

# Surgery of the Hip

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[Instructions for Use](#)

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Commercial Policy
<ul style="list-style-type: none"> <li><a href="#">Surgery of the Hip</a></li> </ul>

## Application

This Medical Policy does not apply to the states listed below; refer to the state-specific policy/guideline, if noted:

State	Policy/Guideline
Idaho	<a href="#">Surgery of the Hip (for Idaho Only)</a>
Indiana	None
Kansas	<a href="#">Surgery of the Hip (for Kansas Only)</a>
Kentucky	<a href="#">Surgery of the Hip (for Kentucky Only)</a>
Nebraska	<a href="#">Surgery of the Hip (for Nebraska Only)</a>
New Jersey	<a href="#">Surgery of the Hip (for New Jersey Only)</a>
New Mexico	<a href="#">Surgery of the Hip (for New Mexico Only)</a>
North Carolina	<a href="#">Surgery of the Hip (for North Carolina)</a>
Ohio	<a href="#">Surgery of the Hip (for Ohio Only)</a>
Pennsylvania	<a href="#">Surgery of the Hip (for Pennsylvania Only)</a>
Tennessee	<a href="#">Surgery of the Hip (for Tennessee Only)</a>

## Coverage Rationale

Surgery of the hip and surgical treatment for [Femoroacetabular Impingement \(FAI\) Syndrome](#) is proven and medically necessary in certain circumstances. For medical necessity clinical coverage criteria, refer to the InterQual®

CP: Procedures:

- Arthroscopy, Diagnostic, +/- Synovial Biopsy, Hip
- Arthroscopy, Surgical, Hip
- Arthroscopy, Surgical, Hip (Pediatric)
- Arthrotomy, Hip
- Hemiarthroplasty, Hip
- Removal and Replacement, Total Joint Replacement (TJR), Hip
- Total Joint Replacement (TJR), Hip

[Click here to view the InterQual® criteria.](#)

**Surgical treatment for Femoroacetabular Impingement (FAI) Syndrome is unproven and not medically necessary in the presence of advanced osteoarthritis (i.e., Tönnis Grade 2 or 3) and/or severe cartilage damage (i.e., Outerbridge Grade III or IV).**

## Medical Records Documentation Used for Reviews

Benefit coverage for health services is determined by the federal, state, or contractual requirements, and applicable laws that may require coverage for a specific service. Medical records documentation may be required to assess whether the member meets the clinical criteria for coverage but does not guarantee coverage of the service requested; refer to the guidelines titled [Medical Records Documentation Used for Reviews](#).

## Definitions

**Disabling Pain:** Western Ontario and McMaster Universities Arthritis Index (WOMAC) pain domain > 40 (Quintana, 2009).

**Femoroacetabular Impingement (FAI) Syndrome:** FAI occurs because of either (1) hip formation at birth or (2) bone overgrowth (bone spurs) around the femoral head and/or along the acetabulum causing abnormal contact between the hip bones preventing them from moving smoothly during activity. Over time, this may result in tears in the labrum and the breakdown of articular cartilage (osteoarthritis) causing pain and stiffness, limited internal hip rotation, limping, and joint damage (Witstein et al., 2024; Agricola et al., 2024). There are three types of FAI:

- **Pincer:** This type of impingement occurs when extra bone extends out over the normal rim of the acetabulum. The labrum can be crushed under the prominent rim of the acetabulum (i.e., radiographic evidence of FAI by imaging includes: over coverage of the femoral head by the acetabulum with resultant pistol-grip deformity or the lateral center edge angle of greater than 40 degrees, or coxa profunda, or acetabular retroversion) (Witstein et al., 2024; Pun et al., 2015).
- **Cam:** In Cam-type impingement, the femoral head is not round and cannot rotate smoothly inside the acetabulum. A bone spur forms on the edge of the femoral head that grinds the cartilage inside the acetabulum (i.e., radiographic evidence of FAI by imaging includes: the loss of sphericity of the femoral head with resultant bony prominence or alpha angle greater than 50 degrees) (Witstein et al., 2024; Pun et al., 2015).
- **Combined (Mixed):** Combined Impingement means that both the Pincer and Cam types are present (Witstein et al., 2024).

**Functional Disability:** Western Ontario and McMaster Universities Arthritis Index (WOMAC) functional limitation domain > 40 (Quintana, 2009).

