- Osteonecrosis of the femoral head without collapse(29)
- Fracture amenable to arthroscopic repair(30)
- Septic hip requiring debridement and lavage(1)(2)(3)(31)(32)
- ☐ Proximal hamstring avulsion and **1 or more** of the following(1)(6)(7):
 - Avulsion of 2 tendons with retraction of 2 cm or more
 - Complete tear of all 3 tendons
- Snapping hip refractory to nonoperative treatment (eg, physical therapy, activity modification)(1)(6)(33)(34)
- Capsular adhesion refractory to nonoperative treatment (eg, physical therapy, activity modification)(35)(36)
- Trauma amenable to arthroscopic treatment (eg, bullet removal, labral repair, traumatic dislocation with loose intra-articular bodies, chondral lesions, or labral or ligamentum teres tears)(3)(9)(37)
- Tenosynovial giant cell tumor (also known as pigmented villonodular tenosynovitis)(10)(11)
- ☐ Evaluation of hip, as indicated by **ALL** of the following(8):
 - Presence of signs or symptoms, including **1 or more** of the following:
 - Unexplained pain
 - Functional impairment
 - Joint instability or dislocation
 - Nondiagnostic findings on imaging (eg, CT scan, MRI)
 - Nonoperative therapy has been tried and failed (eg, analgesics, rest, physical therapy, anti-inflammatory agents).

Alternatives to Procedure

- Alternatives include(1)(17):
 - Nonoperative treatment(10)(12)(19)(26)(36)(38)(39):
 - Cessation or modification of activities that precipitate or exacerbate symptoms
 - NSAIDs
 - Analgesics
 - Physical therapy(13)(16)(39)
 - Corticosteroid injection(39)(40)
 - Image-guided biopsy(10)

- o For septic arthritis(31)(32):
 - Open drainage
 - Joint aspiration
- o Periacetabular osteotomy(5)(28)
- o Radiosynovectomy(41)(42)
- o Open arthrotomy(14)(31)(43)
- o Open synovectomy(10)
- o Hip arthroplasty. See Hip Arthroplasty [ISC guideline](#).
- o Hip resurfacing. See Hip Resurfacing [ISC guideline](#).

Operative Status Criteria

Goal Length of Stay: Ambulatory

Note: The definition of an ambulatory procedure depends on payer-provider contractual agreement or regulatory language (eg, CMS' Two-Midnight Rule). An ambulatory procedure may include one postoperative overnight stay in a facility; therefore, MCG's ambulatory Goal Length of Stay (GLOS) attainment calculation reports the sum of same-day and next-day postoperative discharges. Depending on various patient and procedural factors, some patients undergoing a procedure with an ambulatory GLOS require inpatient care (eg, medical necessity for hospital-based care across 2 or more postoperative midnights). Some of these factors are described in the Extended Stay section of this guideline.

- Ambulatory
- Inpatient (eg, medical necessity for hospital-based care across 2 or more postoperative midnights)
- Inpatient (Medicare patient, and specific procedure is on CMS Inpatient Only List)

Hospitalization

Optimal Recovery Course

Day	Level of Care	Clinical Status	Activity	Routes	Interventions	Medications
1	• Social Determinants of Health Assessment • OR to recovery room to discharge[C] • Discharge planning	• Hemodynamic stability • No evidence of neurologic injury post procedure • No evidence of vascular injury post procedure • Pain absent or managed • Discharge plans and education understood	• Ambulatory or acceptable for next level of care[D][E]	• IV fluids, medications for procedure • Oral hydration[F] • Oral medications or regimen acceptable for next level of care • Oral diet or acceptable for next level of care	• Warming of irrigation fluids[G]	• Oral analgesics as indicated

(1)(17)(45)N

Recovery Milestones are indicated in **bold**.

Goal Length of Stay: Ambulatory

Note: Goal Length of Stay assumes optimal recovery, decision making, and care. Patients may be discharged to a lower level of care (either later than or sooner than the goal) when it is appropriate for their clinical status and care needs.

Extended Stay

Minimal (a few hours to 1 day), Brief (1 to 3 days), Moderate (4 to 7 days), and Prolonged (more than 7 days).

- Inpatient stay (eg, need for hospital-based care beyond postoperative day 1) may be needed for(1)(46):
 - Failure to meet discharge criteria (recovery milestones in Optimal Recovery Course)
 - Expect brief stay extension.
 - Patient admitted for joint infection (eg, septic hip)
 - Anticipate debridement, lavage, and drain.
 - Expect brief stay extension.
 - Complications of procedure(47)(48)
 - Complications may include extravasations of fluid, chondrolabral injury, nerve palsy (peroneal, femoral, sciatic, lateral femoral cutaneous, or pudendal nerves), or need for conversion to open procedure.
 - Expect brief stay extension.

See Common Complications and Conditions [ISC](#) for further information.

Discharge

Discharge Planning

- Discharge planning includes[H]:
 - Assessment of needs and planning for care, including(50)(51):
 - Develop and modify treatment plan (involving multiple providers) as needed.
 - Evaluate and address preadmission functioning as needed.
 - Evaluate and address psychosocial status issues as indicated. See Psychosocial Assessment [SR](#) for further information.
 - Evaluate and address social determinants of health (eg, housing, food). See Social Determinants of Health Screening Tool [SR](#) for further information.
 - Evaluate and address patient or caregiver preferences as indicated.
 - Identify skilled services needed at next level of care, with specific attention to(52):
 - Neurovascular status assessment(1)
 - Pain management(53)
 - Wound or dressing management(54)
 - Early identification of anticipated discharge destination; options include(51)(55):

- Home; considerations include:
 - Home safety assessment. See Home Safety Assessment [SR](#) for further information.
 - ☐ Patient safe to go home; examples include(56)(57)(58):
 - Medical status stable for patient's condition
 - Functional care can safely be provided with available resources.
 - Mental status stable for patient's condition
 - Medication availability confirmed and reconciliation complete
 - Patient/caregiver education completed with written discharge instructions provided
 - Community resources identified and referrals made, as needed
 - Home care arranged, if indicated
 - Necessary medical equipment delivery arranged or available in home, if indicated
 - Necessary medical supplies ordered, or patient/caregiver can obtain, if indicated
 - Access to follow-up care
 - Self-management ability if appropriate. See Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) Assessment [SR](#) for further information.
 - Caregiver need, ability, and availability
- Post-acute skilled care or custodial care as indicated. See Discharge Planning Tool [SR](#) for further information.
- Transitions of care plan complete, including(51)(55)(59):
 - Patient and caregiver education complete.
 - See Teach-Back Tool [SR](#) for further information.
 - See Hip Arthroscopy: Patient Education for Clinicians [SR](#) for further information.
 - ☐ Medication reconciliation completion includes(60)(61):
 - Compare patient's discharge list of medications (prescribed and over-the-counter) against provider's admission or transfer orders.
 - Assess each medication for correlation to disease state or medical condition.
 - Report medication discrepancies to prescribing provider, attending physician, and primary care provider, and ensure accurate medication order is identified.
 - Provide reconciled medication list to all treating providers.
 - Confirm that patient or caregiver can acquire medication.
 - Educate patient and caregiver.
 - Provide complete medication list to patient and caregiver.
 - Importance of presenting personal medication list to all providers at each care transition, including all provider appointments
 - Reason, dosage, and timing of medication (eg, use "teach-back" techniques)(62)
 - Encourage communication between patient, caregiver, and pharmacy for obtaining prescriptions, setting up home medication delivery, and reviewing for drug-drug interactions.
 - See Medication Reconciliation Tool [SR](#) for further information.
 - Plan communicated to patient, caregiver, and all members of care team, including(63):
 - Inpatient care and service providers
 - Primary care provider
 - All post-discharge care and service providers
 - Appointments planned or scheduled, which may include(1):
 - Primary care provider(64)

