



# CLINICAL GUIDELINES

## CMM-315: Shoulder Surgery- Arthroscopic and Open Procedures

Version 20.0.2018

Effective October 22, 2018



## **CMM-315: Shoulder Surgery-Arthroscopic and Open Procedures**

<b>CMM-315.1: Definitions</b>	<b>3</b>
<b>CMM-315.2: General Guidelines</b>	<b>4</b>
<b>CMM-315.3: Indications and Non-Indications</b>	<b>5</b>
<b>CMM-315.4: Procedure (CPT®) Codes</b>	<b>12</b>
<b>CMM-315.5: References</b>	<b>15</b>

## **CMM-315.1: Definitions**

**Rotator cuff tears** result when there is a disruption of the tendon(s) of the rotator cuff muscles which attach the humerus to the scapula and are important in shoulder movements and maintaining glenohumeral joint stability. The supraspinatus tendon is most commonly involved, but the infraspinatus, teres minor, and subscapularis tendons can also be torn.

- Defining whether a rotator cuff tear is acute has relevance to treatment. In evaluating patients, the surgeon should attempt to properly identify patients with acute tears as opposed to patients with pre-existing chronic tears that become symptomatic after an injury event. A discrete traumatic event is more suggestive of acute tear. Physical examination findings including supraspinatus and infraspinatus muscle atrophy, as well as internal and external rotation lag signs, may be indicative of larger and more chronic rotator cuff tears.
- Evaluation of rotator cuff muscle quality with CT or MRI is an important consideration. Chronic and larger tears are associated with muscle atrophy and fatty replacement, both of which correlate with inferior functional outcome after rotator cuff repair. It is thought that early repair of acute rotator cuff tears might mitigate the development of chronic tendon and muscle pathology and improve functional outcomes.

Classification of rotator cuff tears (based upon surgical findings):

- Partial-thickness tears, also called incomplete tears (Ellman):
  - ◆ Grade 1: < 3 mm deep (< 25% thickness)
  - ◆ Grade 2: 3–6 mm in depth but not exceeding 50% of the tendon thickness
  - ◆ Grade 3: > 6 mm deep (> 50% thickness)
- Full-thickness tears, also called complete tears (Cofield):
  - ◆ Small: < 1 cm
  - ◆ Medium: 1-3 cm
  - ◆ Large: 3-5 cm
  - ◆ Massive: > 5 cm

**Impingement syndrome** commonly results from friction, abrasion, and inflammation of the rotator cuff and the long head of the biceps tendon with the subacromial arch (anterior lip of the acromion, coracoacromial ligament, and acromioclavicular joint) from acute trauma, repetitive use or degenerative changes.

**Distal clavicle excision** is the removal of the end of the clavicle at the acromioclavicular (AC) joint. The superior AC ligament remains intact so that the joint remains stable.

**Acromioplasty** is the removal of bone from the acromion and partial resection of the coracoacromial ligament.

**Subacromial decompression** is the removal of bone or other abnormality to enlarge the space between the rotator cuff musculature and the acromion.

**Labral tears** result when the glenoid labrum becomes injured or torn. Tears are typically classified by the position of the tear in relation to the glenoid.

- **Bankart tear** is a tear in the labrum located in the front, lower (anterior, inferior) part of the glenoid. This type of tear occurs most commonly during a shoulder dislocation and makes the shoulder more prone to recurrent dislocations.
- **SLAP tear (Superior Labral, Anterior and Posterior tear)** is a tear in the labrum that covers the top part of the glenoid from the front to back. A SLAP tear occurs at the point where the long head of biceps tendon attaches. This type of tear occurs most commonly during falls on an outstretched arm.

Shoulder dislocation is defined as the complete loss of the humeral articulation with the glenoid fossa, usually as a result of acute trauma.

**Shoulder subluxation** is defined as a partial loss of humeral articulation with the glenoid fossa (incomplete or partial dislocation) usually as a result of repetitive trauma to the degree that symptoms are produced.