**Hip Dysfunction and Osteoarthritis Outcome Score (HOOS):** The Hip Dysfunction and Osteoarthritis Outcome Score (HOOS) is a self-administered hip-specific questionnaire intended to evaluate symptoms and functional limitations, and it is commonly used to evaluate interventions in individuals with hip dysfunction or hip osteoarthritis. The HOOS consists of 43 questions in five subscales: pain, symptoms, function in daily living, function in sport, and recreation and hip-related quality of life (Nilsson, 2011).

**International Hip Outcome Tool (iHOT-33):** A reference instrument among the Patient-Reported Outcome Measures (PROMs) to assess people with hip disorders, including Femoroacetabular Impingement (FAI) Syndrome. The iHOT-33 consists of four subscales: (1) symptoms and functional limitations (iHOT-Symptoms; 16 items), (2) sports and recreational physical activity (iHOT-Sport; 6 items), (3) job-related concerns (iHOT-Job; 4 items), and (4) social, emotional, and lifestyle concerns (iHOT-Social; 7 items). Each item can be answered from 0 to 100 points and the final score is the sum of points divided by 33 (Bissani Gasparin et al., 2022).

### 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
- (Slattery, 2018)

**Radiographic Findings of Osteoarthritis:** Narrowing of joint space, osteophyte formation, subchondral sclerosis, subchondral cysts, deformity of bony end-plates, and thinning or complete loss of articular cartilage (ACR, 2025).

**Note:** UnitedHealthcare will accept three or more moderate to severe radiographic findings to be sufficient to support the diagnosis of severe osteoarthritis.

**Tönnis 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 (Kovalenko, 2018)

**Western Ontario and McMaster Universities Arthritis Index (WOMAC):** The WOMAC is a disease-specific, self-administered questionnaire developed to evaluate patients with hip or knee osteoarthritis. It uses a multi-dimensional scale composed of 24 items grouped into three dimensions: pain, stiffness, and physical function (Quintana, 2009).

## 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 federal, state, or contractual requirements 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 and Guidelines may apply.

**Note:** Iliopsoas tendon release surgery, capsular repair, and capsular release surgery are considered integral to the primary hip procedure and not separately reimbursable. Debridement during hip arthroscopy is considered integral to the FAI surgery codes 29914, 29915, and 29916 and would therefore not be separately reimbursable.

CPT Code	Description
<b>Arthroscopy, Diagnostic, +/- Synovial Biopsy, Hip</b>	
29860	Arthroscopy, hip, diagnostic with or without synovial biopsy (separate procedure)
<b>Arthroscopy, Surgical, Hip</b>	
29861	Arthroscopy, hip, surgical; with removal of loose body or foreign body
29862	Arthroscopy, hip, surgical; with debridement/shaving of articular cartilage (chondroplasty), abrasion arthroplasty, and/or resection of labrum
29863	Arthroscopy, hip, surgical; with synovectomy
<b>Arthrotomy, Hip</b>	
27120	Acetabuloplasty (e.g., Whitman, Colonna, Haygroves, or cup type)
<b>Hemiarthroplasty, Hip</b>	
27125	Hemiarthroplasty, hip, partial (e.g., femoral stem prosthesis, bipolar arthroplasty)
<b>Removal and Replacement, Total Joint Replacement (TJR), Hip</b>	
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft
27132	Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft
27134	Revision of total hip arthroplasty; both components, with or without autograft or allograft
27137	Revision of total hip arthroplasty; acetabular component only, with or without autograft or allograft
27138	Revision of total hip arthroplasty; femoral component only, with or without allograft
<b>Femoroacetabular Impingement (FAI) Syndrome</b>	
27299	Unlisted procedure, pelvis or hip joint (i.e., capsular plication, gluteal tendon repair)
29914	Arthroscopy, hip, surgical; with femoroplasty (i.e., treatment of cam lesion)

CPT Code	Description
<b>Femoroacetabular Impingement (FAI) Syndrome</b>	
29915	Arthroscopy, hip, surgical; with acetabuloplasty (i.e., treatment of pincer lesion)
29916	Arthroscopy, hip, surgical; with labral repair
29999	Unlisted procedure, arthroscopy (i.e., capsular plication, gluteal tendon repair)

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HCPCS Code	Description
S2118	Metal-on-metal total hip resurfacing, including acetabular and femoral components

## Clinical Evidence

Clinical studies have shown 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, 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.