- Orthopedic surgeon
- Rehabilitation therapy services(65)(66)
- Other
- Outpatient testing and procedure plans made, which may include:
 - Other
- Referrals made for assistance or support, which may include:
 - Financial, for follow-up care, medication, and transportation(67)
 - Tobacco use treatment(68)
 - Other
- Medical equipment and supplies coordinated (ie, delivered or delivery confirmed), which may include:
 - Ambulation devices (eg, cane, crutches, walker)(69)
 - Wound care equipment and supplies(70)
 - Other

Discharge Destination

- Post-hospital levels of admission may include:
 - Home.
 - Home healthcare. See Home Care Indications for Admission Section [HC](#) in Hip Arthroscopy guideline in Home Care.

Evidence Summary

Criteria

The evidence for the clinical indications found in this guideline includes 36 published peer reviewed articles and 1 book section.

For symptomatic patients (eg, chronic pain, significant functional impairment), an orthopedic surgery textbook recommends hip arthroscopy if nonoperative therapy has been tried and failed and there are MRI findings of loose bodies, labral tears or cysts, femoroacetabular impingement, chondral injury, synovial disease, ligamentum teres tear or rupture, iliopsoas or anterior inferior iliac spine impingement, extra-articular impingement (eg, subspine, ischiofemoral), sciatic nerve entrapment, or greater trochanteric pain syndrome.(1) **(EG 2)** For symptomatic os acetabuli, a narrative review supports arthroscopic excision or internal fixation, depending on whether the fragment is required to maintain hip stability.(4) **(EG 2)**

For borderline hip dysplasia, an orthopedic surgery textbook, a narrative review, and systematic reviews support hip arthroscopy treatment to improve symptoms.(1)(2)(5) **(EG 2)**

For a septic hip requiring debridement and lavage, an orthopedic surgery textbook and a narrative review recommend arthroscopy.(1)(2) **(EG 2)**

For proximal hamstring avulsion or a snapping hip refractory to nonoperative treatment, a narrative review supports hip arthroscopy to improve pain and function.(6) **(EG 2)** A cohort study supports surgery for complete proximal hamstring avulsion or for partial avulsion injuries with at least 2 tendons involved with greater than 2 cm of retraction.(7) **(EG 2)**

A narrative review recommends hip arthroscopy evaluation when patients have hip symptoms with nondiagnostic findings on imaging and nonoperative therapy fails.(8) **(EG 2)**

A narrative review recommends hip arthroscopy as an option for traumatic hip dislocation with associated chondral lesions, loose intra-articular bodies, or soft tissue injury (eg, ligamentum teres or labral tears).(9) **(EG 2)**

For tenosynovial giant cell tumor (also known as pigmented villonodular tenosynovitis), a narrative review supports hip arthroscopy for biopsy (eg, for diagnostic uncertainty).(10) **(EG 2)** A systematic review of cohort studies supports the use of hip arthroscopy for treatment (eg, synovectomy and treatment of associated labral tears or other lesions) of tenosynovial giant cell tumor.(11) **(EG 2)**

A study of 222 adults (mean age 36 years) with femoroacetabular impingement syndrome randomized to arthroscopic hip surgery or physiotherapy found, at 3-year follow-up, that the arthroscopic group had lower quantitative hip osteoarthritis MRI scores (9.22 vs 22.76 for arthroscopy and physiotherapy groups, respectively; a lower score indicates less osteoarthritis) and higher hip outcome activity of daily living (HOS ADL) scores (84.2 vs 74.2, mean difference 8.9 (95% confidence interval 7.0 to 10.8); higher scores indicate superior outcomes). However, there was no significant difference in the primary outcome of mean joint space width (3.40 mm vs 3.36 mm).(12) **(EG 1)** There was also a greater percentage of patients in the arthroscopy group who had an improvement in HOS ADL scores that was greater than the minimally clinically important difference of 9 points (67% vs 48%).(12) **(EG 1)**

Length of Stay

Analysis of procedure data for a commercially insured pediatric population shows 99% of patients undergoing hip arthroscopy were discharged the day of or the day after the procedure.(45) **(EG 3)** Analysis of procedure data for a commercially insured adult population shows 99% of patients undergoing hip arthroscopy were discharged the day of or the day after the procedure.(45) **(EG 3)** Analysis of procedure data for a Medicare-insured population shows 97% of patients undergoing hip arthroscopy were discharged the day of or the day after the procedure.(45) **(EG 3)**

Rationale

Use of this MCG care guideline helps the clinician identify, for a given procedure, which patient-specific factors and clinical conditions are appropriate for that procedure. The evidence-based clinical criteria assist the clinician in the decision to appropriately perform a procedure, evaluating whether the potential benefits of a procedure outweigh the potential risks. For Medicare enrollees, surgical MCG care guidelines also identify which procedures CMS has designated as inpatient only.

Use of these evidence-based clinical criteria to support decision making around the need for a given procedure is of benefit to the patient, as all procedures come with inherent risk that must be balanced by anticipated clinical benefit. Utilizing evidence-based clinical criteria enables a more accurate and patient-specific decision-making process. In addition, the use of evidence-based guidelines can help reduce unwarranted variation in care, such as divergent clinical thresholds to perform a procedure for clinically similar patients that vary across geographic regions, between facilities, and among individual clinicians.

Related CMS Coverage Guidance

This guideline supplements but does not replace, modify, or supersede existing Medicare regulations or applicable National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs).