**Shoulder instability and/or laxity** is defined as a partial loss of the glenohumeral articulation of which there are two categories:

- Post-traumatic shoulder instability includes an individual with a previous injury that has stretched or torn the ligaments of the shoulder
- Atraumatic instability and/or laxity includes an individual with generalized looseness of the joints “double-jointed” or “multi-directional instability” usually representing a type of congenital ligamentous laxity

**Adhesive capsulitis** is a condition of the shoulder characterized by stiffness, loss of motion (contracture), and pain due to scarring in and/or around the shoulder joint. Conditions that have been suggested to predispose an individual to adhesive capsulitis are trauma, surgery to the shoulder, inflammatory diseases, diabetes, hyperthyroidism, dyslipidemia. Often called frozen shoulder, adhesive capsulitis is clinically divided into classes:

- Primary adhesive capsulitis is characterized by a significant limitation of both active and passive motions on the shoulder; individuals are typically unable to recall a possible cause of the condition (idiopathic adhesive capsulitis)
- Secondary adhesive capsulitis is characterized by a trauma or a possible cause prior to the onset of the symptoms, such as fracture of the humerus, rotator cuff repair, shoulder girdle injury/surgery, or prolonged immobilization

**Non-surgical management**, with regard to the treatment of shoulder pain, is defined as any provider-directed non-surgical treatment that has been demonstrated in the scientific literature to be efficacious and/or is considered reasonable care in the treatment of shoulder pain. The types of treatment involved can include, but are not limited to: relative rest/activity modification, supervised physiotherapy modalities and therapeutic exercises, oral prescription and non-prescription medications, assistive devices (e.g., sling, splint, brace), and/or injections (i.e., steroid).

### **CMM-315.2: General Guidelines**

- The determination of medical necessity for the performance of shoulder surgery is always made on a case-by-case basis.
- Shoulder arthroscopic or open surgical procedures may be considered **medically necessary** for individuals when surgery is being performed for fracture, tumor, infection or foreign body that has led to or will likely lead to progressive destruction.
- In-office diagnostic arthroscopy (e.g., Mi-Eye™, VisionScope®) is considered **experimental, investigational, or unproven**.
- Refer to **MS-19: Shoulder** for advanced imaging indications for conditions of the shoulder.

### **CMM-315.3: Indications and Non-Indications**

#### **Diagnostic Arthroscopy**

Diagnostic arthroscopy is considered **medically necessary** as a separate procedure when **ALL** of the following criteria have been met:

- Function-limiting pain (e.g., loss of shoulder function which interferes with the ability to carry out age appropriate activities of daily living and/or demands of employment) for at least six (6) months in duration.
- Individual demonstrates **ANY** of the following abnormal shoulder physical examination findings as compared to the non-involved side:
  - ◆ Functionally limited range of motion (active or passive)
  - ◆ Measurable loss in strength
  - ◆ Positive Neer Impingement Test or Hawkins-Kennedy Impingement Test
- Failure of provider-directed non-surgical management for at least three (3) months in duration
- Advanced diagnostic imaging study (e.g., MRI, CT) is inconclusive for internal derangement/pathology
- Other potential pathological conditions including, but not limited to: fracture, thoracic outlet syndrome, brachial plexus disorders, referred neck pain, and advanced glenohumeral osteoarthritis have been excluded

Diagnostic arthroscopy is considered **not medically necessary** for any other indication or condition.

### **Loose Body/Foreign Body Removal**

Loose body or foreign body removal is considered **medically necessary** when **ALL** of the following criteria have been met:

- Function-limiting pain (e.g., loss of shoulder function which interferes with the ability to carry out age appropriate activities of daily living and/or demands of employment)
- Mechanical symptoms including painful locking, clicking, catching, or popping
- Failure of provider-directed non-surgical management for at least three (3) months in duration, except when the loose body or foreign body has caused an acute restriction of shoulder joint range of motion (i.e., locking)
- Advanced diagnostic imaging study (e.g., MRI, CT) is conclusive for the presence of a loose body or foreign body within the shoulder joint
- Other potential pathological conditions including, but not limited to: fracture, thoracic outlet syndrome, brachial plexus disorders, referred neck pain, and advanced glenohumeral osteoarthritis have been excluded

Loose body or foreign body removal is considered **not medically necessary** for any other indication or condition.

