BSC7.14	Partial Thickness Rotator Cuff Tears and Acromioplasty/ Subacromial Decompression		
Original Policy Date:	June 1, 2018	**Effective Date:**	May 1, 2023
Section:	7.0 Surgery	**Page:**	Page 1 of 12

Policy Statement

Shoulder Arthroscopy

I. Arthroscopy of the shoulder for the repair of partial thickness rotator cuff tears may be considered **medically necessary** when **all** of the following criteria are met:
   A. Individual has painful range of motion, documented loss of muscle strength of the rotator cuff musculature, or documented shoulder function disability, **any** of which significantly interferes with the ability to perform activities of daily living, duties of employment, athletic participation, or sleep
   B. Documentation of a positive result of **one or more** of the following orthopedic tests when compared to the non-affected side (see Policy Guidelines):
      1. Neer Impingement Test
      2. Hawkins Kennedy Impingement Test
      3. Painful Arc Test
      4. Full/Empty Can Test
      5. Pain or weakness with infraspinatus and supraspinatus maneuvers such as:
         a. External Lag Sign at 90 Degrees Test
         b. Infraspinatus Test
         c. Empty Can Test (or the similar Jobe's Test)
      6. Liftoff/Modified Liftoff Test
      7. Belly-Press Test
      8. Drop Arm Test
   C. Documentation, including formal radiological interpretation and detailed report of bony or soft tissue pathology or abnormality (e.g., ultrasound, CT scan, or MRI) that demonstrates rotator cuff pathology (Grade II – see Policy Guidelines) that corresponds with the individual's symptoms and clinical findings. In-office reports (ultrasound and x-rays) should include a comprehensive description of the radiographic findings. In rare instances where the imaging is normal and does not support the need for this procedure, the history, physical exam, and MD rationale need to clearly show why surgery is indicated on exception, including why another cause is less likely.
   D. When present, other possible causative conditions of shoulder pain are documented to have been excluded, less likely, or mild in nature. These conditions may include but are not limited to glenohumeral arthritis, frozen shoulder/adhesive capsulitis, brachial plexus disorders, fracture, referred neck pain, and thoracic outlet syndrome.
   E. Documentation of unsuccessful conservative therapy for at least six weeks (non-surgical medical management, see Policy Guidelines), or documentation of rationale if conservative therapy is considered inappropriate

Acromioplasty, Subacromial Decompression

II. Acromioplasty and/or subacromial decompression may be considered **medically necessary** when performed at the same time as a rotator cuff repair when **either** of the following criteria are met:
   A. Documentation, including radiological interpretation and report of bony or soft tissue pathology (e.g., CT scan and/or MRI) demonstrating evidence of impingement
   B. Intra-operative decision based on subacromial space available after repair of a rotator cuff tear to avoid secondary mechanical impingement

NOTE: Refer to Appendix A to see the policy statement changes (if any) from the previous version.

Policy Guidelines

This policy is not meant to address full thickness rotator cuff tears.

Repair of partial thickness rotator cuff tears may include the following arthroscopy procedures when criteria are met:

- Shoulder arthroscopy with rotator cuff repair
- Acromioplasty, subacromial decompression

Sprains, Strains, and Other Soft-Tissue Injuries

The American Academy of Orthopaedic Surgeons[1], defines sprains, strains, and other soft-tissue injuries as overstretching or tearing of the ligament/muscle/tendon, and are typically graded on a severity scale of I, II or III:

- ***Grade I***: mild sprain/strain caused by overstretching or slight tearing of the ligament/muscle/tendon with no instability and has minimal pain, swelling, and little or no loss of functional ability associated with it
- ***Grade II***: sprain/strain caused by incomplete tearing of the ligament/muscle/tendon and is characterized by bruising, moderate pain, and swelling; "partial thickness tear"
- ***Grade III***: sprain/strain that result in complete tear or rupture of a ligament/muscle/tendon; "full thickness tear"

Table PG1: Shoulder Orthopedic Tests

Test	Description
Neer Impingement Test	Commonly used to identify possible subacromial impingement syndrome. The examiner should stabilize the individual's scapula with one hand, while passively flexing the arm while it is internally rotated. If the individual reports pain in this position, then the result of the test is considered to be positive.
Hawkins Kennedy Impingement Test	Commonly used to identify possible subacromial impingement syndrome. In the starting position, the examiner forcefully moves the individual's shoulder into internal rotation to the end of range of motion or until reports of pain. The test is considered positive if pain is reported in the superior-lateral aspect of the shoulder.
Painful Arc Test	Commonly used to identify possible subacromial impingement syndrome. The Painful Arc Test is considered positive for supraspinatus impingement if the individual reports pain between 60 degrees and 120 degrees of abduction. Pain should reduce after 120 degrees of abduction. If the individual instead reports pain at the end of abduction, acromioclavicular joint dysfunction is indicated.
Full/Empty Can Test	Used to diagnose shoulder injuries. The tests differ in the rotation of the arm; in the Empty can test, the arm is rotated to full internal rotation (thumb down) and in the Full can test, the arm is rotated to 45° external rotation. Both are performed with abduction in the scapular plane. Once rotated, the clinician pushes down on either the wrists or the elbow, and the individual is instructed to resist the downward pressure. The test is considered positive if weakness, pain, or both are present during resistance. A positive test result suggests a tear to the supraspinatus tendon or muscle, or neuropathy of the suprascapular nerve.
Pain or Weakness with Infraspinatus and Supraspinatus Maneuvers	Examples of tests used to diagnose pain or weakness in the infraspinatus and supraspinatus, which are muscles in the rotator cuff: • *External Lag Sign at 90 Degrees Test*: The individual is asked to sit with his back to the clinician who holds the individual's arm at 90 degrees of elevation in the scapular plane with the elbow flexed to 90 degrees and the shoulder externally rotated. The clinician then releases the wrist while supporting the elbow while asking the individual to maintain this position. The test is positive if a lag or drop occurs as the infraspinatus is responsible for holding the arm in external rotation in this position. The magnitude of the lag is recorded.