Code of Federal Regulations (CFR): 42 CFR 412.3(71); 42 CFR 419.22(72); 42 CFR 422.101(73)

Internet-Only Manual (IOM) Citations: CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 1 - Inpatient Hospital Services Covered Under Part A(74); CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 6 - Hospital Services Covered Under Part B(75); CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 15 - Covered Medical and Other Health Services(76); CMS IOM Publication 100-08, Medicare Program Integrity Manual, Chapter 6, Section 6.5 - Medical Review of Inpatient Hospital Claims for Part A Payment(77)

References

1. Phillips BB, Mihalko MJ. Arthroscopy of the lower extremity. In: Azar FM, Beaty JH, editors. *Campbell's Operative Orthopaedics*. 14th ed. Philadelphia, PA: Elsevier; 2021:2576-2662.e8. [Context Link 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22]
2. Crofts H, McConkey M, Lodhia P. Pediatric hip arthroscopy: a review of indications and treatment outcomes. *Current Reviews in Musculoskeletal Medicine* 2023;16(7):284-294. DOI: 10.1007/s12178-023-09842-2. [Context Link 1, 2, 3, 4, 5] View abstract...
3. Shah S, Stavinoha T, Nepple JJ, Crepeau AE, PRiSM Hip RIG (Research Interest Group), Carsen S. The evolving role and technique of hip arthroscopy in children and adolescents. *Journal of the Pediatric Orthopaedic Society of North America* 2024;7:100064. DOI: 10.1016/j.jposna.2024.100064. [Context Link 1, 2, 3, 4, 5] View abstract...
4. Yoshitani J, Schoyer B, Shah A, Khanduja V. Current concepts in the diagnosis and management of Os Acetabuli. *International Orthopaedics* 2024;48(3):657-666. DOI: 10.1007/s00264-023-06078-0. [Context Link 1, 2, 3] View abstract...
5. Boos AM, Nagelli CV, Okoroha KR, Sierra RJ, Krych AJ, Hevesi M. Primary hip arthroscopy in patients with acetabular dysplasia: a systematic review of published clinical outcomes at minimum 5-year follow-up. *American Journal of Sports Medicine* 2024;52(8):2148-2158. DOI: 10.1177/03635465231197177. [Context Link 1, 2, 3] View abstract...
6. Perets I, Rybalko D, Mu BH, Friedman A, Morgenstern DR, Domb BG. Hip arthroscopy: extra-articular procedures. *Hip International : The Journal of Clinical and Experimental Research on Hip Pathology and Therapy* 2019;29(4):346-354. DOI: 10.1177/1120700019840729. [Context Link 1, 2, 3, 4, 5, 6, 7] View abstract...
7. Fletcher AN, Pereira GF, Lau BC, Mather RC. Endoscopic proximal hamstring repair is safe and efficacious with high patient satisfaction at a minimum of two-year follow-up. *Arthroscopy* 2021;37(11):3275-3285. DOI: 10.1016/j.arthro.2021.03.067. [Context Link 1, 2, 3] View abstract...
8. Frank RM, Walker G, Hellman MD, McCormick FM, Nho SJ. Evaluation of hip pain in young adults. *Physician and Sportsmedicine* 2014;42(2):38-47. DOI: 10.3810/psm.2014.05.2056. [Context Link 1, 2] View abstract...
9. Benedick A, Lopas L, Daley E, Jang Y. Traumatic hip dislocation: pediatric and adult evaluation and management. *Journal of the American Academy of Orthopedic Surgeons* 2024;32(14):637-646. DOI: 10.5435/JAAOS-D-23-01013. [Context Link 1, 2] View abstract...
10. Stacchiotti S, et al. Best clinical management of tenosynovial giant cell tumour (TGCT): A consensus paper from the community of experts. *Cancer Treatment Reviews* 2023;112:Online. DOI: 10.1016/j.ctrv.2022.102491. [Context Link 1, 2, 3, 4, 5] View abstract...
11. Giai Via R, et al. Arthroscopic management of pigmented villonodular synovitis of the hip: a systematic review. *Journal of Clinical Medicine* 2024;13(21):DOI: 10.3390/jcm13216446. [Context Link 1, 2] View abstract...
12. Palmer A, et al. Medium-term results of arthroscopic hip surgery compared with physiotherapy and activity modification for the treatment of femoroacetabular impingement syndrome: a multi-centre randomised controlled trial. *British Journal of Sports Medicine* 2025;59(2):109-117. DOI: 10.1136/bjsports-2023-107712. [Context Link 1, 2, 3, 4] View abstract...
13. Martin SD, et al. Hip arthroscopy versus physical therapy for the treatment of symptomatic acetabular labral tears in patients older than 40 years: 24-month results from a randomized controlled trial. *American Journal of Sports Medicine* 2024;52(10):2574-2585. DOI: 10.1177/03635465241263595. [Context Link 1, 2] View abstract...
14. Hassan MM, et al. Open and arthroscopic management of femoroacetabular impingement: a review of current concepts. *Journal of Hip Preservation Surgery* 2022;9(4):265-275. DOI: 10.1093/jhps/hnac043. [Context Link 1, 2, 3] View abstract...
15. Gaudiani MA, Samuel LT, Burkhart RJ, Acuna AJ, Rosneck JT, Kamath AF. What is the utility of hip arthroscopy in patients with joint laxity? A contemporary systematic review of patient-reported and surgical outcomes. *Archives of Orthopaedic and Trauma Surgery* 2023;143(8):5133-5142. DOI: 10.1007/s00402-022-04737-2. [Context Link 1] View abstract...
16. Mahmoud SSS, Takla A, Meyer D, Griffin D, O'Donnell J. Arthroscopic hip surgery offers better early patient-reported outcome measures than targeted physiotherapy programs for the treatment of femoroacetabular impingement syndrome: a systematic review and meta-analysis of randomized controlled trials. *Journal of Hip Preservation Surgery* 2022;9(2):107-118. DOI: 10.1093/jhps/hnac012. [Context Link 1, 2] View abstract...
17. Lynch TS, et al. Best practice guidelines for hip arthroscopy in femoroacetabular impingement: results of a Delphi Process. *Journal of the American Academy of Orthopedic Surgeons* 2020;28(2):81-89. DOI: 10.5435/JAAOS-D-18-00041. [Context Link 1, 2, 3] View abstract...