### **Synovectomy**

Synovectomy (partial or complete) is considered **medically necessary** when **ALL** of the following criteria have been met:

- Function-limiting pain (e.g., loss of shoulder function which interferes with the ability to carry out age appropriate activities of daily living and/or demands of employment)
- Individual demonstrates functionally limited range of motion (active or passive) on physical examination as compared to the non-involved side
- Failure of provider-directed non-surgical management for at least three (3) months in duration
- Advanced diagnostic imaging study (e.g., MRI, CT) demonstrates underlying pathology consistent with the individual's reported medical condition (e.g., synovitis, joint effusion) which correlates with the individual's reported symptoms and physical exam findings

- Presence of any **ONE** of the following:
  - ◆ Inflammatory arthritis (i.e., rheumatoid arthritis, gout, pseudogout, psoriatic arthritis)
  - ◆ Pigmented villonodular synovitis (PVNS)
  - ◆ Synovial chondromatosis
  - ◆ Lyme synovitis
  - ◆ Hemophilia
  - ◆ Hemochromatosis
  - ◆ Non-specific synovitis (including proliferative synovitis, post-operative synovitis as a sequela from a shoulder replacement, etc.)
  - ◆ Recurrent hemarthrosis (i.e., secondary to sickle cell anemia, bleeding diathesis, etc.)
- Other potential pathological conditions including, but not limited to: fracture, thoracic outlet syndrome, brachial plexus disorders, referred neck pain, and advanced glenohumeral osteoarthritis have been excluded

Synovectomy is considered **not medically necessary** for any other indication or condition.

### **Debridement**

Debridement (limited or extensive) is considered **medically necessary** when **ALL** of the following criteria have been met:

- Function-limiting pain (e.g., loss of shoulder function which interferes with the ability to carry out age appropriate activities of daily living and/or demands of employment)
- Individual demonstrates the following on physical examination when compared to the non-involved side:
  - ◆ **EITHER** of the following:
    - Functionally limited range of motion
    - Measurable loss of strength
  - ◆ **ONE OR MORE** of the following positive orthopedic tests/signs:
    - Drop Arm Test
    - Painful Arc Test
    - Jobe or Empty Can Test
    - External Rotation Lag Sign
    - Lift-Off Test
    - Belly-Press Test
    - Cross Body Adduction Test
    - Resisted AC Joint Extension Test
    - Neer Impingement Test
    - Hawkins-Kennedy Impingement Test

- O'Brien's Test
  - Biceps Load Test
  - Clunk Test
  - Anterior Slide Test
  - Compression Rotation Test
  - Speed's Test
- Failure of provider-directed non-surgical management for at least three (3) months in duration
  - Advanced diagnostic imaging study (e.g., MRI, CT) demonstrates underlying pathology which correlates with the individual's reported symptoms and physical exam findings
  - Other potential pathological conditions including, but not limited to: fracture, thoracic outlet syndrome, brachial plexus disorders, referred neck pain, and advanced glenohumeral osteoarthritis have been excluded

Debridement is considered **not medically necessary** for any other indication or condition.

### **Rotator Cuff Repair**

Rotator cuff repair is considered **medically necessary** when **ALL** of the following criteria have been met:

- Function-limiting pain (e.g., documented loss of shoulder function to the extent which interferes with ability to carry out age appropriate activities of daily living and/or demands of employment)
- Individual demonstrates the following on physical examination when compared to the non-involved side:
  - ◆ **EITHER** of the following :
    - Functionally limited range of motion
    - Measurable loss of strength of the rotator cuff musculature
  - ◆ **ONE OR MORE** of the following positive orthopedic tests/signs:
    - Drop Arm Test
    - Painful Arc Test
    - Jobe or Empty Can Test
    - External Rotation Lag Sign
    - Lift-Off Test
    - Belly-Press Test
    - Neer Impingement Test
    - Hawkins-Kennedy Impingement
- Failure of provider-directed non-surgical management for at least three (3) months in duration, except for an individual who suffers a discrete traumatic event that results in an acute full-thickness rotator cuff tear AND associated function-limiting pain



- ◆ Advanced diagnostic imaging (e.g., MRI, CT) findings of fatty infiltration and/or muscle atrophy are not suggestive of an acute rotator cuff tear. The failure of provider-directed non-surgical management for at least three (3) months in duration is required in the presence of these findings, regardless of whether a discrete traumatic event occurred
- Advanced diagnostic imaging study (e.g., MRI, CT) demonstrates a Grade 2 or 3 partial-thickness rotator cuff tear (Ellman classification) or a full-thickness rotator cuff tear (Cofield classification) that correlates with the individual's reported symptoms and physical exam findings
- Other potential pathological conditions including, but not limited to: fracture, thoracic outlet syndrome, brachial plexus disorders, referred neck pain, and advanced glenohumeral osteoarthritis have been excluded

Rotator cuff repair is considered **not medically necessary** for any other indication or condition.

