

## Clinical Review Criteria

### Hip Surgery Procedures for Femoroacetabular Impingement Syndrome

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## Criteria

### For Medicare Members

Source	Policy
CMS Coverage Manuals	None
National Coverage Determinations (NCD)	None
Local Coverage Determinations (LCD)	None
Kaiser Permanente Medical Policy	Due to the absence of a NCD, LCD, or other coverage guidance, Kaiser Permanente has chosen to use their own Clinical Review Criteria, " <b>Hip Surgery Procedures for Femoroacetabular Impingement Syndrome</b> " for medical necessity determinations. Use the Non-Medicare criteria below.

### For Non-Medicare Members

Femoroacetabular impingement (FAI) may be medically necessary in skeletally mature patients when **ALL** of the following criteria are met:

- Mechanical symptoms of the hip (e.g., catching, locking, or giving way) associated with moderate-to-severe, groin-dominant hip pain with duration of at least 6 months that is worsened by flexion activities (e.g., squatting or prolonged sitting) and significantly limits activities.
- Documentation of **one or more of the following** positive provocative tests for intra-articular hip pathology on physical examination:
  - Anterior impingement sign (i.e., hip or groin pain with forced hip flexion, adduction, and internal rotation)
  - FABER test (i.e., hip or groin pain with forced flexion, abduction, and external rotation).
  - Fitzgerald test (i.e., hip or groin pain with extension, internal rotation, and adduction from forced hip flexion, abduction, and external rotation or with extension, external rotation, and abduction from forced hip flexion, adduction, and internal rotation)
- Imaging (X-rays, MRI or CT scans) confirms **one or more of the following**:
  - cam impingement (alpha angle greater than 50 degrees)
  - pincer impingement (acetabular retroversion or coxa profunda) (center edge angle greater than or equal to 40 degrees), or
  - pistol grip deformity (non-spherical femoral head shape); *and*
- Failure to respond to all available conservative treatment options, or documentation that conservative therapy is contraindicated, including: activity modification (e.g., restriction of athletic pursuits and avoidance of symptomatic motion), pharmacological intervention (e.g., nonsteroidal anti-inflammatory drugs [NSAIDs]), and physical therapy. The treatment should be for at least 12 weeks in the past year with at least 6 weeks of formal physical therapy.
- Positive but transient response to an image-guided intra-articular hip injection with local anesthetic with or without corticosteroid.

Presence of **one or more of the following** is considered a contraindication to FAI procedures:

- Tönnis grade 2 osteoarthritis (i.e., small cysts in femoral head or acetabulum with moderate joint space narrowing [i.e., < 2mm wide on plain radiographs of the pelvis] and moderate loss of femoral head sphericity)

- Tönnis grade 3 osteoarthritis (i.e., large cysts in the femoral head or acetabulum, severe joint space narrowing [e.g., bone-on-bone] or obliteration of the joint space, and severe deformity and loss of sphericity of the femoral head)
- Joint space narrowing on plain radiograph of less than 2 mm wide anywhere along the source; **and**
- Generalized joint laxity especially in diseases connected with hypermobility of the joints, such as Marfan syndrome and Ehlers-Danlos syndrome; **and**
- Osteogenesis imperfecta.

**If requesting review for these services, please send the following documentation:**

- Last 6 months of clinical notes from requesting provider &/or specialist

The following information was used in the development of this document and is provided as background only. It is provided for historical purposes and does not necessarily reflect the most current published literature. When significant new articles are published that impact treatment option, Kaiser Permanente will review as needed. This information is not to be used as coverage criteria. Please only refer to the criteria listed above for coverage determinations.

## Background

Femoroacetabular impingement (FAI) syndrome is a recently recognized diagnosis in primarily younger individuals where relatively minor abnormalities in the joint (orientation or morphology) are thought to cause friction/impingement and pain. It is theorized that FAI starts the breakdown of cartilage, leading to osteoarthritis. There are two types of FAI: cam impingement (non-spherical femoral head or abnormality at the head-neck junction) and pincer impingement (deep or retroverted acetabulum resulting in over coverage of the femoral head). Proponents believe that surgical correction of the impinging deformities will alleviate the symptoms and retard the progression of OA degeneration. Surgery to correct FAI includes arthroscopy, open dislocation of the hip, and arthroscopy combined with a mini-open approach. The purpose of the surgery is to remove abnormal outgrowths of bone and damaged cartilage, and to reshape the femoral neck to ensure that there is sufficient clearance between the rim of the acetabulum and the neck of the femur.