18. Rosinsky PJ, Shapira J, Lall AC, Domb BG. All about the ligamentum teres: from biomechanical role to surgical reconstruction. *Journal of the American Academy of Orthopedic Surgeons* 2020;28(8):e328-e339. DOI: 10.5435/JAAOS-D-19-00352. [Context Link 1] View abstract...
19. Parvaresh KC, Rasio J, Azua E, Nho SJ. Hip instability in the athlete: anatomy, etiology, and management. *Clinics in Sports Medicine* 2021;40(2):289-300. DOI: 10.1016/j.csm.2020.11.005. [Context Link 1, 2] View abstract...
20. Matthewson G, Williams A, Macciachera M, Shahabinezhad A, Duong A, Ayeni OR. Effective management options for treatment of microinstability of the hip: a scoping review. *Current Reviews in Musculoskeletal Medicine* 2023;16(1):9-18. DOI: 10.1007/s12178-022-09808-w. [Context Link 1] View abstract...
21. Sheridan GA, Neufeld ME, Moshkovitz R, Garbuz DS, Masri BA. Tendinopathies and allied disorders of the hip. *Orthopedic Clinics of North America* 2022;53(4):393-401. DOI: 10.1016/j.ocl.2022.06.003. [Context Link 1, 2, 3] View abstract...
22. Giai Via R, et al. Arthroscopic and endoscopic techniques for iliopsoas release in THA are safe and effective: a systematic review of the literature. *European Journal of Orthopaedic Surgery and Traumatology* 2024;34(6):2845-2857. DOI: 10.1007/s00590-024-04042-1. [Context Link 1] View abstract...
23. Shapira J, et al. Intraoperative findings and clinical outcomes associated with arthroscopic management of subspine impingement: a propensity-matched, controlled study. *Arthroscopy* 2021;37(10):3090-3101. DOI: 10.1016/j.arthro.2021.03.057. [Context Link 1] View abstract...
24. Nakano N, Shoman H, Khanduja V. Treatment strategies for ischiofemoral impingement: a systematic review. *Knee Surgery, Sports Traumatology, Arthroscopy* 2020;28(9):2772-2787. DOI: 10.1007/s00167-018-5251-5. [Context Link 1] View abstract...
25. Schaver AL, Leary SM, Henrichsen JL, Larson CM, Westermann RW. Outcomes of arthroscopic decompression of the anterior inferior iliac spine: a systematic review and meta-analysis. *American Journal of Sports Medicine* 2022;Online. DOI: 10.1177/03635465211062903. [Context Link 1] View abstract...
26. Thaumat M, Pacoret V, Saad M, Saint-Etienne A, Morvan A, Francophone Arthroscopy Society (SFA). Endoscopic treatment of gluteus medius tendon tear. *Orthopaedics & Traumatology, Surgery & Research : OTSR* 2022;108(8S):Online. DOI: 10.1016/j.otsr.2022.103393. [Context Link 1, 2] View abstract...
27. Maldonado DR, et al. Outcomes of open and endoscopic repairs of chronic partial- and full-thickness proximal hamstring tendon tears: a multicenter study with minimum 2-year follow-up. *American Journal of Sports Medicine* 2021;49(3):721-728. DOI: 10.1177/0363546520981767. [Context Link 1] View abstract...
28. Domb BG, Owens JS, Glein RM, Jimenez AE, Maldonado DR. Borderline dysplasia after primary hip arthroscopy with capsular plication and labral preservation: ten-year survivorship and patient-reported outcomes. *Journal of Bone and Joint Surgery. American Volume* 2023;105(9):687-699. DOI: 10.2106/JBJS.22.00340. [Context Link 1, 2] View abstract...
29. Kunze KN, Sullivan SW, Nwachukwu BU. Updates on management of avascular necrosis using hip arthroscopy for core decompression. *Frontiers in Surgery* 2022;9:Online. DOI: 10.3389/fsurg.2022.662722. [Context Link 1] View abstract...
30. Begly JP, Robins B, Youm T. Arthroscopic treatment of traumatic hip dislocation. *Journal of the American Academy of Orthopedic Surgeons* 2016;24(5):309-317. DOI: 10.5435/JAAOS-D-15-00088. [Context Link 1] View abstract...
31. Mallet C, Ilharreborde B, Caseris M, Simon AL. Treatment of septic arthritis of the hip in children. *Orthopaedics & Traumatology, Surgery & Research : OTSR* 2025;111(1S):104064. DOI: 10.1016/j.otsr.2024.104064. [Context Link 1, 2, 3] View abstract...
32. D'Angelo F, Monestier L, Zagra L. Active septic arthritis of the hip in adults: what's new in the treatment? A systematic review. *EFORT Open Reviews* 2021;6(3):164-172. DOI: 10.1302/2058-5241.6.200082. [Context Link 1, 2] View abstract...
33. Giai Via R, Elzeiny A, Pante S, De Vivo S, Masse A, Giachino M. Can we encourage the endoscopic treatment for external snapping hip (ESH)? A systematic review of current concepts. *European Journal of Orthopaedic Surgery and Traumatology* 2024;34(6):2835-2844. DOI: 10.1007/s00590-024-04030-5. [Context Link 1] View abstract...
34. Walker P, Ellis E, Scofield J, Kongchum T, Sherman WF, Kaye AD. Snapping hip syndrome: a comprehensive update. *Orthopedic Reviews* 2021;13(2):Online. DOI: 10.52965/001c.25088. [Context Link 1] View abstract...
35. Ruzbarsky JJ, Comfort SM, Martin MD, Briggs KK, Philippon MJ. Outcomes for treatment of capsulolabral adhesions with a capsular spacer during revision hip arthroscopy. *American Journal of Sports Medicine* 2023;51(2):487-493. DOI: 10.1177/03635465221145704. [Context Link 1] View abstract...
36. Philippon MJ, Ryan M, Martin MB, Huard J. Capsulolabral adhesions after hip arthroscopy for the treatment of femoroacetabular impingement: strategies during rehabilitation and return to sport to reduce the risk of revision. *Arthroscopy, Sports Medicine, and Rehabilitation* 2022;4(1):e255-e262. DOI: 10.1016/j.asmr.2021.10.031. [Context Link 1, 2] View abstract...