### **Distal Clavicle Excision/Subacromial Decompression/Acromioplasty**

Distal clavicle excision is considered **medically necessary** when **ALL** of the following criteria have been met:

- Function-limiting pain (e.g., documented loss of shoulder function which interferes with the ability to carry out age appropriate activities of daily living and/or demands of employment)
- Individual demonstrates localized tenderness to palpation of the acromioclavicular (AC) joint and **ONE or MORE** of the following positive orthopedic tests on physical examination when compared to the non-involved side:
  - ◆ Cross Body Adduction Test
  - ◆ Resisted AC Joint Extension Test
  - ◆ Neer Impingement Test
  - ◆ Hawkins-Kennedy Impingement Test
- Failure of provider-directed non-surgical management for at least three (3) months in duration
- Plain radiographs demonstrate findings consistent with pathology in the subacromial space and/or at the AC joint
- Advanced diagnostic imaging study (e.g., MRI, CT) demonstrates underlying pathology (e.g., AC joint arthritis, impingement, etc.) which correlates with the individual's reported symptoms and physical exam findings
- Other potential pathological conditions including, but not limited to: fracture, thoracic outlet syndrome, brachial plexus disorders, referred neck pain, and advanced glenohumeral osteoarthritis have been excluded

Subacromial decompression/acromioplasty is considered **medically necessary** as an add-on procedure only when performed with other medically necessary primary shoulder surgical procedures **AND ALL** of the above criteria have been met with the exception of localized tenderness to palpation of the acromioclavicular joint

Subacromial decompression/acromioplasty cannot be approved as a stand-alone procedure.

Distal clavicle excision/subacromial decompression/acromioplasty is considered **not medically necessary** for any other indication or condition.

### **Labral Repair/Biceps Tenodesis**

Labral repair/biceps tenodesis is considered **medically necessary** when **ALL** of the following criteria have been met:

- Function-limiting pain (e.g., loss of shoulder function which interferes with the ability to carry out age appropriate activities of daily living and/or demands of employment)
- Individual demonstrates **BOTH** of the following on physical examination when compared to the non-involved side:
  - ◆ Minimally limited or full shoulder range of motion
  - ◆ **ONE OR MORE** of the following positive orthopedic tests
    - O'Brien's Test
    - Biceps Load Test
    - Clunk Test
    - Anterior Slide Test
    - Compression Rotation Test
    - Speed's Test
- Failure of provider-directed non-surgical management for at least three (3) months in duration
- Advanced diagnostic imaging study (e.g., MRI, CT) demonstrates labral tear/biceps tendon pathology (e.g., SLAP, Bankart) and correlates with the individual's reported symptoms and physical exam findings
- Other potential pathological conditions including, but not limited to: fracture, thoracic outlet syndrome, brachial plexus disorders, referred neck pain, and advanced glenohumeral osteoarthritis have been excluded

Labral repair/biceps tenodesis is considered **not medically necessary** for any other indication or condition.

## **Shoulder Instability and/or Laxity**

Arthroscopic or open surgical procedures for shoulder instability and/or laxity are considered **medically necessary** when **ALL** of the following criteria have been met:

