CIGNA MEDICAL COVERAGE POLICIES - MUSCULOSKELETAL

CMM-315: Shoulder Surgery - Arthroscopic and Open Procedures

Effective Date: December 08, 2026

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.

These guidelines include procedures EviCore does not review for Cigna. Please refer to the **Cigna CPT code list** for the current list of high-tech imaging procedures that EviCore reviews for Cigna.

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Definitions

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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, and 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 of 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	a condition that 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.

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Labral Tear	a tear of the glenoid labrum. 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 the 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, which has been demonstrated in the scientific literature as 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, the following: relative rest/activity modification; supervised physiotherapy modalities and therapeutic exercises; prescription and non-prescription medications; assistive devices; and/or injections.
Rotator Cuff Arthropathy	a condition that results from ALL of the following: • rotator cuff dysfunction (e.g., secondary to unrepairable/ irreparable massive rotator cuff tear) • advanced glenohumeral arthritis • radiographically diminished acromio-humeral distance

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Rotator Cuff Tear (RCT)

a disruption of the tendon(s) of the rotator cuff muscles which attach the humerus to the scapula. These tendons 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 individuals, the surgeon should attempt to properly identify individuals with acute tears as opposed to individuals with pre-existing chronic tears that become symptomatic after an injury event. A discrete traumatic event is more suggestive of acute tear. Physical exam 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: <3mm deep (<25% thickness)
    - Grade 2: 3-6mm in depth, but not exceeding 50% of the tendon thickness
    - Grade 3: >6mm deep (>50% thickness)
  - Full-thickness tears, also called complete tears (Cofield):
    - Small: <1cm
    - Medium: 1-3cm
    - Large: 3-5cm
    - Massive: >5cm

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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 stretched or torn ligaments of the shoulder as a result of a previous injury. • Atraumatic instability and/or laxity includes 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.
Acromioplasty	the removal of bone from the acromion and partial resection of the coracoacromial ligament.

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General Guidelines

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Application of Guideline

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

Health Equity Considerations

Health equity is the highest level of health for all individuals; health inequity is the avoidable difference in health status or distribution of health resources due to the social conditions in which individuals are born, grow, live, work, and age. Social determinants of health are the conditions in the environment that affect a wide range of health, functioning, and quality of life outcomes and risks. Examples include the following: safe housing, transportation, and neighborhoods; racism, discrimination, and violence; education, job opportunities, and income; access to nutritious foods and physical activity opportunities; access to clean air and water; and language and literacy skills.

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Arthroscopic or Open Procedures for Fracture, Tumor, Infection, or Foreign Body

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Arthroscopic or Open Procedures for Fracture, Tumor, Infection, or Foreign Body

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- Arthroscopic or open shoulder surgery may be considered **medically necessary** when surgery is being performed for fracture, tumor, infection, or foreign body that has led to, or will likely lead to, progressive destruction.

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Diagnostic Arthroscopy Indications

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

- MRI or CT is inconclusive for internal derangement/pathology
- Physical exam demonstrates ANY of the following findings (as compared to the non-involved side):
  - functionally-limited range of motion (active or passive)
  - measurable loss of strength
  - positive Neer impingement test or Hawkins-Kennedy impingement test
- Symptoms include 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' duration
- Failure of provider-directed non-surgical management for at least three (3) months' duration
- Other potential pathological conditions have been excluded, including, but not limited to the following: fracture, thoracic outlet syndrome, brachial plexus disorders, referred neck pain, cervical radiculopathy, and advanced glenohumeral osteoarthritis.

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Diagnostic Arthroscopy Non-Indications

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Not Medically Necessary

- Diagnostic arthroscopy is considered **not medically necessary** for ANY other indication or condition.
- Based on lack of scientific evidence of efficacy and safety, "in-office" diagnostic arthroscopy (e.g., Mi-Eye™, VisionScope®) is considered **not medically necessary**.

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Loose Body/Foreign Body Removal

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Loose Body/Foreign Body Removal Indications

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

- MRI or CT shows findings of a loose body or foreign body within the shoulder joint
- Symptoms include BOTH of the following:
  - 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' duration
  - **Criteria exception**: Three (3) months of provider-directed non-surgical management is not required if the loose body or foreign body has caused an acute restriction of shoulder joint range of motion (i.e., locking).
- Other potential pathological conditions have been excluded, including, but not limited to the following: fracture, thoracic outlet syndrome, brachial plexus disorders, referred neck pain, cervical radiculopathy, and advanced glenohumeral osteoarthritis.