Migliorini et al. (2025) conducted a systematic review aimed at evaluating the long-term effectiveness of arthroscopic management for FAI syndrome, hypothesizing that it will significantly improve patient-reported outcomes (PROMs) over a follow-up period exceeding ten years. The review focused on studies published in peer-reviewed journals with a minimum follow-up of 120 months and assessed outcomes such as PROMs and complication rates. It adhered to PRISMA guidelines and used the PICOT algorithm to evaluate the literature. Data extraction covered study characteristics, PROMs, and complications. Statistical analyses were conducted using IBM SPSS software to summarize continuous and dichotomous data. Of 1,245 identified articles, seven were included after rigorous screening. Risk of bias assessment with the ROBINS-I tool revealed a serious or moderate risk of bias due to confounding, although overall methodological quality was acceptable. Data from 478 patients showed improvements in PROMs from baseline to follow-up. The authors concluded that this systematic review indicates that arthroscopic management for FAI syndrome improves PROMs with a mean follow-up of approximately 130 months. Nevertheless, 32% of patients required THA within ten years, underscoring the importance of careful patient selection and consideration of factors like OA and age. While conservative treatments such as physical therapy may yield comparable short-term outcomes, recent evidence suggests that arthroscopy provides superior results, particularly for younger patients and those without preoperative OA. This study has several limitations. Pre-existing OA as a factor influencing clinical outcomes after surgery was not considered, as this review focused solely on evaluating long-term clinical outcomes. Additionally, the number of included studies is small, particularly for prospective studies, which may contribute to high heterogeneity between studies. The authors did not prospectively register the present systematic review into a public registry, potentially increasing the risk of bias. The data did not account for different morphology types of FAI syndrome, potentially introducing reporting bias. Larger, multicenter, high-quality randomized controlled trials (RCTs) are needed to validate the outcomes of this systematic review.

Palmer et al. (2025) conducted a randomized controlled trial (RCT) to report three-year follow-up from the FemoroAcetabular Impingement Trial (FAIT), comparing arthroscopic surgery with physiotherapy in the management of Femoroacetabular impingement (FAI) syndrome for the dual primary outcomes of radiographic hip osteoarthritis and patient reported outcome measures (PROMS) of Activities of Daily Living (ADL). Two-group parallel, assessor-blinded, pragmatic randomized controlled trial across seven sites. A total of 222 participants aged 18 to 60 years with FAI syndrome confirmed clinically and radiologically were randomized (1:1) to receive arthroscopic hip surgery (n = 112) or physiotherapy (n = 110). The dual primary outcome measure was minimum Joint Space Width (mJSW) on anteroposterior radiograph at 38 months post randomization and Hip Outcome Score ADL (HOS ADL) (higher score indicates superior outcomes). Secondary outcome measures were Scoring Hip Osteoarthritis with MRI (SHOMRI) (lower score indicates less pathology). The mJSW, HOS ADL, and MRI data were available for 45%, 77%, and 62% of participants at 38 months, respectively. No difference in mJSW was seen between groups at 38 months. HOS ADL was higher in the arthroscopy group [mean (SD) 84.2 (17.4)] compared with the physiotherapy group [74.2 (21.9)], difference 8.9 [95% CI 7.0, 10.8]. SHOMRI score total at 38 months was lower in the arthroscopy group [mean (SD) 9.22 (11.43)] compared to the physiotherapy group [22.76 (15.26)], differences (95% CIs) -15.94 (-18.69, -13.19). The authors concluded that no difference was seen between groups on radiographic measures of OA progression. Patients with FAI syndrome treated surgically may experience superior pain and function outcomes, and less MRI-measured cartilage damage compared with physiotherapy. The authors stated these results should be interpreted with caution given the midterm outcome assessment, loss to follow-up of the initial cohort, and lack of radiographic differences. Larger and longer-term studies are required to understand how best to prevent osteoarthritis progression in patients with FAI syndrome.