- Documented history of “post-traumatic” or “atraumatic” instability and/or laxity that has resulted in function-limiting pain (e.g., loss of shoulder function which interferes with the ability to carry out age appropriate activities of daily living and/or demands of employment)
- Individual demonstrates **ONE OR MORE** of the following positive orthopedic tests on physical examination when compared to the non-involved side:
  - ◆ Anterior or Posterior Apprehension Test
  - ◆ Sulcus Sign
  - ◆ Load and Shift Test
- Failure of provider-directed non-surgical management for at least three (3) months in duration that includes shoulder stabilization/strengthening exercises, except when **EITHER** of the following criteria are met in an acute traumatic injury setting:
  - ◆ Irreducible shoulder dislocation
  - ◆ Anterior shoulder instability in competitive contact or collision athletes
- Advanced diagnostic imaging study (e.g., MRI, CT) demonstrates labral tear/biceps tendon pathology (e.g., SLAP, Bankart) and correlates with the individual’s reported symptoms and physical exam findings
- Other potential pathological conditions including, but not limited to: fracture, thoracic outlet syndrome, brachial plexus disorders, referred neck pain, and advanced glenohumeral osteoarthritis have been excluded

Arthroscopic or open surgical procedures for shoulder instability and/or laxity are considered **not medically necessary** for any other indication or condition.

## **Arthroscopic Capsular Release/Lysis of Adhesions/Manipulation Under Anesthesia (MUA)**

Arthroscopic capsular release/lysis of adhesions/manipulation under anesthesia (MUA) for an individual with documented chronic refractory adhesive capsulitis/arthrofibrosis which has resulted from disease, injury or surgery is considered **medically necessary** when **ALL** of the following criteria have been met:

- Function-limiting pain (e.g., loss of shoulder function which interferes with the ability to carry out age appropriate activities of daily living and/or demands of employment) for at least six (6) months in duration
- Individual demonstrates functionally limited and painful global loss of active and passive range of motion of at least 50% when compared to the non-involved side
- Failure of provider-directed non-surgical management for at least three (3) months in duration, including a combination of anti-inflammatory medication, cortisone injection,

and at least two (2) months of physical therapy (i.e., active exercise and manual therapy designed to increase joint mobility and range of motion)

- Other potential pathological conditions including, but not limited to: fracture, thoracic outlet syndrome, brachial plexus disorders, referred neck pain, and advanced glenohumeral osteoarthritis have been excluded

Manipulation under anesthesia (MUA) should be performed in conjunction with an active rehabilitation/therapeutic exercise program. Manipulation performed in isolation without the individual participating in an active rehabilitation/therapeutic exercise program is considered **not medically necessary**.

Arthroscopic capsular release/lysis of adhesions/manipulation under anesthesia (MUA) is considered **not medically necessary** for any other indication or condition.

### CMM-315.4: Procedure (CPT®) Codes

This guideline relates to the CPT® code set below. Codes are displayed for informational purposes only. Any given code's inclusion on this list does not necessarily indicate prior authorization is required.	
CPT®	Code Description/Definition
23000	Removal of subdeltoid calcareous deposits, open
23020	Capsular contracture release (e.g. Sever type procedure)
23030	Incision and drainage, shoulder area; deep abscess or hematoma
23031	Incision and drainage, shoulder area; infected bursa
23035	Incision, bone cortex (e.g., osteomyelitis or bone abscess), shoulder area
23040	Arthrotomy, glenohumeral joint, including exploration, drainage, or removal of foreign body
23044	Arthrotomy, acromioclavicular, sternoclavicular joint, including exploration, drainage, or removal of foreign body
23065	Biopsy, soft tissue of shoulder area; superficial
23066	Biopsy, soft tissue of shoulder area; deep
23071	Excision, tumor, soft tissue of shoulder area, subcutaneous; 3 cm or greater
23073	Excision, tumor, soft tissue of shoulder area, subfascial (e.g. intramuscular); 5 cm or greater
23075	Excision, tumor, soft tissue of shoulder area, subcutaneous; less than 3 cm
23076	Excision, tumor, soft tissue of shoulder area, subfascial (e.g. intramuscular); less than 5 cm
23077	Radical resection of tumor (e.g. sarcoma), soft tissue of shoulder area; less than 5 cm
23078	Radical resection of tumor (e.g. sarcoma), soft tissue of shoulder area; 5 cm or greater
23100	Arthrotomy, glenohumeral joint, including biopsy
23101	Arthrotomy, acromioclavicular joint or sternoclavicular joint, including biopsy and/or excision of torn cartilage
23105	Arthrotomy; glenohumeral joint, with synovectomy, with or without biopsy