## Medical Technology Assessment Committee (MTAC)

### **Femoroacetabular Impingement Syndrome**

#### **06/17/2013: MTAC REVIEW**

**Evidence Conclusion:** There is no new evidence that would change or add to the recommendations of the HTA review as regards the conservative or surgical treatment of femoroacetabular impingement. The results of these non-randomized observational studies as well as other published retrospective series with or without a comparison group should be interpreted with caution. Due to the nature of the study design, they are subject to selection bias, observation bias, confounding and other limitations, and only provide the lowest grade of evidence.

**Articles:** Larson CM, Givens R, Stone RM, et al. Arthroscopic debridement versus refixation of the acetabular labrum associated with femoroacetabular impingement. Mean 3.5 –year follow-up. *Am J Sports Med.* 2012; 40:1015-1021. Larson and colleagues (2012) reported on outcomes of two cohorts of patients with femoroacetabular impingement who were treated with either arthroscopic debridement or refixation of the acetabular labrum in one center, but at different time periods. The mean follow-up ranged between 24 and 72 months with a mean of 42 months. The results indicate that the labral fixation was associated with better Harris Hip Scores (HHS), Short Form-12 (SF-12) and visual analog scale (VAS) for pain outcomes compared to arthroscopic focal debridement. Zingg PO, Ulbrich EJ, Buehler TC, et al. Surgical hip dislocation versus hip arthroscopy for femoroacetabular impingement. Clinical and morphological short-term results. *Arch Orthop Trauma Surg.* 2013; 133:69-79. Zingg and colleagues (2013) compared surgical hip dislocation versus hip arthroscopy in 38 patients presenting with clinically FAI that was morphologically verified with plain radiographs and MRI. In 28 of the 38 participants the selection of the procedure was based on the patient's decision, and only 10 agreed to be randomly allocated to either procedure. There were statistically significant differences in the morphological pathology (in terms of acetabular coverage angle, and head-neck offset ratio) between the two groups at baseline. The primary outcome of the study was the alpha angle on a cross-table view. The results of the study showed that patients in the hip arthroscopy group had faster recovery and better short-term outcomes compared to those treated with surgical hip dislocation. However, the hip arthroscopy showed some overcorrection of the cam deformity and limited frequency of labrum refixations, which the authors indicate that they may lead to negative impact on long-term outcomes.

The use of FIS does not meet the *Kaiser Permanente Medical Technology Assessment Criteria*.

Per the Washington State Health Care Authority Health Technology Clinical Committee (HTCC) coverage determination following Femoroacetabular Impingement Syndrome re-review (adopted 1/17/2020):

*Hip surgery for femoroacetabular impingement syndrome is not a covered benefit.*

## Applicable Codes

**Considered not medically necessary:**

CPT® Codes	Description
27299	Unlisted procedure, pelvis or hip joint
29914	Arthroscopy, hip, surgical; with femoroplasty (i.e., treatment of cam lesion)
29915	Arthroscopy, hip, surgical; with acetabuloplasty (i.e., treatment of pincer lesion)

**\*Note:** Codes may not be all-inclusive. Deleted codes and codes not in effect at the time of service may not be covered.

**\*\*To verify authorization requirements for a specific code by plan type, please use the [Pre-authorization Code Check](#).**

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Date Created	Date Reviewed	Date Last Revised
08/06/2013	02/04/2013 <sup>MPC</sup> , 12/02/2014 <sup>MPC</sup> , 10/06/2015 <sup>MPC</sup> , 08/02/2016 <sup>MPC</sup> , 06/06/2017 <sup>MPC</sup> , 04/03/2018 <sup>MPC</sup> , 04/02/2019 <sup>MPC</sup> , 04/07/2020 <sup>MPC</sup> , 04/06/2021 <sup>MPC</sup> , 04/05/2022 <sup>MPC</sup> , 04/04/2023 <sup>MPC</sup> , 07/02/2024 <sup>MPC</sup>	07/02/2024

<sup>MPC</sup> Medical Policy Committee

Revision History	Description
06/06/2017	Adopted KP policy for Medicare members
04/07/2020	Removed generic service code 27299 and added more specific codes 29914, 29915 and 29916
04/29/2020	Added CPT codes 27299 and 29862 and ICD-10 codes M25.851, M25.852 and M25.859
04/26/2021	Removed CPT code 29862 and ICD-10 codes M25.851, M25.852 and M25.859
11/06/2021	Removed CPT code 29916
04/05/2022	Added the Washington Health Care Authority HTCC decision from January 2020.
01/09/2024	MPC approved to revise the FAI policy to allow for FAI procedures to be authorized when a separate procedure for labral repair is indicated. 60-day notice is not required.
07/02/2024	MPC approved the proposed criteria for the FAI procedure to cover with indications. 60-day notice required; effective December 1, 2024.