Bonin et al., ReSurg, and Viamon-Guerra (2024) conducted a randomized controlled trial (RCT) to compare two-year clinical outcomes of primary hip arthroscopy with versus without capsular closure after interportal capsulotomy in patients with cam- or mixed-type femoroacetabular impingement (FAI). Patients with cam- or mixed-type FAI undergoing primary hip arthroscopy with interportal capsulotomy were prospectively enrolled in this RCT and allocated into either capsular closure or no capsular closure groups. Patients were blinded to group allocation. Clinical outcomes were assessed preoperatively and at two-year follow-up using the 12-item International Hip Outcome Tool (iHOT-12), modified Harris Hip Score (mHHS), and six subsections of the Copenhagen Hip and Groin Outcome Score (HAGOS). Complications and reoperations were noted. Eighty-four patients (100 hips) were enrolled, 49 hips in the capsular closure group and 51 in the no capsular closure group, with no significant differences in age ( $28.5 \pm 7.5$  vs.  $30.4 \pm 8.4$ ,  $p = .261$ ), body mass index ( $23.5 \pm 3.0$  vs.  $23.4 \pm 1.9$ ,  $p = .665$ ), and sex distribution (female: 10.2% vs. 13.7%,  $p = .760$ ) per the authors. Four patients were lost to follow-up (2.0% vs. 5.9%,  $p = .618$ ) and six had reoperations (6.1% vs. 5.9%,  $p = 1.000$ ), which left 45 hips per group for clinical assessment. There were no significant differences between groups in the net change of iHOT-12 ( $28.3 \pm 19.6$  vs.  $32.5 \pm 22.7$ ,  $p = .388$ ), mHHS ( $7.6 \pm 13.1$  vs.  $7.5 \pm 10.2$ ,  $p = .954$ ), and subsections of HAGOS ( $p > .05$ ) per the authors. Complication rates were also similar between groups ( $p > .05$ ). The authors concluded that the RCT compared primary hip arthroscopy with versus without capsular closure after interportal capsulotomy in a male-dominated, non-dysplastic, non-arthritic cohort with cam- or mixed-type FAI and found no significant differences in patient-reported clinical outcomes, complication rates, or reoperation rates. This RCT has limitations. First, only one surgeon performed all surgeries; therefore, the technique used for performing the capsulotomy and closure may be different for other surgeons. Second, capsular resection occurred in some patients during cam resection, resulting in tightening of the capsule, which could have created capsular inflammation leading to pain. Third, there were 12 bilateral patients in the final cohort who were randomized per hip, with seven having a hip in each group, two having both hips in the capsular closure group, and three having both hips in the no capsular closure group. Although bilateral patients were explicitly instructed to complete one questionnaire for each hip, the inherent nature of certain questions, such as the patient's ability to walk a certain distance, could make it difficult to provide a response for only one hip. Fourth, postoperative satisfaction was measured on a four-point scale instead of a visual analog scale. Finally, the cohort was predominantly male, which may be a confounder, as female patients are more likely to have hypermobility and thus poorer outcomes due to instability. The findings of this study need to be validated by well-designed studies.

Zhu et al. (2022) performed a systematic review and meta-analysis to compare the efficacy and outcomes of patients with femoroacetabular impingement (FAI) syndrome treated with hip arthroscopy versus those treated with conservative care alone. Identified randomized trials were assessed for inclusion by two reviewers. Any disagreement between them on the eligibility of certain studies was resolved through discussion with a third reviewer. The titles of journals and names of authors were not masked during the study selection process. Six observational studies were assessed. The data were extracted and analyzed by RevMan5.3. Mean differences and 95% confidence intervals were calculated. The methodological quality of the trials indicated five of six studies had a low risk of bias and one article had a high risk of bias. The authors stated that differences were statistically significant between arthroscopy and conservative treatment for Hip Outcome Score (HOOS) (follow-up for 6 months), iHOT-33 (follow-up for 6 months) improvement, iHOT-33 (follow-up for 12 months) improvement, iHOT-33 (follow-up for 12 months), EQ-5D-5L index score (follow-up for 12 months) and arthroscopic surgery showed higher benefits than conservative therapy. No statistically significant differences were found in iHOT-33 (follow-up for 6 months), EQ-5D-5L index score (follow-up for 6 months), EQ5D-VAS (follow-up for 6 months) and EQ5D-VAS (follow-up for 12 months). The authors concluded that arthroscopy and conservative therapy both can have clinical effects when facing FAI, and that in this meta-analysis, hip arthroscopy is statistically superior to conservative treatment in both long-term and short-term effects. Further research is needed to determine the clinical relevance of these findings.