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Loose Body/Foreign Body Removal Non-Indications

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Not Medically Necessary

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

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Synovectomy

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Synovectomy Indications

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

- MRI or CT arthrogram shows findings of synovitis
- Presence of ANY of the following conditions:
  - inflammatory arthritis (i.e., rheumatoid arthritis, gout, pseudogout, psoriatic arthritis)
  - pigmented villonodular synovitis (PVNS)
  - synovial chondromatosis
  - Lyme synovitis
  - hemophilia
  - hemochromatosis
  - non-specific synovitis (e.g., proliferative synovitis, post-operative synovitis as a sequela from a shoulder replacement, etc.)
  - recurrent hemarthrosis
- Physical exam demonstrates functionally-limited range of motion (active or passive) (as compared to the non-involved side)
- Symptoms include 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' duration
- Other potential pathological conditions have been excluded, including, but not limited to the following: fracture, thoracic outlet syndrome, brachial plexus disorders, referred neck pain, cervical radiculopathy, and advanced glenohumeral osteoarthritis.

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Synovectomy Non-Indications

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Not Medically Necessary

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

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Debridement Indications

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

- MRI or CT shows findings of underlying pathology which correlates with the individual's reported symptoms and physical exam findings
- Physical exam demonstrates BOTH of the following findings (as compared to the non-involved side):
  - EITHER of the following findings:
    - functionally-limited range of motion
    - measurable loss of strength
  - ANY of the following positive orthopedic tests/signs:
    - drop arm test
    - painful arc test
    - Jobe test or empty can test
    - external rotation lag sign (dropping sign)
    - lift-off test
    - belly press test (Napoleon)
    - 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
    - upper cut test
    - Yergason's test
    - proximal biceps (groove) tenderness
    - modified dynamic labral shear
- Symptoms include 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)

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- Failure of provider-directed non-surgical management for at least three (3) months' duration
- Other potential pathological conditions have been excluded, including, but not limited to the following: fracture, thoracic outlet syndrome, brachial plexus disorders, referred neck pain, cervical radiculopathy, and advanced glenohumeral osteoarthritis.

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Debridement Non-Indications

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Not Medically Necessary

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

Rotator Cuff Repair

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Rotator Cuff Repair Indications

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

- MRI or CT shows EITHER of the following findings:
  - Grade 2 or 3 partial-thickness rotator cuff tear (Ellman classification)
  - full-thickness rotator cuff tear (Cofield classification)
- Physical exam demonstrates BOTH of the following findings (as compared to the non-involved side):
  - EITHER of the following findings:
    - functionally-limited range of motion
    - measurable loss of strength of the rotator cuff musculature
  - ANY of the following positive orthopedic tests/signs:
    - drop arm test
    - painful arc test
    - Jobe test or empty can test
    - lateral Jobe test
    - external rotation lag sign (dropping sign)
    - external rotation resistance test
    - full can test
    - hug up test
    - internal rotation lag sign
    - internal resistance rotation test (IRRT)
    - internal rotation resistance test at maximal 90° of abduction and maximal external rotation test (IRRTM)
    - lift-off test
    - bear hug test
    - belly press test (Napoleon)
    - belly-off test
    - Neer impingement test
    - Hawkins-Kennedy impingement test
    - Hornblower test (Patte)
    - Yocum test
- Symptoms include 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)

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- Failure of provider-directed non-surgical management for at least three (3) months' duration
  - **Criteria exception**: Three (3) months of provider-directed non-surgical management is not required for an individual who suffers a discrete traumatic event that results in an acute full-thickness rotator cuff tear without evidence of a pre-existing chronic rotator cuff tear.
    - **Note**: The presence of fatty infiltration and/or muscle atrophy on MRI or CT is considered evidence of a pre-existing chronic rotator cuff tear.
      - Therefore, when fatty infiltration and/or muscle atrophy is also present on MRI or CT, three (3) months of provider-directed non-surgical management is required, regardless of whether a discrete traumatic event occurred.
- Other potential pathological conditions have been excluded, including, but not limited to the following: fracture, thoracic outlet syndrome, brachial plexus disorders, referred neck pain, cervical radiculopathy, and advanced glenohumeral osteoarthritis.