<b>23106</b>	Arthrotomy; sternoclavicular joint, with synovectomy, with or without biopsy
<b>23107</b>	Arthrotomy, glenohumeral joint, with joint exploration, with or without removal of loose or foreign body
<b>23120</b>	Claviculectomy; partial
<b>23125</b>	Claviculectomy; total
<b>23130</b>	Acromioplasty or acromionectomy, partial, with or without coracoacromial ligament release
<b>23140</b>	Excision or curettage of bone cyst or benign tumor of clavicle or scapula
<b>23145</b>	Excision or curettage of bone cyst or benign tumor of clavicle or scapula; with autograft (includes obtaining graft)
<b>23146</b>	Excision or curettage of bone cyst or benign tumor of clavicle or scapula; with allograft
<b>23150</b>	Excision or curettage of bone cyst or benign tumor of proximal humerus
<b>23155</b>	Excision or curettage of bone cyst or benign tumor of proximal humerus; with autograft (includes obtaining graft)
<b>23156</b>	Excision or curettage of bone cyst or benign tumor of proximal humerus; with allograft
<b>23170</b>	Sequestrectomy (e.g. for osteomyelitis or bone abscess), clavicle
<b>23172</b>	Sequestrectomy (e.g. for osteomyelitis or bone abscess), scapula
<b>23174</b>	Sequestrectomy (e.g. for osteomyelitis or bone abscess), humeral head to surgical neck
<b>23180</b>	Partial excision (craterization, saucerization, or diaphysectomy) bone (e.g. osteomyelitis), clavicle
<b>23182</b>	Partial excision (craterization, saucerization, or diaphysectomy) bone (e.g. osteomyelitis), scapula
<b>23184</b>	Partial excision (craterization, saucerization, or diaphysectomy) bone (e.g. osteomyelitis), proximal humerus
<b>23190</b>	Ostectomy of scapula, partial (e.g., superior medial angle)
<b>23195</b>	Resection, humeral head
<b>23200</b>	Radical resection of tumor; clavicle
<b>23210</b>	Radical resection of tumor; scapula
<b>23220</b>	Radical resection of tumor, proximal humerus
<b>23395</b>	Muscle transfer, any type, shoulder or upper arm; single
<b>23397</b>	Muscle transfer, any type, shoulder or upper arm; multiple
<b>23405</b>	Tenotomy, shoulder area; single tendon
<b>23406</b>	Tenotomy, shoulder area; multiple tendons through same incision
<b>23410</b>	Repair of ruptured musculotendinous cuff (e.g. rotator cuff) open; acute
<b>23412</b>	Repair of ruptured musculotendinous cuff (e.g. rotator cuff) open; chronic
<b>23415</b>	Coracoacromial ligament release, with or without acromioplasty
<b>23420</b>	Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)
<b>23430</b>	Tenodesis of long tendon of biceps
<b>23440</b>	Resection or transplantation of long tendon of biceps

<b>23450</b>	Capsulorrhaphy, anterior; Putti-Platt procedure or Magnuson type operation
<b>23455</b>	Capsulorrhaphy, anterior; with labral repair (e.g. Bankart procedure)
<b>23460</b>	Capsulorrhaphy, anterior, any type; with bone block
<b>23462</b>	Capsulorrhaphy, anterior, any type; with coracoid process transfer
<b>23465</b>	Capsulorrhaphy, glenohumeral joint, posterior, with or without bone block
<b>23466</b>	Capsulorrhaphy, glenohumeral joint, any type multi-directional instability
<b>23480</b>	Osteotomy, clavicle, with or without internal fixation
<b>23485</b>	Osteotomy, clavicle, with or without internal fixation; with bone graft for nonunion or malunion (includes obtaining graft and/or necessary fixation)
<b>23490</b>	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate; clavicle
<b>23491</b>	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate; proximal humerus
<b>23700</b>	Manipulation under anesthesia, shoulder joint, including application of fixation apparatus (dislocation excluded)
<b>29805</b>	Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure)
<b>29806</b>	Arthroscopy, shoulder, surgical; capsulorrhaphy
<b>29807</b>	Arthroscopy, shoulder, surgical; repair of SLAP lesion
<b>29819</b>	Arthroscopy, shoulder, surgical; with removal of loose body or foreign body
<b>29820</b>	Arthroscopy, shoulder, surgical; synovectomy, partial
<b>29821</b>	Arthroscopy, shoulder, surgical; synovectomy, complete
<b>29822</b>	Arthroscopy, shoulder, surgical; debridement, limited
<b>29823</b>	Arthroscopy, shoulder, surgical; debridement, extensive
<b>29824</b>	Arthroscopy, shoulder, surgical; distal claviclectomy including distal articular surface (Mumford procedure)
<b>29825</b>	Arthroscopy, shoulder, surgical; with lysis and resection of adhesions, with or without manipulation
<b>29826</b>	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (i.e. arch) release when performed (List separately in addition to code for primary procedure)
<b>29827</b>	Arthroscopy, shoulder, surgical; with rotator cuff repair
<b>29828</b>	Arthroscopy, shoulder, surgical; biceps tenodesis
This list may not be all inclusive and is not intended to be used for coding/billing purposes. The final determination of reimbursement for services is the decision of the health plan and is based on the individual's policy or benefit entitlement structure as well as claims processing rules.	