Mok et al. (2021) conducted a meta-analysis to compare the outcome and differences between arthroscopic hip surgery versus conservative therapy in the management of femoroacetabular impingement (FAI) syndrome. Only randomized controlled trials (RCTs) comparing arthroscopic hip surgery (AHS) and conservative therapy were included in this meta-analysis of FAI syndrome management. Two authors determined eligibility, extracted the needed data, and assessed the risk of bias of eligible studies independently. The authors collected 52 articles in total after removing duplicates and screened by titles and abstracts. A total of three RCTs were included with a total of 650 individuals. Evidence of additional benefit of arthroscopic hip surgery against conservative therapy in the field of improving quality of life (three trials, 575 participants,  $ES = 2.109$ , 95% CI: 1.373 to 2.845,  $I^2 = 42.8\%$ ,  $p = 0.000$ ) and activity of daily living (two trials, 262 participants,  $ES = 9.220$ , 95% CI: 5.931 to 12.508,  $I^2 = 16.5\%$ ,  $p = 0.000$ ) was noted. However, no significant difference could be seen in sports function improvement (two trials,  $ES = 7.562$ , 95% CI: -2.957 to 18.082,  $I^2 = 60.1\%$ ,  $p = 0.159$ ). The authors concluded that this meta-analysis suggests that AHS provided essential benefit compared with conservative therapy in improving activity of daily living and quality of life. In addition, the authors stated this meta-analysis was designed to assess the better choice between AHS and conservative therapy, while several factors, such as complications, BMI, occupation, alcohol abuse, or diabetes mellitus, could lead to a different condition of the hip resulting in different outcomes. The option of treatment strategy could be changed in the above situations. Accordingly, further

specific investigations targeting patients with different baseline characteristics and complications are still necessary as well as long-term evaluations of the results and prospective randomized studies.

Kim et al. (2021) performed a systematic review and meta-analysis to compare the clinical outcomes of femoroacetabular impingement (FAI) patients who underwent hip arthroscopy with those who underwent non-operative treatment. Presently, hip arthroscopy is a widely adopted surgical intervention for the treatment of femoroacetabular impingement (FAI). However, there is insufficient evidence regarding which between arthroscopy and non-operative treatment is more optimal for symptomatic FAI. The authors included studies that directly compared surgical and nonsurgical treatment for symptomatic FAI and excluded those that did not use arthroscopic treatment as a surgical technique and studies performed on patients with concomitant diagnoses instead of pure FAI. The authors compared clinical outcome scores at 6 and 12 months of follow-up for iHOT-33, HOOS, EuroQol-visual analog scale (EQ-VAS), modified Harris hip score (mHHS), and nonarthritic hip score (NAHS). Five studies totaling 838 patients were included in the qualitative and quantitative synthesis; 382 patients underwent hip arthroscopy, and 456 patients were treated by nonoperative interventions. At 6 months of follow-up, the authors noted no statistically significant differences in iHOT-33 ratings [mean difference (MD) = 7.92,  $p = .15$ ], HOOS (MD of HOOS-ADL = 5.15,  $p = .26$  and MD of HOOS-Sports = 2.65,  $p = .79$ , respectively), and EQ-VAS (MD = 1.22,  $p = .76$ ) between the two treatment strategies. At 12 months of follow-up, the arthroscopy group had a greater mean improvement in iHOT-33 score than the conservative treatment group (MD = 8.42,  $p = .002$ ), but there was no difference between the groups in terms of mHHS rating (MD = -0.24,  $p = .83$ ) and NAHS (MD = -2.08,  $p = .09$ ). The authors concluded that despite arthroscopy being associated with significantly superior iHOT-33 scores after 12 months of follow-up, they were unable to discern the difference between the treatment strategies using other scoring methods, such as HOOS, EQ-VAS, mHHS, and NAHS. Further studies will be needed to conclusively determine if 1 strategy is superior to the other for treating FAI. This analysis had several limitations. First, the number of included studies was relatively small, and particularly for each sub-outcome of the pooled analysis, only a couple of studies dictated most results. Owing to the characteristics of the study materials, it is difficult to unify the treatment protocols. Most studies adopted different physical therapy protocols, and some studies even combined injection therapy with nonsurgical treatment. The main weakness of this analysis was that the authors could not investigate longer-term outcomes. There were a few studies that evaluated clinical outcomes 2 years after the intervention, but data were insufficient to perform a pooled analysis. Moreover, the authors could not find previous studies that compared the results of surgical and non-surgical FAI treatment over the long term. Further long-term follow-up studies are needed because the rationale supporting surgical FAI correction is not only instant symptom alleviation but also meaningful delayed joint degeneration. Further investigation is needed before clinical usefulness of this procedure is proven.

