This Clinical Policy provides assistance in interpreting Oxford benefit plans. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members. Oxford reserves the right, in its sole discretion, to modify its policies as necessary. This Clinical Policy is provided for informational purposes. It does not constitute medical advice. The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies.

When deciding coverage, the member specific benefit plan document must be referenced. The terms of the member specific benefit plan document [e.g., Certificate of Coverage (COC), Schedule of Benefits (SOB), and/or Summary Plan Description (SPD)] may differ greatly from the standard benefit plan upon which this Clinical Policy is based. In the event of a conflict, the member specific benefit plan document supersedes this Clinical Policy. All reviewers must first identify member eligibility, any federal or state regulatory requirements, and the member specific benefit plan coverage prior to use of this Clinical Policy. Other Policies may apply.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

### CONDITIONS OF COVERAGE

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<tr>
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¹Precertification with review by a Medical Director or their designee is required.
BENEFIT CONSIDERATIONS

Before using this policy, please check the member specific benefit plan document and any federal or state mandates, if applicable.

**Essential Health Benefits for Individual and Small Group**

For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits ("EHBs"). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage for benefits which are deemed EHBs, the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute EHBs is made on a state by state basis. As such, when using this policy, it is important to refer to the member specific benefit plan document to determine benefit coverage.

COVERAGE RATIONALE

**Information Pertaining to Medical Necessity Review**

Surgical treatment for femoroacetabular impingement (FAI) syndrome is medically necessary in patients who have ALL of the following criteria:**

- Pain unresponsive to medical management (e.g., restricted activity, nonsteroidal anti-inflammatory drugs)
- Moderate-to-severe persistent hip or groin pain that limits activity and is worsened by flexion activities (e.g., squatting or prolonged sitting)
- Positive impingement sign (i.e., sudden pain on 90 degree hip flexion with adduction and internal rotation or extension and external rotation)
- Radiographic confirmation of FAI (e.g., pistol-grip deformity, alpha angle greater than 50 degrees, coax profunda, and/or acetabular retroversion)
- Do not have advanced osteoarthritis (i.e., Tönnis grade 2 or 3) and/or severe cartilage damage (i.e., Outerbridge grade III or IV)

** (Tannast, 2007; Filigenzi, 2008; Zebala, 2007; Clohisy 2010)

**Tonnis Classification of Osteoarthritis by Radiographic Changes**

- **Grade 0**: No signs of osteoarthritis (OA)
- **Grade 1**: Increased sclerosis of femoral head or acetabulum, slight joint space narrowing or slight slipping of joint margin, no or slight loss of head sphericity
- **Grade 2**: Small cysts in femoral head or acetabulum, moderate joint space narrowing, moderate loss of head sphericity
- **Grade 3**: Large cysts, severe joint space narrowing or obliteration of joint space, severe deformity of the head, avascular necrosis

**Outerbridge Grades**

- **Grade 0**: Normal
- **Grade I**: Cartilage with softening and swelling
- **Grade II**: Partial-thickness defect with fissures on the surface that do not reach subchondral bone or exceed 1.5 cm in diameter
- **Grade III**: Fissuring to the level of subchondral bone in an area with a diameter more than 1.5 cm
- **Grade IV**: Exposed subchondral bone head

**APPLICABLE CODES**

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies may apply.

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**CPT Code** | **Description**  
---|---  
29999 | Unlisted procedure, arthroscopy

**Coding Clarification:** The specific codes for femoroacetabular impingement syndrome surgery listed above should be used instead of 27299 and/or 29999.

**DESCRIPTION OF SERVICES**

Femoroacetabular impingement (FAI), formerly called acetabular rim syndrome or cervicoacetabular impingement, is the main cause of early damage to the acetabular labrum and articular cartilage of the hip, particularly in young, active patients and high-level athletes. In patients with FAI, limitation of both flexion and internal rotation occur at the hip joint as a result of premature pathologic contact between the skeletal prominences of the acetabulum and the femur. FAI generally occurs in one joint; however, in rare cases both hips can be involved. The earlier FAI is diagnosed, the more successful the treatment and retardation of degeneration. Initially, the patient is managed with medical treatment. Conservative measures, including physical therapy, restriction of activities, core strengthening, improvement of sensory-motor, and control and nonsteroidal anti-inflammatories (NSAIDs) are the mainstays of nonsurgical treatment (Samora, et al., 2011).

