Cigna Medical Coverage Policies – Musculoskeletal Shoulder Surgery – Arthroscopic and Open Procedures

Effective May 31, 2023

Instructions for use

The following coverage policy applies to health benefit plans administered by Cigna. Coverage policies are intended to provide guidance in interpreting certain standard Cigna benefit plans and are used by medical directors and other health care professionals in making medical necessity and other coverage determinations. Please note the terms of a customer's particular benefit plan document may differ significantly from the standard benefit plans upon which these coverage policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a coverage policy.

In the event of a conflict, a customer's benefit plan document always supersedes the information in the coverage policy. In the absence of federal or state coverage mandates, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of:

1. The terms of the applicable benefit plan document in effect on the date of service
2. Any applicable laws and regulations
3. Any relevant collateral source materials including coverage policies
4. The specific facts of the particular situation

Coverage policies relate exclusively to the administration of health benefit plans. Coverage policies are not recommendations for treatment and should never be used as treatment guidelines.

This evidence-based medical coverage policy has been developed by eviCore, Inc. Some information in this coverage policy may not apply to all benefit plans administered by Cigna.

CMM-315: Shoulder Surgery-Arthroscopic and Open Procedures

Definitions

- **Acromioplasty:** the removal of bone from the acromion and partial resection of the coracoacromial ligament.
- **Adhesive Capsulitis/Arthrofibrosis:** 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 include 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.
- **Distal Clavicle Excision:** 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.
- **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.
- **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**: 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)**: 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 the biceps tendon attaches. This type of tear occurs most commonly during falls on an outstretched arm.
- **Non-Surgical Management** (with regard to the treatment of shoulder pain)**:** 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 supervised therapeutic exercises, prescription and non-prescription medications, assistive devices (e.g., sling, splint, brace), and/or injections (i.e., steroid).
- **Rotator Cuff Tears:** 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

- **Shoulder Dislocation:** the complete loss of the humeral articulation with the glenoid fossa, usually as a result of acute trauma.
- **Shoulder Instability and/or Laxity:** 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.
- **Shoulder Subluxation**: 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.
- **Subacromial Decompression:** the removal of bone or other abnormality to enlarge the space between the rotator cuff musculature and the acromion.

General Guidelines

Application of Guideline

- The determination of medical necessity for the performance of shoulder surgery is always made on a case-by-case basis.

- For advanced imaging indications for conditions of the shoulder, refer to **MS-19: Shoulder** For advanced imaging indications for conditions of the shoulder,
- Manipulation of a shoulder joint under general anesthesia is included in all arthroscopic shoulder procedures and is therefore considered incidental to the base procedure requiring medical necessity review.
- Arthroscopic or Open Procedure for Fracture, Tumor, Infection, or Foreign BodyShoulder arthroscopic or open 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.

Diagnostic Arthroscopy

Diagnostic Arthroscopy Indications

- Diagnostic arthroscopy is considered **medically necessary** as a stand-alone 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 have been excluded including, but not limited to: fracture, thoracic outlet syndrome, brachial plexus disorders, referred neck pain and advanced glenohumeral osteoarthritis.

Diagnostic Arthroscopy Non-Indications

Not Medically Necessary

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

Experimental, Investigational, or Unproven

- Based on lack if scientific safety and efficacy, the following is considered **experimental, investigational, or unproven (EIU)**:
  - In-office diagnostic arthroscopy (e.g., Mi-Eye™, VisionScope®)

Loose Body/Foreign Body Removal

Loose Body/Foreign Body Removal Indications

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

Loose Body/Foreign Body Removal Non-Indications

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

Synovectomy

Synovectomy Indications

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

Synovectomy Non-Indications

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

Debridement

Debridement Indications

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

Debridement Non-Indications

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

Rotator Cuff Repair

Rotator Cuff Repair Indications

- Rotator cuff repair **is considered medically necessary** when **ALL** of the following criteria have been met:
  - Function-limiting pain (e.g., 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 (Dropping Sign)
      - Internal Rotation Lag Sign
      - Lift-Off Test
      - Bear Hug Test
      - Belly-Press Test (Napoleon)
      - Neer Impingement Test
      - Hawkins-Kennedy Impingement Test
      - Hornblower Test (Patte)
  - 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 **AN**D associated function-limiting pain
    - **Note**: The failure of provider-directed non-surgical management for at least three (3) months in duration is required in the presence of these advanced