Gatz et al. (2020) conducted a meta-analysis to compare the treatment outcomes of physiotherapy versus arthroscopic treatment for femoroacetabular impingement (FAI). FAI is thought to play an important role in the development of hip osteoarthritis. However, there is no consensus about the optimal treatment options, since non-operative therapy such as physiotherapy and surgical treatment such as arthroscopic hip surgery can both improve symptoms. The present meta-analysis was carried out according to the PRISMA guidelines. In November 2019, the main online databases were accessed. All randomized clinical trials (RCTs) comparing surgical arthroscopic treatment versus physiotherapy for FAI were considered for inclusion. Data from 644 patients were evaluated with a mean follow-up of 14.67  $\pm$  8.3 months. The unpaired t-test detected an optimal baseline comparability in terms of side, gender, years, duration of symptoms and BMI ( $p = 0.08$ -0.9). The VAS subscale of the score EQ-5D and the mean iHOT33 reported favorable values in the arthroscopic group ( $p = 0.03$  and  $p < 0.0001$ , respectively). Similar findings were evidenced in the iHOT33 subgroup 6-months ( $p = 0.70$ ) and 12-months ( $p = 0.0002$ ). The HOOS score, the ADL ( $p < 0.0001$ ) and the sport ( $p = 0.0003$ ) subscales reported both greater values in the arthroscopic group. No statistical significance was found concerning the risk to incur in further total hip arthroplasty ( $p = 0.72$ ). The authors concluded that based on only three high-quality RCTs, arthroscopic hip surgery is an effective therapeutic treatment for FAI revealing superior results than a non-surgical approach with physiotherapy. The most relevant limitation of the present study is the reduced number of papers eligible for inclusion and overall procedures. Having a small study sample, specific limitations of each single study influence the results of the present meta-analysis. Further relevant limitation of this meta-analysis is the relatively short follow-up period. Only the study by Mansell et al. evaluated the outcome after 24 months, while the FAIT and UK FASHIoN trial had a follow-up of only 8 months and 12 months, respectively. This limits the evaluation of long-term outcome parameters like the prevention of hip arthroplasty. Moreover, no analysis of the various impingement morphologies was possible because CAM Impingement was the predominant type in the analyzed studies with only limited cases of pincer and mixed FAI. A further considered limitation is the incongruence between clinical score improvement and general subjective changes, reducing the explanatory power of clinical results. Even though the iHOT-33 and HOOS score are validated scores for FAI, the MCID does not seem to directly correlate to the subjective improvement of the patients. Further research is necessary as participation, load, and performance in sports is still remarkably reduced 1 year after arthroscopic surgery. For the future direction in the field of research, studies need to consider the relation between clinical scores and the MCID, patient acceptable symptomatic state (PASS) and the fragility index to find out what really contributes to the clinical changes, besides reporting only significant score differences between study cohorts. Future studies need to reveal the influence of

perioperative physiotherapy and the placebo effect of the surgical procedures. There is a need to provide data about the right timing for arthroscopic surgery since physiotherapy might be still considered as a useful first therapeutic module. In this case, long-term studies are of particular interest considering further factors like the specific type of impingement, the exact anatomic pathological and the conducted surgical procedure. Consequently, future studies need to define clear indications for surgical therapy and to provide data for supporting evidence.

A systematic review and meta-analysis were conducted by Gohal et al. (2019) to assess the health-related quality of life (HRQL) outcomes after arthroscopic management of FAI. A total of 29 studies (24 case series, 3 case-control studies, 1 retrospective comparative study, and 1 RCT; some with control groups) were included for assessment. Of the 6,476 patients (6,959 hips), significant improvements were reported in all studies assessing generic HRQL outcomes, including the 12-Item Short Form Health Survey (range of mean postoperative scores, 82.2-89.8), and EuroQOL-5D scores (range of mean postoperative scores, 0.74-0.87) between 12 and 24 months postoperatively. Significant improvements were similarly identified in the hip-specific HRQL outcomes scores, with the majority of studies also reporting improvement between 12 and 24 months postoperatively. Mean improvement in International Hip Outcome Tool-33 scores from preoperative values to postoperative values ranged from 22.7 to 43.2, for studies with follow-up between 12 and 24 months. The authors concluded that hip arthroscopy can lead to significant improvement in generic and hip-specific HRQL outcomes at 12 to 24 months postoperatively in patients with FAI who do not have advanced hip osteoarthritis.