37. Howse EA, Rogers JP, Stone AV, Mannava S, Stubbs AJ. Arthroscopic bullet removal from the central and peripheral compartments of the hip joint. *Arthroscopy Techniques* 2016;5(2):e217-21. DOI: 10.1016/j.eats.2015.11.001. [Context Link 1] View abstract...
38. Kolasinski SL, et al. 2019 American College of Rheumatology/Arthritis Foundation guideline for the management of osteoarthritis of the hand, hip, and knee. *Arthritis Care & Research* 2020;72(2):149-162. DOI: 10.1002/acr.24131. (Reaffirmed 2025 Mar) [Context Link 1] View abstract...
39. Pasculli RM, Callahan EA, Wu J, Edralin N, Berrigan WA. Non-operative management and outcomes of femoroacetabular impingement syndrome. *Current Reviews in Musculoskeletal Medicine* 2023;16(11):501-513. DOI: 10.1007/s12178-023-09863-x. [Context Link 1, 2, 3] View abstract...
40. Expert Panel on Musculoskeletal Imaging, et al. ACR Appropriateness Criteria® chronic hip pain: 2022 update. *Journal of the American College of Radiology* 2023;20(5S):S33-S48. DOI: 10.1016/j.jacr.2023.02.019. [Context Link 1] View abstract...
41. Rodriguez-Merchan EC, De la Corte-Rodriguez H, Alvarez-Roman MT, Gomez-Cardero P, Jimenez-Yuste V. Radiosynovectomy for the treatment of chronic hemophilic synovitis: an old technique, but still very effective. *Journal of Clinical Medicine* 2022;11(24):Online. DOI: 10.3390/jcm11247475. [Context Link 1] View abstract...
42. Rodriguez-Merchan EC. Synovitis in hemophilia: preventing, detecting, and treating joint bleeds. *Expert Review of Hematology* 2023;1-10. DOI: 10.1080/17474086.2023.2209717. [Context Link 1] View abstract...
43. Nepple JJ, et al. Surgical treatment of femoroacetabular impingement: hip arthroscopy versus surgical hip dislocation: a propensity-matched analysis. *Journal of Bone and Joint Surgery. American Volume* 2020;102(Suppl 2):51-58. DOI: 10.2106/JBJS.20.00265. [Context Link 1] View abstract...
44. Steelman VM, Chae S, Duff J, Anderson MJ, Zaidi A. Warming of irrigation fluids for prevention of perioperative hypothermia during arthroscopy: a systematic review and meta-analysis. *Arthroscopy* 2018;34(3):930-942.e2. DOI: 10.1016/j.arthro.2017.09.024. [Context Link 1] View abstract...
45. Proprietary health insurance data sources (2023-2024); and Medicare 5% Standard Analytical File (2022-2023). [Context Link 1, 2, 3, 4]
46. Premier PINC AI™ Healthcare Database (PHD), 01/01/2023-12/31/2024. Premier, Inc. [Context Link 1]
47. Brand JC, Rossi MJ, Lubowitz JH. Hip arthroscopy complications are rare, but there is room for improvement. *Arthroscopy* 2019;35(5):1297-1299. DOI: 10.1016/j.arthro.2019.03.009. [Context Link 1] View abstract...
48. Leland DP, et al. Neurological complications following arthroscopic and related sports surgery: prevention, work-up, and treatment. *Sports Medicine and Arthroscopy Review* 2022;30(1):Online. DOI: 10.1097/JSA.0000000000000322. [Context Link 1] View abstract...
49. Hudson T. The role of social determinates of health in discharge practices. *Nursing Clinics of North America* 2021;56(3):369-378. DOI: 10.1016/j.cnur.2021.04.004. [Context Link 1] View abstract...
50. Chovanec KA, Arsene C, Beck A, Zachrich K, Liedel B, Wolff-Elliott J. Association of discharge disposition with outcomes. *Population Health Management* 2021;24(1):116-121. DOI: 10.1089/pop.2019.0176. [Context Link 1] View abstract...
51. Centers for Medicare and Medicaid Services. "Condition of participation: Discharge planning." 42 CFR Pt. 482.43 Washington, DC 2025 Jan 01 [accessed 2025 Jul 22] Accessed at: <https://www.ecfr.gov/>. [Context Link 1, 2, 3]
52. Management of patients with musculoskeletal disorders. In: Hinkle JL, Cheever KH, Overbaugh KJ, editors. *Brunner & Suddarth's Textbook of Medical-Surgical Nursing*. 15th ed. Wolters Kluwer; 2022:1113-1151. [Context Link 1]
53. Filson R. Musculoskeletal trauma and orthopedic surgery. In: Harding MM, Kwong J, Hagler D, Reinisch C, editors. *Lewis's Medical-Surgical Nursing: Assessment and Management of Clinical Problems*. 12th ed. St. Louis, MO: Mosby; 2023:1638-1672. [Context Link 1]
54. Skin integrity and wound care. In: Lynn P, editor. *Taylor's Clinical Nursing Skills*. 6th ed. Wolters Kluwer; 2023:452-540. [Context Link 1]
55. Targeted care planning and care transitions. In: Perez R, editor. *CMSA's Integrated Case Management*. 2nd ed. Springer Publishing Company LLC; 2023:178-189. [Context Link 1, 2]
56. Elements of Excellence in Transitions of Care (TOC). TOC Checklist [Internet] National Transitions of Care Coalition. 2006 Accessed at: <https://www.ntocc.org/>. [accessed 2025 Sep 16] [Context Link 1]
57. Medical-surgical nursing. In: Hinkle JL, Cheever KH, Overbaugh KJ, editors. *Brunner & Suddarth's Textbook of Medical-Surgical Nursing*. 15th ed. Wolters Kluwer; 2022:33-55. [Context Link 1]