diagnostic imaging (e.g., MRI, CT) findings of fatty infiltration and/or muscle atrophy, regardless of whether a discrete traumatic event occurred.
- Advanced diagnostic imaging (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 have been excluded including, but not limited to: fracture, thoracic outlet syndrome, brachial plexus disorders, referred neck pain and advanced glenohumeral osteoarthritis.

Rotator Cuff Repair Non-Indications

Not Medically Necessary

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

Experimental, Investigational, or Unproven (EIU)

- Based on the lack of scientific evidence of efficacy and safety, the following is considered **experimental, investigational, or unproven (EIU)**:
  - Superior capsular reconstruction using any type of graft (e.g., autograft, allograft, xenograft, or synthetic)

Distal Clavicle Excision/Subacromial Decompression/ Acromioplasty

Distal Clavicle Excision Indications

- 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

    - **Note**: Advanced diagnostic imaging is not required for isolated distal clavicle excision when not associated with subacromial decompression/acromioplasty surgery.
  - Other potential pathological conditions have been excluded including, but not limited to: fracture, thoracic outlet syndrome, brachial plexus disorders, referred neck pain, and advanced glenohumeral osteoarthritis

Subacromial Decompression/Acromioplasty Indications

- 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.

Distal Clavicle Excision/ Subacromial Decompression/ Acromioplasty Non-Indications

- Distal clavicle excision/subacromial decompression/acromioplasty is considered **not medically necessary** for **ANY** other indication or condition.
- Arthroscopic subacromial decompression/acromioplasty is considered **not medically necessary** as a stand-alone procedure.

Labral Repair

Labral Repair Indications

- Labral repair 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)
  - 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 (e.g., SLAP, Bankart) and correlates with the individual's reported symptoms and physical exam findings
  - Other potential pathological conditions have been excluded including, but not limited to: fracture, thoracic outlet syndrome, brachial plexus disorders, referred neck pain, cervical radiculopathy, and advanced glenohumeral osteoarthritis.
  - **BOTH** of the following are present 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
- Modified dynamic labral shear

Labral Repair Non-Indications

- Labral repair is considered **not medically necessary** for **ANY** other indication or condition.

Biceps Tenodesis

Biceps Tenodesis Indications

- 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)
  - 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 proximal biceps tendon rupture **AND** associated function-limiting pain
  - Advanced diagnostic imaging study (e.g., MRI, CT) demonstrates labral tear/biceps tendon pathology (e.g., SLAP, Bankart, full-thickness subscapularis tear) and correlates with the individual's reported symptoms and physical exam findings
  - Other potential pathological conditions have been excluded including, but not limited to: fracture, thoracic outlet syndrome, brachial plexus disorders, referred neck pain, cervical radiculopathy, and advanced glenohumeral osteoarthritis
  - **BOTH** of the following are present 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 physical exam findings
      - O'Brien's Test
      - Biceps Load Test
      - Clunk Test
      - Anterior Slide Test
      - Compression Rotation Test
      - Speed's Test
      - Upper cut test
      - Popeye sign
      - Yergason's test
      - Proximal biceps (groove) tenderness

Biceps Tenodesis Non-Indications

- Biceps tenodesis is considered **not medically necessary** for **ANY** other indication or condition.