If the patient becomes refractory to medical management, surgical intervention may be indicated. Surgical treatment has been utilized to improve the clearance for motion at the hip joint and lessen the femoral thrust against the acetabular rim. Three surgical approaches are commonly used to accomplish the goals of surgical intervention; an open approach, arthroscopy or arthroscopy with a limited open approach (mini-open).

The appropriate surgical technique depends on the type of impingement, the extent of damage, the labral and cartilage pathology, and the physician/patient preferences and desired outcomes (Barton, et al., 2009).

Components that may be performed during FAI surgery include but are not limited to:
- Removing the nonspherical sections of the femoral head and prominent sections of the anterior femoral neck (osteoplasty)
- Debridement of chondral lesions
- Labral debridement (resection) or labral repair (refixation or reattachment)
- Evaluation and repair of chondral defects using microfracture or drilling chondroplasty
- Excising bony prominence and reshaping the acetabular rim (NICE, 2011)

FAI is common in patients presenting with low back pain, cartilage damage, hip pain, loss of range of motion, disability, and sport hernias. Most patients can be diagnosed with a good history, physical examination, plain x-ray, and magnetic resonance imaging (MRI). The three types of FAI include the following:
1. **Cam impingement** - due to an aspherical portion of the femoral head-neck junction (i.e., femoral cause) which is most common in young athletes
2. **Pincer impingement** - due to focal or wide-ranging excessive coverage of the ball or femoral head (i.e., acetabular cause) which is most common in athletic, middle-aged women
3. **Mixed pincer and cam impingement** - the most common type of FAI

**CLINICAL EVIDENCE**

Open incision, limited open approach, and arthroscopy are established surgical approaches for the treatment of FAI. Significant improvements in activity level, pain scores, and range of motion, as well as absence of impingement pain have been consistently reported following surgical intervention for FAI that is nonresponsive to medical management.

Khan et al. (2016) conducted a systematic comprehensive review in duplicate of Arthroscopy and The American Journal of Sports Medicine (AJSM) from February 2012 to February 2015 for all articles related to Femoroacetabular Impingement (FAI). A total of 4,131 patients in 104 studies were included in this review. The modified Harris Hip Score (mHHS) mean values after arthroscopic surgery for FAI showed improvements at the midterm from 60.5 points to 80.5 points out of a possible 100 points. The outcomes for labral repair showed mean mHHS improvements from 63.8 points preoperatively to 86.9 points up to 24 months postoperatively. The authors concluded arthroscopic intervention results in improvements in functional outcomes at both the short-term and midterm for patients with symptomatic FAI in the absence of significant existing degenerative changes. Labral repair may result in improvements over labral debridement. The primary limitation of this study is the potential risk of bias in the findings from restricting this review to two journals. This however was done to allow for a comparison in the quality and content between these publications.
Nwachukwu et al. (2015) performed a systematic review and meta-analysis to determine whether there was a significant difference in clinical outcomes and progression to total hip arthroscopy between hip arthroscopy and open surgical hip dislocation treatment for FAI at minimum medium-term follow-up (36 months). They concluded that both hip arthroscopy and open surgical hip dislocation showed excellent and equivalent hip survival rates at 36 months with hip-specific outcome measures, demonstrating equivalence between groups. However, hip arthroscopy was shown to have superior results regarding general health-related quality of life in comparison to open treatment. Further studies are needed through well-conducted clinical trials to assess long-term outcomes for patients with FAI and increase understanding of the natural history of FAI.