58. Transition of care. In: Gillingham DC, editor. Foundations of Case Management. Blue Bayou Press; 2021:137-144. [Context Link 1]
59. Becker C, et al. Interventions to improve communication at hospital discharge and rates of readmission: a systematic review and meta-analysis. JAMA Network Open 2021;4(8):e2119346. DOI: 10.1001/jamanetworkopen.2021.19346. [Context Link 1] View abstract...
60. The nursing process in drug therapy and patient safety. In: Tucker RG, editor. Karch's Focus on Nursing Pharmacology. 9th ed. Wolters Kluwer; 2023:47-57. [Context Link 1]
61. Adverse drug reactions and medication errors. In: Burchum JR, Rosenthal LD, editors. Lehne's Pharmacology for Nursing Care. 12th ed. Elsevier; 2025:64-75. [Context Link 1]
62. Safe medication preparation. In: Perry AG, Potter PA, Ostendorf WR, Laplante N, editors. Clinical Nursing Skills and Techniques. 11th ed. Elsevier; 2025:586-607. [Context Link 1]
63. The case manager's roles, functions, and activities. In: Gillingham DC, editor. Foundations of Case Management. Blue Bayou Press; 2021:9-14. [Context Link 1]
64. Anderson TS, Ayanian JZ, Herzig SJ, Souza J, Landon BE. Gaps in primary care follow-up after hospital discharge among Medicare beneficiaries. Journal of the American Geriatrics Society 2025;DOI: 10.1111/jgs.19496. [Context Link 1] View abstract...
65. Alter TD, et al. Return to sport in athletes with borderline hip dysplasia after hip arthroscopy for femoroacetabular impingement syndrome. American Journal of Sports Medicine 2022;50(1):30-39. DOI: 10.1177/03635465211056082. [Context Link 1] View abstract...
66. The intervention. In: Dutton M, editor. Dutton's Orthopaedic Examination, Evaluation, and Intervention. 6th ed. McGraw-Hill Education; 2023:343-368. [Context Link 1]
67. Bragg-Underwood T. Family health. In: Nies MA, editor. Community/Public Health Nursing. 8th ed. Elsevier; 2024:404-427. [Context Link 1]
68. Harding MM. Substance use disorders in acute care. In: Harding MM, Kwong J, Hagler D, Reinisch C, editors. Lewis's Medical-Surgical Nursing: Assessment and Management of Clinical Problems. 12th ed. St. Louis, MO: Mosby; 2023:162-178. [Context Link 1]
69. Activity. In: Lynn P, editor. Taylor's Clinical Nursing Skills. 6th ed. Wolters Kluwer; 2023:541-632. [Context Link 1]
70. Management of patients with dermatologic disorders. In: Hinkle JL, Cheever KH, Overbaugh KJ, editors. Brunner & Suddarth's Textbook of Medical-Surgical Nursing. 15th ed. Wolters Kluwer; 2022:1815-1864. [Context Link 1]
71. Centers for Medicare and Medicaid Services. "Admissions." 42 CFR 412.3 Washington, DC 2025 Jul [accessed 2025 Jul 22] Accessed at: <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412>. [Context Link 1]
72. Centers for Medicare and Medicaid Services. "Hospital services excluded from payment under the hospital outpatient prospective payment system." 42 CFR 419.22 Washington, DC 2023 Jul [accessed 2025 Jul 22] Accessed at: <https://www.ecfr.gov/>. [Context Link 1]
73. Centers for Medicare and Medicaid Services. "Requirements relating to basic benefits." 42 CFR 422.101 Washington, DC 2025 Jun 03 [accessed 2025 Jul 23] Accessed at: <https://www.ecfr.gov/>. [Context Link 1]
74. Centers for Medicare and Medicaid Services. Medicare Benefit Policy Manual. Chapter 1 - Inpatient Hospital Services Covered Under Part A Rev. 10892 [Internet] Centers for Medicare and Medicaid Services. 2021 Aug Accessed at: <https://www.cms.gov/manuals/>. [accessed 2025 Sep 09] [Context Link 1]
75. Centers for Medicare and Medicaid Services. Medicare Benefit Policy Manual. Chapter 6 - Hospital Services Covered Under Part B Rev. 12425 [Internet] Centers for Medicare and Medicaid Services. 2023 Dec Accessed at: <http://www.cms.gov/manuals/>. [accessed 2025 Sep 09] [Context Link 1]
76. Centers for Medicare and Medicaid Services. Medicare Benefit Policy Manual. Chapter 15 - Covered Medical and Other Health Services Rev. 13108 [Internet] Centers for Medicare and Medicaid Services. 2025 Apr 11 Accessed at: <https://www.cms.gov/manuals/>. [accessed 2025 Sep 09] [Context Link 1]
77. Centers for Medicare and Medicaid Services. Medicare Program Integrity Manual. Chapter 6, Section 6.5 - Medical Review of Inpatient Hospital Claims for Part A Payment Rev. 10365 [Internet] Centers for Medicare and Medicaid Services. 2020 Oct 02 Accessed at: <https://www.cms.gov/medicare/regulations-guidance/manuals/internet-only-manuals-ioms>. [accessed 2025 Sep 09] [Context Link 1]
78. Medicare Coverage Database. [Internet] Centers for Medicare and Medicaid Services. Accessed at: <https://www.cms.gov/medicare-coverage-database/search.aspx>? Updated 2025 [accessed 2025 Oct 23] [Context Link 1]

Footnotes

[A] Causes of femoroacetabular impingement include athletic activity, aseptic necrosis of the femoral epiphysis (Legg-Calve-Perthes syndrome), slipped capital femoral epiphysis, ligamentous laxity, juvenile arthritis, and primary (idiopathic) impingement.(3)(14)(15) [A in Context Link 1]

[B] Os acetabuli are small areas of secondary ossification along the acetabular rim that have not fused with the acetabulum. Arthroscopic management may include either excision or internal fixation, depending on whether the fragment is required to maintain hip stability.(4) [B in Context Link 1]

[C] See Ambulatory Surgery Discharge and Complications: Common Complications and Conditions  ISC for further information. [C in Context Link 1]

[D] The patient may require partial-weight-bearing with crutches postoperatively.(1) [D in Context Link 1]

[E] The patient is ambulatory or near baseline activity for age and development. [E in Context Link 1]

[F] Some patients may have their hydration needs met via alternative means (eg, percutaneous endoscopic gastrostomy tube). [F in Context Link 1]

[G] Warming of irrigation fluids can reduce the risk of hypothermia and postoperative shivering.(44) [G in Context Link 1]

[H] Discharge instructions should be given in the patient's and caregiver's native language using trained language interpreters whenever possible.(49) [H in Context Link 1]

Definitions

Hemodynamic stability

- Hemodynamic stability, as indicated by **1 or more** of the following:
 - Hemodynamic abnormalities at baseline or acceptable for next level of care
 - Patient hemodynamically stable, as indicated by **ALL** of the following(1)(2):
 - Tachycardia absent
 - Hypotension absent
 - No evidence of inadequate perfusion (eg, no myocardial ischemia)
 - No other hemodynamic abnormalities (eg, no Orthostatic hypotension)

References

1. Schriger DL. Approach to the patient with abnormal vital signs. In: Goldman L, Cooney KA, editors. Goldman-Cecil Medicine. 27th ed. Elsevier; 2024:32-35.
2. Ramgopal S, Sepanski RJ, Martin-Gill C. Empirically derived age-based vital signs for children in the out-of-hospital setting. Annals of Emergency Medicine 2023;81(4):402-412. DOI: 10.1016/j.annemergmed.2022.09.019.

Hypotension absent

- Hypotension absent,[A] as indicated by **1 or more** of the following:
 - Hypotension absent in adult patient, as indicated by **1 or more** of the following:
 - Systolic blood pressure greater than or equal to 90 mm Hg[A](1)
 - Mean arterial pressure[B] greater than or equal to 70 mm Hg  MAP Calculator[A](1)(2)
 - Blood pressure at patient's baseline (eg, healthy adult with low systolic blood pressure), at intentional therapeutic goal (eg, patient with heart failure), or acceptable for next level of care (eg, blood pressure stable and no significant signs or symptoms due to low blood pressure)

- Hypotension absent in pediatric patient, as indicated by **1 or more** of the following:
 - Systolic blood pressure greater than or equal to 110 mm Hg in child 13 to 17 years of age^{[A](3)}
 - Systolic blood pressure greater than or equal to 100 mm Hg in child 6 to 12 years of age^{[A](3)}
 - Systolic blood pressure greater than or equal to 95 mm Hg in child 3 to 5 years of age^{[A](3)}
 - Systolic blood pressure greater than or equal to 90 mm Hg in child 1 or 2 years of age^{[A](3)}
 - Systolic blood pressure greater than or equal to 80 mm Hg in infant 6 to 11 months of age^{[A](3)}
 - Systolic blood pressure greater than or equal to 70 mm Hg in infant 3 to 5 months of age^{[A](3)}
 - Systolic blood pressure greater than or equal to 65 mm Hg in infant 1 or 2 months of age^{[A](3)}
 - Blood pressure at patient's baseline (eg, healthy child with low systolic blood pressure), at intentional therapeutic goal, or acceptable for next level of care (eg, blood pressure stable and no significant signs or symptoms due to low blood pressure)