Arthroscopic or Open Surgical Procedures for Shoulder Instability and/or Laxity

Arthroscopic or Open Surgical Procedures for 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 (e.g., Bankart, capsular tear) and correlates with the individual's reported symptoms and physical exam findings
  - Other potential pathological conditions have been excluded including, but not limited to: fracture, thoracic outlet syndrome, brachial plexus disorders, referred neck pain, cervical radiculopathy, and advanced glenohumeral osteoarthritis

Arthroscopic or Open Surgical Procedures for Shoulder Instability and/or Laxity Non-Indications

Not Medically Necessary

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

Experimental, Investigational, or Unproven (EIU)

- Based on the lack of scientific evidence of efficacy and safety, the following is considered **experimental, investigational, or unproven (EIU):**
  - Superior capsular reconstruction using any type of graft (e.g., autograft, allograft, xenograft, or synthetic)

Arthroscopic Capsular Release/Lysis of Adhesions

Arthroscopic Capsular Release/Lysis of Adhesions Indications

- Arthroscopic capsular release/lysis of adhesions 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 a trial of physical therapy (i.e., active exercise and manual therapy designed to increase joint mobility and range of motion)
  - Other potential diagnostic conditions including but not limited to fracture, thoracic outlet syndrome, brachial plexus disorders, referred neck pain, cervical radiculopathy, and advanced glenohumeral osteoarthritis have been excluded.

Arthroscopic Capsular Release/Lysis of Adhesions Non-Indications

- Arthroscopic capsular release/lysis of adhesions is considered **not medically necessary** for **ANY** other indication or condition.

Arthroscopic or Open Coracoplasty/Subcoracoid Decompression

- Based on lack of scientific safety and efficacy, arthroscopic or open coracoplasty/subcoracoid decompression for the treatment of subcoracoid impingement is considered experimental, investigational or unproven (EIU).

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)
23120	Claviculectomy; partial
23125	Claviculectomy; total
23130	Acromioplasty or acromionectomy, partial, with or without coracoacromial ligament release
23145	Excision or curettage of bone cyst or benign tumor of clavicle or scapula; with autograft (includes obtaining graft)
23155	Excision or curettage of bone cyst or benign tumor of proximal humerus; with autograft (includes obtaining graft)
23172	Sequestrectomy (e.g. for osteomyelitis or bone abscess), scapula
23174	Sequestrectomy (e.g. for osteomyelitis or bone abscess), humeral head to surgical neck
23190	Ostectomy of scapula, partial (eg, superior medial angle)
23195	Resection, humeral head
23395	Muscle transfer, any type, shoulder or upper arm; single
23397	Muscle transfer, any type, shoulder or upper arm; multiple
23405	Tenotomy, shoulder area; single tendon
23406	Tenotomy, shoulder area; multiple tendons through same incision
23410	Repair of ruptured musculotendinous cuff (e.g. rotator cuff) open; acute
23412	Repair of ruptured musculotendinous cuff (e.g. rotator cuff) open; chronic
23415	Coracoacromial ligament release, with or without acromioplasty
23420	Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)
23430	Tenodesis of long tendon of biceps
23440	Resection or transplantation of long tendon of biceps
23450	Capsulorrhaphy, anterior; Putti-Platt procedure or Magnuson type operation
23455	Capsulorrhaphy, anterior; with labral repair (e.g. Bankart procedure)
23460	Capsulorrhaphy, anterior, any type; with bone block
23462	Capsulorrhaphy, anterior, any type; with coracoid process transfer
23465	Capsulorrhaphy, glenohumeral joint, posterior, with or without bone block
23466	Capsulorrhaphy, glenohumeral joint, any type multi-directional instability
23480	Osteotomy, clavicle, with or without internal fixation
23485	Osteotomy, clavicle, with or without internal fixation; with bone graft for nonunion or malunion (includes obtaining graft and/or necessary fixation)
29805	Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure)
29806	Arthroscopy, shoulder, surgical; capsulorrhaphy
29807	Arthroscopy, shoulder, surgical; repair of SLAP lesion
29819	Arthroscopy, shoulder, surgical; with removal of loose body or foreign body
29820	Arthroscopy, shoulder, surgical; synovectomy, partial
29821	Arthroscopy, shoulder, surgical; synovectomy, complete
29822	Arthroscopy, shoulder, surgical; debridement, limited, 1 or 2 discrete structures (e.g., humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies])
29823	Arthroscopy, shoulder, surgical; debridement, extensive, 3 or more discrete structures (e.g., humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies])
29824	Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure)

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
29825	Arthroscopy, shoulder, surgical; with lysis and resection of adhesions, with or without manipulation
29826	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)
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
29828	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.

References

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