Collins et al. (2015) conducted a systematic review of the literature to determine if prophylactic surgical intervention for asymptomatic patients with radiographic evidence of FAI is warranted to prevent early degenerative joint disease of the hip. Inclusion criteria were prospective or retrospective studies comparing skeletally mature asymptomatic patients with radiographic evidence of FAI treated with prophylactic hip arthroscopic surgery versus nonoperative management. As none of the references met the eligibility criteria, they conclude that current evidence does not support prophylactic surgery for asymptomatic FAI in the vast majority of cases. However, they also identified that limited evidence suggests that asymptomatic patients who have previously undergone total hip arthroplasty for FAI-induced osteoarthritis of the contralateral hip are at a significantly increased risk for early degenerative joint disease. Further research is needed through well-conducted clinical trials to better clarify surgical indications for prophylactic surgical intervention of patients with asymptomatic FAI.

de Sa et al. (2015) conducted a systematic review aimed to establish specific indications, outcomes, and complications of surgical management of adolescent FAI (patients aged 10-19 years of age). There were 6 eligible case series (4 with arthroscopic and 2 with open technique) and 2 conference abstracts examining 388 patients in total (435 hips), 81% of which were treated with hip arthroscopy. Overall, patients were followed up for a mean of 23.4 months postoperatively (range, 3 to 75 months). The main indication for surgery was a confirmed diagnosis of FAI with persistent pain and impaired function refractory to nonsurgical interventions (activity modification, intra-articular injections, etc.). The review concluded that both arthroscopic and open surgical dislocation approaches for the treatment of adolescent FAI appear to be safe and effective options for patients with persistent pain and limited function after an appropriate trial of nonoperative therapy.

Ayeni, et al. (2014) systematically reviewed the clinical literature to determine the identify outcomes addressing femoroacetabular impingement, especially those comparing labral debridement to labral repair. Six studies met the inclusion criteria. The authors concluded that the review demonstrates better reporting of clinical outcomes with labral repair compared to labral debridement in all studies. Five of six studies reported statistically significant improvements (of repair over debridement). However, given the lack of high quality evidence and associated limitations in study design, these results should be interpreted with caution. Definitive treatment recommendations require further investigation with well-conducted clinical trials.

Byrd and Jones (2011) found that most athletes treated with arthroscopic hip surgery were able to resume their activities. The authors reported on a case series of 200 patients identified who underwent arthroscopic management of femoroacetabular impingement, participated in athletic activities, and had achieved minimum 1-year follow up. The authors stated that there was 100% follow-up at an average of 19 months. A total of 116 athletes had achieved 2-year follow-up. The median preoperative score was 72 with a postoperative score of 96 and the median improvement was 20.5 points, which was statistically significant. The authors reported that 95% percent of professional athletes and 85% of intercollegiate athletes were able to return to their previous level of competition. There were 5 transient neurapraxias (all resolved) and 1 minor heterotopic ossification. One athlete (0.5%) underwent conversion to total hip arthroplasty and 4 (2%) underwent repeat arthroscopy. For the group with minimum 2-year follow up, the median improvement was 21 points with a postoperative score of 96.

Clohisy et al. (2010) completed a systematic review of 2,834 studies of which 11 met the eligibility criteria and underwent comprehensive quality appraisal and review. Most studies were relatively small, single-surgeon cohorts. The review was completed to (1) determine the level of clinical evidence regarding FAI surgery; (2) determine whether impingement surgery relieves pain and improves hip function; (3) identify complications associated with these procedures; and (4) identify modifiable causes of failure. The current evidence regarding femoroacetabular impingement (FAI) surgery is primarily Level IV (case series) with no Level I (systematic review/randomized controlled trials) or II (prospective cohort) studies identified. All studies documented short decreased pain and improved function in the majority (65 to 96%) of patients with short term follow-up. Many of the studies also propose that certain factors are associated with a subjectively defined fair or poor functional score and/or surgical failure. These poor prognostic factors, although variably reported, include more advanced preoperative osteoarthritis (OA), advanced articular cartilage disease, older age, and more severe preoperative pain. These observations highlight the negative impact of secondary osteoarthritis on the long-term results of surgical intervention. Therefore, joint preservation impingement surgery should be undertaken with caution in the presence of secondary osteoarthritis. The authors concluded that the literature suggests hip impingement surgery is associated with early relief of pain and
improved function; however, the impact on long-term clinical results and natural history has not been established. Future studies must focus on an improved set of end points to study this patient population more precisely. Refined, standardized, and validated methods of documenting disease classification, measuring clinical outcomes, and reporting perioperative complications are needed to facilitate more sophisticated clinical investigation. Most importantly, future clinical trials are needed to determine the relative efficacy of nonsurgical and surgical treatment. Predictors of treatment outcome and the efficacy of various surgical techniques need to be established in well-designed clinical trials.