References

1. Schriger DL. Approach to the patient with abnormal vital signs. In: Goldman L, Cooney KA, editors. Goldman-Cecil Medicine. 27th ed. Elsevier; 2024:32-35.
2. Puskarch MA, Jones AE. Shock. In: Walls RM, editor. Rosen's Emergency Medicine: Concepts and Clinical Practice. 10th ed. Elsevier; 2023:34-41.e1.
3. Anderson CC, Kapoor S, Mark TE. Pediatric parameters and equipment. In: Anderson CC, Kapoor S, Mark TE, editors. The Harriet Lane Handbook: A Manual for Pediatric House Officers. 23rd ed. Elsevier; 2024:i-iii.

Footnotes

- A. Criteria based upon clinician-acquired numeric values (eg, vital signs, oxygen saturation) should be used if they are accurate reflections of the patient's condition. Transitory findings (eg, abnormal only upon initial emergency department intake or only one time out of multiple readings) that rapidly improve with no or minimal treatment usually do not reflect disease severity or risk for deterioration. This does not imply that an initial or one-time reading cannot ever be applicable. The goal is to separate erroneous or incidental findings from those that truly represent the patient's clinical picture.
- B. The mean arterial pressure (MAP) takes into account both SBP and DBP readings.

Orthostatic hypotension

- Orthostatic hypotension,^{[A][B]} as indicated by **1 or more** of the following⁽¹⁾⁽²⁾⁽³⁾:
 - Fall in SBP of 20 mm Hg or more 1 to 3 minutes after patient sits or stands from recumbent position
 - Fall in DBP of 10 mm Hg or more 1 to 3 minutes after patient sits or stands from recumbent position

References

1. Shibao C, Lipsitz LA, Biaggioni I, American Society of Hypertension Writing Group. Evaluation and treatment of orthostatic hypotension. Journal of the American Society of Hypertension 2013 Jul-Aug;7(4):317-324. DOI: 10.1016/j.jash.2013.04.006.
2. Dalal AS, Van Hare GF. Syncope. In: Kliegman RM, et al., editors. Nelson Textbook of Pediatrics. 22nd ed. Elsevier; 2025:592-599.
3. Fang JC, O'Gara PT. History and physical examination: an evidence-based approach. In: Libby P, Bonow RO, Mann DL, Tomaselli GF, Bhatt DL, Solomon SD, editors. Braunwald's Heart Disease: A Textbook of Cardiovascular Medicine. 12th ed. Elsevier; 2022:123-140.

Footnotes

- A. Concomitant measurements of the heart rate are important to measure to help diagnose subtypes of orthostatic hypotension (eg, the lack of a compensatory increase in heart rate is typical of autonomic failure and an exaggerated tachycardia may be reflective of volume depletion). However, the heart rate is not a

component of the definition of orthostatic hypotension, which relies upon blood pressure alone.(1)(2)(3)

- B. Criteria based upon clinician acquired numeric values (eg, vital signs, oxygen saturation) should be used if they are accurate reflections of the patient's condition. Transitory findings (eg, abnormal only upon initial emergency department intake or only one time out of multiple readings) that rapidly improve with no or minimal treatment usually do not reflect disease severity or risk for deterioration. This does not imply that an initial or one-time reading cannot ever be applicable. The goal is to separate erroneous or incidental findings from those that truly represent the patient's clinical picture.

Social Determinants of Health Assessment

- Risk of poor health outcomes may be increased by the presence of **1 or more** of the following social determinants of health(1)(2)(3):
 - Housing insecurity, as indicated by **1 or more** of the following:
 - Individual or caregiver's current living situation is **1 or more** of the following(4):
 - Does not have own housing (eg, staying in a hotel, shelter, or with others)
 - Has own housing (eg, house, apartment), but at risk of losing it in the future (ie, behind on rent or mortgage)
 - Has own housing (eg, house, apartment), but has lived in 3 or more places in past year
 - Current housing has **1 or more** of the following:
 - Electrical appliances (eg, stove, refrigerator) not working or unavailable
 - Insufficient heating or cooling
 - Insufficient ventilation
 - Lead paint or pipes
 - Mold
 - Pests (eg, bugs) or rodents
 - Smoke detectors not working or unavailable
 - Food insecurity, as indicated by **1 or more** of the following(5):
 - In the past year, individual or caregiver ran out of food and did not have money to buy more food.
 - In the past year, individual or caregiver worried that they would run out of food before they received money to buy more food.
 - Insufficient transportation, as indicated by **1 or more** of the following(6):
 - In the past year, individual or caregiver missed medical appointments or could not get medications due to lack of transportation.
 - In the past year, individual or caregiver missed nonmedical activities, work, or could not get things needed for daily living due to lack of transportation.
 - Insufficient utilities, as indicated by **1 or more** of the following(7):
 - Utilities (eg, electricity, water, gas, or oil) are currently shut off or unavailable.
 - In the past year, electric, water, gas, or oil company threatened to shut off services.
 - Personal safety risk, as indicated by **2 or more** of the following(5):
 - Individual is sometimes or frequently physically hurt by another person (including family member).
 - Individual is sometimes or frequently insulted or talked down to by another person (including family member).
 - Individual is sometimes or frequently threatened with physical harm by another person (including family member).
 - Individual is sometimes or frequently screamed or cursed at by another person (including family member).
 - Insufficient dependent care, as indicated by **1 or more** of the following:
 - In the past year, individual or caregiver was unable to work due to lack of dependent care.
 - In the past year, individual or caregiver was unable to work more (additional) hours due to lack of dependent care.
 - In the past year, individual or caregiver missed medical appointments or could not get medications due to lack of dependent care.
 - In the past year, individual or caregiver missed nonmedical activities (eg, school, church, social activity) due to lack of dependent care.
- Depression risk, as indicated by **ALL** of the following(8):

- In the past 2 weeks, individual had little interest or pleasure in normal activities on at least several days.
- In the past 2 weeks, individual felt down, depressed, or hopeless on at least several days.