In a meta-analysis performed by Lei et al. (2019), the prognostic value of osteoarthritis (OA) on the overall failure rate, pain, and function of surgical management of femoroacetabular impingement (FAI) was evaluated. Seven studies were identified with 1,129 total patients, with 819 patients in the FAI group and 310 patients in the FAI with OA group. Pooled analyses showed that the overall failure rate was significantly higher in the FAI-OA group than in the FAI group. In addition, the rate of conversion to total hip arthroplasty was significantly higher in the FAI-OA group (37.3%) than in the FAI group (9.7%). The authors concluded that radiographic OA was correlated with higher failure rates, increased conversion to total hip arthroplasty, and worse outcomes after surgical management of FAI. Sansone et al. (2015) performed a prospective study to evaluate the arthroscopic treatment of FAI in the presence of osteoarthritis (OA) in terms of pain, symptoms, function, physical activity level and quality of life using outcome measures validated for young, active patients with hip symptoms. Seventy-five patients undergoing arthroscopic surgery for FAI, all with preoperative radiological signs of mild to moderate OA (Tonnis grades 1 or 2) were included in this study. All patients completed patient reported outcome measures, including the International Hip Outcome Tool (iHOT), Copenhagen Hip and Groin Outcome (HAGOS), EQ-5D, Hip Sports Activity Scale (HSAS) for physical activity level. A visual analogue scale (VAS) for overall hip function was performed, with radiographic evaluation. At two-year follow-up, comparison with the preoperative scores revealed improvements for all measured outcomes; the iHOT-12 (42 versus 65), VAS for global hip function (48 versus 68), HSAS (2.5 versus 3), EQ5D index (0.62 versus 0.76), EQ VAS (69 versus 75) and different HAGOS subscales (54 versus 72, 47 versus 67, 56 versus 75, 40 versus 61, 33 versus 56, 31 versus 55). Fifty-six (82%) patients reported that they were satisfied with the outcome of surgery. The authors concluded that arthroscopic treatment for patients with FAI in the presence of mild to moderate OA resulted in statistically significant and clinically relevant improvements in outcome measures related to pain, symptoms, function, physical activity level and quality of life in the majority of patients.

## U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

Surgeries of the hip are procedures and, therefore, not regulated by the FDA. However, devices and instruments used during the surgery may require FDA approval. Refer to the following website for additional information: <http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmnm.cfm>. (Accessed July 31, 2025)

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## Policy History/Revision Information

Date	Summary of Changes
04/01/2026	<p data-bbox="337 205 500 268"><b>Application Louisiana</b></p> <ul data-bbox="337 273 1136 304" style="list-style-type: none"><li data-bbox="337 273 1136 304">• Removed content/language pertaining to the state of <b>Louisiana</b></li></ul> <p data-bbox="337 308 492 340"><b>Definitions</b></p> <ul data-bbox="337 344 1112 375" style="list-style-type: none"><li data-bbox="337 344 1112 375">• Updated definition of “Radiographic Findings of Osteoarthritis”</li></ul> <p data-bbox="337 380 586 411"><b>Applicable Codes</b></p> <ul data-bbox="337 415 1511 531" style="list-style-type: none"><li data-bbox="337 415 1511 531">• Added notation to indicate iliopsoas tendon release surgery, capsular repair, and capsular release surgery are considered integral to the primary hip procedure and not separately reimbursable; debridement during hip arthroscopy is considered integral to the FAI surgery CPT codes 29914, 29915, and 29916 and would therefore not be separately reimbursable</li></ul> <p data-bbox="337 535 665 567"><b>Supporting Information</b></p> <ul data-bbox="337 571 1445 634" style="list-style-type: none"><li data-bbox="337 571 1445 602">• Updated <i>Clinical Evidence</i> and <i>References</i> sections to reflect the most current information</li><li data-bbox="337 606 876 634">• Archived previous policy version CS056.Z</li></ul>

## Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state, or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state, or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state, or contractual requirements for benefit plan coverage govern. Before using this policy, check the federal, state, or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

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