## **CMM-315.5: References**

1. AAOS Clinical Practice Guidelines Unit. Optimizing The Management of Rotator Cuff Problems: Guideline and Evidence Report. 2010 Dec 4. V1.1\_033011:i-293.
2. Arciero RA, Wheeler JH, Ryan JB, et al. Arthroscopic Bankart Repair Versus Nonoperative Treatment for Acute, Initial Anterior Shoulder Dislocations. *Am J Sports Med.* 1994;22(5):589-594.
3. Boileau P, Baque F, Valerio Let al. Isolated Arthroscopic Biceps Tenotomy or Tenodesis Improves Symptoms in Patients with Massive Irreparable Rotator Cuff Tears. *J Bone Joint Surg Am.*2007;89(4):747-757.
4. Budoff J, Nirschl R, Guidi E. Current Concepts Review-Debridement of Partial-Thickness Tears of the Rotator Cuff without Acromioplasty. Long-term follow-up and review of the literature. *J Bone Joint Surg Am.* 1998; 80(5):733-748.
5. Choi L. Overuse injuries. In: DeLee J, et al. DeLee and Drez's Orthopaedic Sports Medicine. 3 ed. Philadelphia, Pa.: Saunders Elsevier; 2009.
6. Cofield RH. Subscapular muscle transposition for repair of chronic rotator cuff tears. *Surg Gynecol Obstet.* 1982;154(5):667-672.
7. DeOrto JK, Cofield RH. Results of a second attempt at surgical repair of a failed initial rotator-cuff repair. *J Bone Joint Surg Am.* 1984;66(4):563-567.
8. Dunn WR, Kuhn JE, Sanders R, et al. 2013 Neer Award: predictors of failure of nonoperative treatment of chronic, symptomatic, full-thickness rotator cuff tears. *J Shoulder Elbow Surg.* 2016;25:1303-1311.
9. Galatz LM Ball C, Teefey S, et al. The outcome and repair integrity of completely arthroscopically repaired large and massive rotator cuff tears. *J Bone Joint Surg Am.* 2004; 86(2):219-224
10. Gartsman G, TavernaE: The incidence of glenohumeral joint abnormalities associated with complete, reparable rotator cuff tears. *Arthroscopy.* 1997;12:575-579.
11. Hovelius L, Olofsson A, Sandström B. Nonoperative treatment of primary anterior shoulder dislocation in patients forty years of age and younger. a prospective twenty-five-year follow-up. *J Bone Joint Surg Am.* 2008;90(5):945-952.
12. Hovis W, Dean M, Mallon W, Hawkins R. Posterior instability of the shoulder with secondary impingement in elite golfers. *Am J Sports Med.* 2002;30(6):886-890.
13. Keener JD, Galatz LM, Teefey SA, et al. A Prospective Evaluation of Survivorship of Asymptomatic Degenerative Rotator Cuff Tears. *J Bone Joint Surg Am.* 2015;97:89-98.
14. Khazzam M, Kane SM, Smith MJ. Open Shoulder Stabilization Using bone block technique for treatment of chronic glenohumeral instability associated with glenoid deficiency. *Am J Orthop (Belle Mead NJ).* 2009;38(7):329-335
15. Kim H, Teefey S, Zelig A, et al. Shoulder strength in asymptomatic individuals with intact compared with torn rotator cuffs. *J Bone Joint Surg Am.* 2009; 91(2):289-296.
16. Kukkonen J, Joukainen A, Lehtinen J, et al. Treatment of Nontraumatic Rotator Cuff Tears: A Randomized Control Trial with Two Years of Clinical and Imaging Follow-up. *J Bone Joint Surg Am.* 2015;97:1729-37.
17. Leroux, TS, Saltzman BM, Meyer M, et al. The Influence of Evidence-Based Surgical Indications and Techniques on Failure Rates After Arthroscopic Shoulder Stabilization in the Contact or Collision Athlete with Anterior Shoulder Instability. *Am J Sports Med.* 2017;45(5):1218-1225.
18. McKee M, Yoo D. The effect of surgery for rotator cuff disease on general health status. Results of a prospective trial. *J Bone Joint Surg Am.* 2000; 82(7):970-979Mishra D, Fanton G. Two-year outcome of arthroscopic Bankart repair and electrothermal-assisted capsulorrhaphy for recurrent traumatic anterior shoulder instability. *Arthroscopy.* 2001;17(8):844- 849.
19. Park M, Jun B, Park C, et al. Biomechanical Analysis of a Knotless Transtendon Interimplant Mattress Repair for Partial-Thickness Articular-Sided Rotator Cuff Tears. *Am J Sports Med.* 2009;37(12):2427-2434.
20. Petrera A, Dwyer T, Tsuji MRS, et al. Outcomes of Arthroscopic Bankart Repair in Collision Versus Noncollision Athletes. *Orthopedics.* 2013;36(5):e621-e626.
21. Rees J. The pathogenesis and surgical treatment of tears of the rotator cuff. *J Bone Joint Surg Br.* 2008;90-B(7):827-832.