References

1. Scanlon A, Reinisch C. Social determinants of health. In: Harding MM, Kwong J, Hagler D, Reinisch C, editors. Lewis's Medical-Surgical Nursing: Assessment and Management of Clinical Problems. 12th ed. St. Louis, MO: Mosby; 2023:18-20.
2. Billioux A, Verlander K, Anthony S, Alley D. Standardized Screening for Health-Related Social Needs in Clinical Settings: the Accountable Health Communities Screening Tool. [Internet] National Academy of Sciences. 2017 May Accessed at: <https://nam.edu/>. [accessed 2025 Sep 12]
3. Addressing social determinants of health. In: Perez R, editor. CMSA's Integrated Case Management. 2nd ed. Springer Publishing Company LLC; 2023:62-75.
4. Sandel M, et al. Unstable housing and caregiver and child health in renter families. *Pediatrics* 2018;14(2):e20172199. DOI: 10.1542/peds.2017-2199.
5. Children's HealthWatch Survey. Screening Instrument [Internet] Children's HealthWatch. 2024 Feb 13 Accessed at: <https://childrenshealthwatch.org/>. [accessed 2025 Mar 31]
6. PRAPARE®: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences Screening Tool. 2.0 [Internet] Association of Asian Pacific Community Health Organizations (AAPCHO) and National Association of Community Health Centers (NACHC). 2025 Accessed at: <https://prapare.org/the-prapare-screening-tool/>. [accessed 2025 Sep 08]
7. Cook JT, et al. A brief indicator of household energy security: associations with food security, child health, and child development in US infants and toddlers. *Pediatrics* 2008;122(4):e867-75. DOI: 10.1542/peds.2008-0286.
8. Kroenke K, Spitzer RL, Williams JB. The Patient Health Questionnaire-2: validity of a two-item depression screener. *Medical Care* 2003;41(11):1284-92. DOI: 10.1097/01.MLR.0000093487.78664.3C.

Tachycardia absent

- Tachycardia[A][B] absent, as indicated by **1 or more** of the following:
 - Heart rate less than or equal to 100 beats per minute in adult[A][B](1)
 - Heart rate less than or equal to 85 beats per minute in child 13 to 17 years of age[A][B](2)
 - Heart rate less than or equal to 95 beats per minute in child 6 to 12 years of age[A][B](2)
 - Heart rate less than or equal to 110 beats per minute in child 1 to 5 years of age[A][B](2)
 - Heart rate less than or equal to 120 beats per minute in infant 3 to 11 months of age[A][B](2)
 - Heart rate less than or equal to 150 beats per minute in infant 1 or 2 months of age[A][B](2)

References

1. Schrager DL. Approach to the patient with abnormal vital signs. In: Goldman L, Cooney KA, editors. Goldman-Cecil Medicine. 27th ed. Elsevier; 2024:32-35.
2. Anderson CC, Kapoor S, Mark TE. Pediatric parameters and equipment. In: Anderson CC, Kapoor S, Mark TE, editors. The Harriet Lane Handbook: A Manual for Pediatric House Officers. 23rd ed. Elsevier; 2024:i-iii.

Footnotes

- A. Criteria based upon clinician acquired numeric values (eg, vital signs, oxygen saturation) should be used if they are accurate reflections of the patient's condition. Transitory findings (eg, abnormal only upon initial emergency department intake or only one time out of multiple readings) that rapidly improve with no or minimal treatment usually do not reflect disease severity or risk for deterioration. This does not imply that an initial or one-time reading cannot ever be applicable. The goal is to separate erroneous or incidental findings from those that truly represent the patient's clinical picture.

B. Interpretation of heart rate requires clinical judgment and consideration of several patient-specific factors, such as the patient's baseline heart rate, medications, and clinical impact. For example, an elderly patient on a beta-blocker medication with a baseline resting heart rate of 60 beats per minute may be clinically tachycardic at a heart rate of 94 beats per minute. Likewise, a patient who is upset, in pain, or nervous in the emergency department with a heart rate of 106 beats per minute may meet the technical definition of tachycardia, but this tachycardia (absent associated findings such as chest pain or hypotension) may not be clinically important. The numeric values included in this definition are provided to allow for consistency in terms of a technical definition of the term tachycardia. Whether a heart rate above or below the technical threshold is clinically meaningful is a matter of persistence, context, and clinical judgment.

Codes

ICD-10 Diagnosis: A01.04, A18.02, A39.83, A54.42, M00.051, M00.052, M00.059, M00.151, M00.152, M00.159, M00.251, M00.252, M00.259, M00.851, M00.852, M00.859, M12.551, M12.552, M12.559, M16.0, M16.10, M16.11, M16.12, M16.2, M16.30, M16.31, M16.32, M16.4, M16.50, M16.51, M16.52, M16.6, M16.7, M16.9, M24.051, M24.052, M24.059, M24.151, M24.152, M24.159, M24.851, M24.852, M24.859, M25.051, M25.052, M25.059, M25.151, M25.152, M25.159, M25.251, M25.252, M25.259, M25.351, M25.352, M25.359, M25.451, M25.452, M25.459, M25.551, M25.552, M25.559, M25.651, M25.652, M25.659, M25.851, M25.852, M25.859, M87.051, M87.052, M87.059, M87.151, M87.152, M87.159, M87.251, M87.252, M87.256, M87.350, M87.351, M87.352, M87.353, M87.851, M87.852, M87.859, M90.551, M90.552, M90.559, S73.101A, S73.102A, S73.109A, S73.111A, S73.112A, S73.119A, S73.121A, S73.122A, S73.129A, S73.191A, S73.192A, S73.199A, S76.011A, S76.012A, S76.019A [Hide]

ICD-10 Procedure: 0M5L4ZZ, 0M5M4ZZ, 0M9L4ZX, 0M9M4ZX, 0MBL4ZX, 0MBL4ZZ, 0MBM4ZX, 0MBM4ZZ, 0MRL07Z, 0MRL0JZ, 0MRL0KZ, 0MRL47Z, 0MRL4JZ, 0MRL4KZ, 0MRM07Z, 0MRM0JZ, 0MRM0KZ, 0MRM47Z, 0MRM4JZ, 0MRM4KZ, 0MTL4ZZ, 0MTM4ZZ, 0S594ZZ, 0S5B4ZZ, 0S994ZX, 0S9B4ZX, 0SB94ZX, 0SB94ZZ, 0SBB4ZX, 0SBB4ZZ, 0SC94ZZ, 0SCB4ZZ, 0SJ94ZZ, 0SJB4ZZ, 0SN94ZZ, 0SNB4ZZ, 0SQ94ZZ, 0SQB4ZZ [Hide]

CPT®: 29860, 29861, 29862, 29863, 29914, 29915, 29916, 29999

CPT copyright 2025 American Medical Association. All rights reserved.

MCG Health
Inpatient & Surgical Care 30th Edition
Copyright © 2026 MCG Health, LLC
All Rights Reserved

Last Update: 1/25/2026 6:19:37 AM
Build Number: 30.0.2026012500524.025256