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Rotator Cuff Repair Non-Indications

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Not Medically Necessary

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

Experimental, Investigational, or Unproven (EIU)

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

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Distal Clavicle Excision

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Distal Clavicle Excision Indications

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

- Imaging shows BOTH of the following findings:
  - plain radiographs show findings of underlying pathology in the subacromial space and/or at the AC joint (e.g., AC joint arthritis)
  - MRI or CT shows findings of underlying pathology (e.g., AC joint arthritis, impingement, etc.) which correlates with the individual's reported symptoms and physical exam findings
    - **Criteria exception**: Advanced imaging is not required for an isolated distal clavicle excision when the procedure is not associated with subacromial decompression/acromioplasty surgery.
- Physical exam demonstrates BOTH of the following findings (as compared to the non-involved side):
  - localized tenderness to palpation of the acromioclavicular (AC) joint
  - ANY of the following positive orthopedic tests/signs:
    - cross body adduction test
    - resisted AC joint extension test
- Symptoms include 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' duration
- Other potential pathological conditions have been excluded, including, but not limited to the following: fracture, thoracic outlet syndrome, brachial plexus disorders, referred neck pain, cervical radiculopathy, and advanced glenohumeral osteoarthritis.

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Distal Clavicle Excision Non-Indications

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Not Medically Necessary

- Distal clavicle excision is considered **not medically necessary** for ANY other indication or condition.

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Subacromial Decompression/ Acromioplasty

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Subacromial Decompression/ Acromioplasty Indications

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Subacromial decompression/acromioplasty is considered **medically necessary** when ALL of the following criteria have been met:

- When requested as an arthroscopic procedure (add-on procedure), it is required to be performed with other medically necessary primary arthroscopic shoulder surgical procedures (with the exception of diagnostic shoulder arthroscopy)
- Imaging shows BOTH of the following findings:
  - plain radiographs show findings of underlying pathology in the subacromial space and/or at the AC joint (e.g., AC joint arthritis, Type 3 hooked acromion, down-sloping acromion, etc.)
  - MRI or CT shows findings of underlying pathology (e.g., AC joint arthritis, impingement, etc.) which correlates with the individual's reported symptoms and physical exam findings
- Physical exam demonstrates ANY of the following positive orthopedic tests/signs (as compared to the non-involved side):
  - Neer impingement test
  - Hawkins-Kennedy impingement test
- Symptoms include 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' duration
- Other potential pathological conditions have been excluded, including, but not limited to the following: fracture, thoracic outlet syndrome, brachial plexus disorders, referred neck pain, cervical radiculopathy, and advanced glenohumeral osteoarthritis.

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Subacromial Decompression/ Acromioplasty Non-Indications

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Not Medically Necessary

- Subacromial decompression/acromioplasty is considered **not medically necessary** for ANY other indication or condition.

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Labral Repair

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Labral Repair Indications

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

- MRI or CT shows labral tear (e.g., SLAP) and correlates with the individual's reported symptoms and physical exam findings
- Physical exam demonstrates BOTH of the following findings (as compared to the non-involved side):
  - minimally limited or full shoulder range of motion
  - ANY of the following positive orthopedic tests/signs:
    - O'Brien's test
    - biceps load test
    - clunk test
    - anterior slide test
    - compression rotation test
    - Speed's test
    - modified dynamic labral shear
- Symptoms include 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' duration
- Other potential pathological conditions have been excluded, including, but not limited to the following: fracture, thoracic outlet syndrome, brachial plexus disorders, referred neck pain, cervical radiculopathy, and advanced glenohumeral osteoarthritis.

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Labral Repair Non-Indications

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Not Medically Necessary

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

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Biceps Tenodesis

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Biceps Tenodesis Indications

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Biceps tenodesis is considered **medically necessary** when ALL of the following criteria have been met:

- MRI or CT shows labral tear/biceps tendon pathology (e.g., SLAP or full-thickness subscapularis tear) and correlates with the individual's reported symptoms and physical exam findings
- Physical exam demonstrates BOTH of the following findings (as compared to the non-involved side):
  - minimally limited or full shoulder range of motion
  - ANY of the following positive orthopedic tests/signs:
    - O'Brien's test
    - biceps load test
    - clunk test
    - anterior slide test
    - compression rotation test
    - Speed's test
    - upper cut test
    - Yergason's test
    - proximal biceps (groove) tenderness
    - modified dynamic labral shear
    - Popeye sign
- Symptoms include 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' duration
  - **Criteria exception**: Three (3) months of provider-directed non-surgical management is not required for an individual who suffers a discrete traumatic event that results in an acute proximal biceps tendon rupture.
- Other potential pathological conditions have been excluded, including, but not limited to the following: fracture, thoracic outlet syndrome, brachial plexus disorders, referred neck pain, cervical radiculopathy, and advanced glenohumeral osteoarthritis.