Ng et al. (2010) conducted a systematic review of 23 reports (970 cases) to review the efficacy of surgical treatment for femoroacetabular impingement and which patients will have best outcomes. Multiple different outcome scores were used, including the Western Ontario and McMaster Osteoarthritic Index (WOMAC), the Harris hip score (HHS), the modified HHS (which includes only the pain and function portion of the original HHS), the visual analog scale (VAS), the SF-12 Health Survey (SF-12), the non-arthritic hip score (NAHS), and the Merle d’Aubigné hip score. The reported outcome scores improved after treatment for femoroacetabular impingement in all studies, and the effect size was significant for improvement in patient outcomes. Despite these improvements, up to 30% of patients will eventually require total hip arthroplasty (THA). Patients requiring revision to arthroplasty are those with Outerbridge grade III or IV cartilage damage seen intra-operatively or with preoperative radiographs showing greater than Tonnis grade I osteoarthritis. Mean improvement in pain ranged from 25.1% to 100%. Patients dissatisfied with the procedure or who had no improvement of their pain ranged from 0% to 31.2%. The authors concluded that surgical treatment for FAI reliably improves patient symptoms in the majority of patients without advanced osteoarthritis or chondral damage.

A systematic review by Bedi et al. (2008) reviewed 19 articles to determine the quality of the literature assessing outcomes after surgical treatment of labral tears and femoroacetabular impingement (FAI), patient satisfaction after open or arthroscopic intervention, and differences in outcome with open or arthroscopic approaches. The studies reviewed support that 65% to 85% of patients are satisfied with their outcome at a mean of 40 months after surgery. A common finding in all series, however, was an increased incidence of failure among patients with substantial pre-existing osteoarthritis. Arthroscopic treatment of labral tears is also effective, with 67% to 100% of patients being satisfied with their outcomes. The authors concluded that the quality of literature reporting outcomes of surgical intervention for labral tears and FAI is limited. Although open surgical dislocation with osteoplasty is the historical gold standard, the scientific data does not show that open techniques have outcomes superior to arthroscopic techniques.

Larson et al. (2016) conducted a cohort study which included 77 patients (88 hips). Dysplastic radiographic findings were retrospectively reviewed at a mean follow-up of 26.0 months after hip arthroscopy. Specific procedures included labral repair (76%), labral debridement (23%), capsular repair/plication (82%), and femoral osteochondroplasty (72%). Pre- and postoperative function were evaluated prospectively with the modified Harris Hip Score (mHHS), 12-Item Short Form Health Survey, and visual analog scale for pain. The results of the dysplastic cohort were compared with a cohort of 231 hips without radiographic dysplasia that underwent arthroscopic Femoroacetabular Impingement (FAI) correction during the study period. At the time of final follow-up, the dysplastic cohort demonstrated a mean mHHS of 81.3 with a mean 15.6-point improvement in mHHS, compared with 88.4 and 24.4 points, respectively, in the FAI cohort. The dysplastic cohort had 60.9% good/excellent results and 32.2% failures, compared with 81.2% good/excellent results and 10.5% failures for the FAI cohort. Failure was defined as a mHHS ≤70 or eventual pelvic/femoral osteotomy or total hip arthroplasty. Dysplastic hips that underwent capsular plication and labral repair had greater good/excellent results (73%) and mean latest mHHS (85), as well as lower failure rates (18%) compared with the remainder of the dysplastic cohort. The authors concluded that arthroscopic management of mild to moderate acetabular dysplasia had inferior good/excellent results and higher failure rates when compared with an FAI cohort; therefore, isolated arthroscopic procedures in this population should be cautiously considered. Labral repair and capsular plication resulted in better clinical outcomes.