22. Rhon DI, Boyles RB, Cleland JA. One-year outcome of subacromial corticosteroid injection compared with manual physical therapy for the management of the unilateral shoulder impingement syndrome: a pragmatic randomized trial. *Ann Intern Med.* 2014;161(3):161-169.
23. Sachs RA, Lin D, Stone ML, et al. Can the Need for Future Surgery for Acute Traumatic Anterior Shoulder Dislocation Be Predicted? *J Bone Joint Surg Am.* 2007;89:1665-74.
24. Shen P, Lien S, Shen Het al. Long-term functional outcomes after repair of rotator cuff tears correlated with atrophy of the supraspinatus muscles on magnetic resonance images. *J Shoulder Elbow Surg.* 2008; 17 (1 Suppl): 1S–7S.
25. Streubel PN, Krych AJ, Simone JP, et al. Anterior Glenohumeral Instability: A Pathology-based Surgical Treatment Strategy. *J Am Acad Orthop Surg.* 2014;22(5):283-294.
26. Ueda Y, Sugaya H, Takahashi N, et al. Rotator Cuff Lesions in Patients with Stiff Shoulders: A Prospective Analysis of 379 Shoulders. *J Bone Joint Surg Am.* 2015;97:1233-7.
27. Vitale M, Arons R, Hurwitz S, et al. The Rising Incidence of Acromioplasty. *J. Bone Joint Surg.* 2010;92(9):1842-1850.
28. Werner BC, Brockmeier SF, Miller MD. Etiology, Diagnosis, and Management of Failed SLAP Repair. *J Am Acad Orthop Surg.* 2014;22(9):554-565.
29. Whittle S, Buchbinder R. In the Clinic: Rotator Cuff Disease. *Ann Intern Med.* 6 Jan 2015. ITC 1-ITC 15.
30. Work Loss Data Institute. Shoulder (acute and chronic). Corpus Christi (TX): Work Loss Data Institute; 2008.
31. Wylie JD, Suter T, Potter MQ, et al. Mental Health Has a Stronger Association with Patient-Reported Shoulder Pain and Function Than Tear Size in Patients with Full-Thickness Rotator Cuff Tears. *J Bone Joint Surg Am.* 2016;98:251-6.