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Biceps Tenodesis Non-Indications

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Not Medically Necessary

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

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

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

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

- MRI or CT shows labral/capsular/bone pathology (e.g., Bankart, capsular tear, Hill-Sachs deformity) and correlates with the individual's reported symptoms and physical exam findings
- Physical exam demonstrates ANY of the following positive orthopedic tests/signs (as compared to the non-involved side):
  - anterior apprehension test
  - posterior apprehension test
  - sulcus sign
  - load and shift test
- 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)
- Failure of provider-directed non-surgical management for at least three (3) months' duration that includes shoulder stabilization/strengthening exercises
  - **Criteria exception**: Three (3) months of provider-directed non-surgical management is not required in an acute traumatic injury setting when EITHER of the following conditions are present:
    - irreducible shoulder dislocation
    - anterior shoulder instability in competitive contact or collision athletes
- Other potential pathological conditions have been excluded, including, but not limited to the following: fracture, thoracic outlet syndrome, brachial plexus disorders, referred neck pain, cervical radiculopathy, and advanced glenohumeral osteoarthritis.

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

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

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Arthroscopic Capsular Release

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Arthroscopic Capsular Release Indications

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Arthroscopic capsular release is considered **medically necessary** when ALL of the following criteria have been met:

- Performed for chronic refractory adhesive capsulitis or arthrofibrosis
- Physical exam demonstrates functionally-limited and painful global loss of active and passive range of motion of at least 50% (as compared to the non-involved side)
- Symptoms include 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' duration
- Failure of provider-directed non-surgical management for at least three (3) months' 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 pathological conditions have been excluded, including, but not limited to the following: fracture, thoracic outlet syndrome, brachial plexus disorders, referred neck pain, cervical radiculopathy, and advanced glenohumeral osteoarthritis.

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Arthroscopic Capsular Release Non-Indications

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Not Medically Necessary

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

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Lysis of Adhesions

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Lysis of Adhesions Indications

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Lysis of adhesions is considered **medically necessary** when ALL of the following criteria have been met:

- Performed for chronic refractory adhesive capsulitis or arthrofibrosis
- Physical exam demonstrates functionally-limited and painful global loss of active and passive range of motion of at least 50% (as compared to the non-involved side)
- Symptoms include 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' duration
- Failure of provider-directed non-surgical management for at least three (3) months' 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 pathological conditions have been excluded, including, but not limited to the following: fracture, thoracic outlet syndrome, brachial plexus disorders, referred neck pain, cervical radiculopathy, and advanced glenohumeral osteoarthritis.

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Lysis of Adhesions Non-Indications

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Not Medically Necessary

- Lysis of adhesions is considered **not medically necessary** for ANY other indication or condition.

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Manipulation Under Anesthesia (MUA)

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Manipulation Under Anesthesia (MUA) Indications

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- See Manipulation Under Anesthesia (MUA) Non-Indications.

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Manipulation Under Anesthesia (MUA) Non-Indications

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Not Medically Necessary

- Manipulation under anesthesia (MUA) of a shoulder joint is included in all arthroscopic

  shoulder procedures and is therefore considered incidental to the base procedure requiring medical necessity review.

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Arthroscopic or Open Coracoplasty/Subcoracoid Decompression

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Arthroscopic or Open Coracoplasty/ Subcoracoid Decompression Non-Indications

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Experimental, Investigational, or Unproven (EIU)

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

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Codes (CMM-315)

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The inclusion of any code in this table does not imply that the code is under management or requires prior authorization. Refer to the applicable health plan for management details. Prior authorization of a code listed in this table is not a guarantee of payment. The Certificate of Coverage or Evidence of Coverage policy outlines the terms and conditions of the member's health insurance policy.

Code	Code Description/Definition
23000	Removal of subdeltoid calcareous deposits, open
23020	Capsular contracture release (e.g. Sever type procedure)
23120	Claviculectomy; partial
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
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

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Code	Code Description/Definition
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
23700	Manipulation under anesthesia, shoulder joint, including application of fixation apparatus (dislocation excluded)
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])

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Code	Code Description/Definition
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)
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

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