Fukui et al. (2015) conducted a study of patients with dysplasia whose affected hip had a Wiberg center-edge angle of 20° to 25° and who underwent primary hip arthroscopy. One hundred two hips underwent hip arthroscopy with labral repair with correction of Femoroacetabular Impingement (FAI) and capsular closure. At a mean follow-up point of 40 months, the preoperative modified Harris Hip Score had improved from a mean of 63.5 points to a mean of 84.9 points. The mean score on the Western Ontario and McMaster Universities Arthritis Index improved from 25.3 to 9.7. The 12-Item Short Form Health Survey Physical Component Summary score also significantly improved (from 42.5 to 50.9), whereas the 12-Item Short Form Health Survey Mental Health Component Summary score showed an insignificant improvement (from 52.4 to 54.1). The authors concluded that this study showed that FAI and labral pathology can be successfully managed using hip arthroscopy, with capsular management, in patients with borderline dysplasia. Patients showed significant improvements in outcomes and high levels of satisfaction after hip arthroscopy.

A prospective study by Philippon et al. (2009) reported 2 year outcomes of 112 patients who underwent arthroscopic surgery of the hip for femoroacetabular impingement. Mean age was 40.6 yrs. At arthroscopy, 23 patients underwent osteoplasty only for cam impingement, 3 underwent rim trimming only for pincer impingement, and 86 underwent...
both procedures for mixed-type impingement. Mean follow-up was 2.3 years. Mean modified Harris hip score (HHS) improved from 58 to 84 (mean difference = 24 and the median patient satisfaction was 9 (1 to 10). Continuous passive motion (CPM) was used at night although compliance with this was not recorded. Ten patients underwent total hip replacement at a mean of 16 months (8 to 26) after arthroscopy. Of the remaining 102 patients, 12 were lost to follow-up and two-year outcomes were thus obtained for 90 patients. Eight patients did not show any improvement in their modified HHS, with a mean pre-operative score of 66 and a mean post-operative score of 50. The authors concluded that hip arthroscopy for femoroacetabular impingement, accompanied by suitable rehabilitation, gives good short-term outcomes and high patient satisfaction; however, it is unclear how this procedure will affect the long-term outcome of the hip joint.

Byrd and Jones (2009) reported on arthroscopic management of cam-type impingement in a prospective study of 200 patients. The average increase in Harris hip score was 20 points; 0.5% converted to THA with a 1.5% complication rate. The short-term outcomes of arthroscopic treatment of cam-type femoroacetabular impingement are comparable to published reports for open methods with the advantage of a less invasive approach. The authors recognized that the surgery can result in successful outcomes, the hip joint can never be truly restored to a disease-free state, and emphasis on injury prevention is essential. A bimodal age distribution with the older cohort reflected the early onset of adult osteoarthritis. The authors indicated that with better recognition of impingement and offending activities, substantial strides could be made in non-operative management.

Horisberger (2010) prospectively followed a cohort of 105 hips (88 patients; 60 males, 28 females) who underwent surgery for symptomatic cam or mixed femoroacetabular impingement. At a minimum follow-up of 1.3 years (average, 2.3 years; range, 1.3-4.1 years), all clinical outcome measures improved. Nine patients (8.6%) underwent THA during follow-up. The outcome measures after arthroscopic therapy for femoroacetabular impingement seem comparable to those reported after open procedures.

Steppacher et al. (2015) surveyed 72 out of 75 original patients with FAI at a minimum of 10 years after having surgical hip dislocation, osteoplasty, and labral reattachment to measure improved hip pain and function, determined the 10-year survival rate and calculated factors predicting failure. Results showed that 80% of patients with FAI treated with this type of surgical intervention had not progressed to total hip arthroscopy, developed worsening osteoarthritis, or had a Merle d’Aubigné-Postel (MAP) score of less than 15 (out of a possible score of 18) which would represent a fair or poor outcome. (The MAP questionnaire is used to assess a patient’s health-related quality of life post-operatively.)

Hartmann (2009) retrospectively evaluated 33 patients 15 months after an arthroscopically assisted mini-open anterior approach to compare it with the results after surgical dislocation for FAI. The mean Harris hip score (HHS) improved from 64 points preoperatively to 85 points at the time of follow-up (P < 0.001). Mean patient satisfaction on the visual analog scale (VAS) was 7 points (range: 2-10 points). In two of the patients observed, a transient femoral nerve palsy (completely resolved at follow-up) was observed and 15 patients reported numbness in the area of the lateral cutaneous femoral nerve. The author concluded that treatment of anterior femoroacetabular impingement through an arthroscopically assisted mini-open anterior approach can reduce pain and improve function in a short-term observation period.

Peters et al. (2009) conducted a retrospective review of 94 patients (96 hips) to evaluate the change in clinical pain and function after open treatment as well as determine whether failure of treatment and progression of osteoarthritis was associated with Outerbridge Grade IV hyaline cartilage injury. Mean follow-up was 26 months (range, 18-96 months). Harris hip scores (HHS) were used to measure outcomes. The average hip score improved from 67 to 91 at final follow-up. Six patients (6.25%) were considered clinical failures and converted to arthroplasty due to worsening of the HHS. At last follow-up, the Tonnis grade worsened in 25 of 96 hips; however 23 of these 25 hips (92%) continued to function well with an improved HHS. In the 71 hips without radiographic progression, 24 had Outerbridge Grade IV lesions, 7 had Grade III, and 40 had Grade 0 to II. There was a lower incidence of Outerbridge Grade IV lesions in the hips without radiographic progression of osteoarthritis (24 of 71 hips, 35%) than those with progression (17 of 25 hips, 70%). The authors concluded that open treatment for femoroacetabular impingement in hips without substantial acetabular hyaline cartilage damage reduced pain and improved function with a low complication rate.

A retrospective study by Beaule et al. (2007) evaluated the quality of life after osteochondroplasty of the femoral head-neck junction for the treatment of femoroacetabular impingement. Thirty-seven hips in 34 patients with persistent hip pain and a mean age of 40.5 years underwent surgical dislocation of the hip and osteochondroplasty of the femoral head-neck junction for the treatment of camtype femoroacetabular impingement. The mean score on the Western Ontario and McMaster Universities Osteoarthritis Index (WOMAC) increased postoperatively, the mean University of California at Los Angeles (UCLA) activity score increased, the mean Short Form-12 (SF-12) physical component score increased, and the mean SF-12 mental component score increased. None of the hips underwent additional reconstructive surgery and 6 of the 34 patients were dissatisfied with the outcome. Ten patients required a reoperation that was directly related to the surgical dislocation approach (e.g., screw removal or a reoperation
because of failed trochanteric fixation). The authors concluded that treatment of cam-type femoroacetabular impingement with osteochondroplasty of the femoral head-neck junction is safe and effective and can provide a significant improvement in the overall quality of life of most patients.

Laude et al. (2009) retrospectively reviewed 97 patients (100 hips) who underwent osteochondroplasty of the femoral head-neck for FAI using a mini-open anterior Hueter approach with arthroscopic assistance. The labrum was refixed in 40 hips, partially excised in 39 cases, completely excised in 14 cases, and left intact in 7. Six patients were lost to follow-up, leaving 91 (94 hips) with a minimum follow-up of 28.6 months (mean, 58.3 months; range, 28.6-104.4 months). One hip developed a femoral neck fracture and 11 hips developed osteoarthritis and required a total hip arthroplasty. The technique for FAI treatment allowed direct visualization of the anterior femoral head-neck junction while avoiding surgical dislocation, had a low complication rate, and improved functional scores.

An uncontrolled study by Larson and Giveans (2008) on 96 patients (100 hips), was conducted to evaluate the early outcomes of arthroscopic management of femoroacetabular impingement (FAI). There were 54 male and 42 female patients with an average age of 34.7 years. The surgical procedures performed were 26 (26%) proximal femoral osteoplasties, 21 (21%) acetabular rim trimmings, and 53 (53%) combination osteoplasties and trimmings. Patients also underwent labral debridement and repair or refixation as needed. At a mean of 10 months follow-up compared with baseline, mean pain score decreased from 6.7 to 1.9, mean Harris Hip score increased from 61 to 83, and mean SF-12 quality-of-life score increased from 60 to 78. All of these improvements were statistically significant (<0.001). A total of 3 (3%) patients underwent total hip arthroplasty due to insufficient relief from arthroscopic surgery. The authors concluded that arthroscopic management of patients with FAI results in significant improvement in outcomes measures, with good to excellent results being observed in 75% of hips at a minimum 1-year follow-up; however, alteration in the natural progression to osteoarthritis and sustained pain relief as a result of arthroscopic management of FAI remain to be seen. This study is further limited by intervening variables in that some patients labral debridement and repair or refixation.

Matsuda et al. (2011) conducted a literature review to analyze the current approaches to the surgical management of symptomatic femoroacetabular impingement (FAI). Eighteen peer-reviewed treatment outcome studies met the inclusion criteria with minimum 1-year follow-up of the surgical treatment of skeletal pathoanatomy and associated chondrolabral pathology in skeletally mature patients with FAI. There were 6 open surgical dislocation, 4 mini-open, and 8 arthroscopic studies. The authors found that open dislocation, mini-open, and arthroscopic methods for treating symptomatic FAI are effective in improving pain and function in short-term to midterm studies and are relatively safe procedures. The historical gold standard of open dislocation surgery had a comparatively high major complication rate primarily because of trochanteric osteotomy-related issues. The mini-open method showed comparable efficacy but a significant incidence of iatrogenic injury to the lateral femoral cutaneous nerve in some studies. The arthroscopic method had surgical outcomes equal to or better than the other methods with a lower rate of major complications when performed by experienced surgeons.

The National Institute for Health and Care Excellence (NICE): The 2011 guidance documents state that the current evidence on the safety and efficacy for arthroscopic and open femoroacetabular surgery for symptomatic FAI syndrome is adequate in terms of symptom relief in the short and medium term. With regard to safety, there are well-recognized complications" (NICE, 2011a, 2011b).

Evidence in the published peer-reviewed scientific literature supports open and arthroscopic hip surgery, including labral repair with or without grafting, as safe and effective for the treatment of femoroacetabular impingement (FAI) syndrome in a carefully selected subset of patients.

U.S. FOOD AND DRUG ADMINISTRATION (FDA)

Although arthroscopic hip surgery for FAI is a procedure that is not subject to FDA regulation, devices and instruments used during the surgery require FDA approval. A search of the FDA 510(k) database revealed over 500 arthroscopies approved for marketing (product code HRX); however, the available studies did not provide sufficient information to determine which 510(k) approvals correspond to the instruments used.


REFERENCES

The foregoing Oxford policy has been adapted from an existing UnitedHealthcare national policy that was researched, developed and approved by UnitedHealthcare Medical Technology Assessment Committee. [2016T0530J]


Steppacher SD, Anwander H, Zurmühle CA, et al. Eighty percent of patients with surgical hip dislocation for femoroacetabular impingement have a good clinical result without osteoarthritis progression at 10 years. Clin Orthop Relat Res. - April 1, 2015; 473 (4); 1333-41.


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