Test	Description
	• *Infraspinatus Test*: The individual stands with their shoulder fully adducted and their arm in neutral and the elbow flexed to 90 degrees. The shoulder is internally rotated to 45 degrees. The clinician then applies an internal rotation force to the forearm which the individual resists. Pain or weakness compared to the contralateral shoulder indicate infraspinatus pathology. • *Empty Can Test (or the similar Jobe's Test)*: The individual is asked to abduct their shoulder 90 degrees while keeping their arm straight with the shoulder in 30 degrees of forward flexion. The shoulder is then completely internally rotated by having the individual point their thumb down at the floor. The individual then resists the clinician's attempt to depress the arm. Pain without weakness suggests tendonitis while pain with weakness could be the result of partial or full thickness supraspinatus tear.
Liftoff/Modified Liftoff Test	Used to diagnose subscapularis tears. The liftoff test is performed by asking the individual to bring the arm behind their lower back with the palm facing outwards. The clinician applies resistance during this maneuver. If the individual exhibits pain or weakness, the test is considered positive. In the modified liftoff test, the clinician holds the individual's thumb in this position off the individual's back and then asks the individual to maintain the position. If the individual is unable to maintain this position and the hand falls back onto the lower back, this test is considered positive.
Belly-Press Test	Used to diagnose subscapularis tears in individuals who may have difficulty reaching behind their back. The individual is asked to hold the palm of their hand against their stomach with their elbow extended forward. The clinician then attempts to pull the wrist away from the individual's stomach while the individual resists this maneuver. If the elbow drops backwards or if there is pain or weakness during this maneuver, the test is considered positive.
Drop Arm Test	Used to assess for complete rotator cuff tears, particularly of the supraspinatus tendon. It is positive if there is pain while lowering the arm, sudden dropping of the arm or weakness in maintaining arm position during lowering (with or without pain), suggesting injury to the supraspinatus.

Drop Arm Test
The Drop Arm Test is usually more an indicator of full or complete rotator cuff injury. If this test is positive, documentation needs to be provided that the problem is partial rather than full thickness.

Conservative Treatment
As medically indicated, members with partial thickness rotator cuff tears should have non-surgical treatment documented in the medical record, including **all** of the following, unless contraindicated:

- Anti-inflammatory medications or analgesics
- Activity modification using the arm at or above the shoulder level
- Supervised physical therapy which could include an instructed home exercise program, including flexibility and muscle-strengthening exercises
- Therapeutic injections into the subacromial space in the shoulder as appropriate (recommended, but not required)
- Conservative treatment for at least six weeks is required except for injury caused by acute trauma or if pain precludes the individual from continuing with a conservative plan (e.g., physical therapy) and exacerbates symptoms

Note: Prior conservative treatment for at least six weeks is required except for injury caused by acute trauma needing urgent repair.

Coding
The use of 29822 (limited debridement) is always included in the primary procedure code for rotator cuff repair (29827) and should not be approved as a separate charge. Similarly, 29823 (extensive debridement) is generally included in 29827 when the debridement is in the same area as the rotator

cuff repair, such as when done for calcific tendonitis. Acromioplasty (29826) can be billed in addition to 29827.

Description

This medical policy is designed to enhance the long-term outcome of the arthroscopic treatment of partial thickness rotator cuff tears by ensuring that conservative therapies are initiated before the surgical procedure, and that every individual who undergoes this treatment knows exactly what to expect from the procedure chosen.

Related Policies

- Knee Arthroscopy in Knee Osteoarthritis

Benefit Application

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal mandates (e.g., Federal Employee Program [FEP]) prohibits plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

Regulatory Status

Arthroscopy of the shoulder is a surgical procedure and therefore is not regulated by the U.S. Food and Drug Administration (FDA).

Rationale

Background
Shoulder pain, reported by 18.7 million of those age 18 and older in 2012, is the second most common joint for chronic pain after knee pain.[2,] "Rotator cuff disorders comprise a large subset of shoulder disorders and are one of the most common causes of shoulder pain in the upper extremity, especially when pooled as a continuum from sub-acromial impingement/bursitis to rotator cuff degeneration/tear."[3,] According to the U.S. Department of Labor Bureau of Labor Statistics, 70,000 work-related shoulder injuries and illnesses involving days away from work were reported in the United States in 2016.[4,]

The rotator cuff is a group of muscles and tendons that form a cuff over the shoulder joint. The rotator cuff helps the shoulder joint to move and is responsible for lifting the arm over the head. Rotator cuff degeneration begins early in life, with partial and full thickness cuff tears increasing in frequency with age. Rotator cuff tears can occur in the tendon, on the bursal side, articular side, or a combination of both. The tears can be the result of normal shoulder use with micro-tearing that will eventually lead to a larger tear or from an injury. If left untreated, rotator cuff tears tend to progress over time.

Shoulder Arthroscopy

Arthroscopy is a surgical procedure in which the inside of the shoulder can be visualized and treated through the use of an arthroscope (a fiber-optic instrument with a camera attached to the end) that is inserted through a small incision in the shoulder. Looking at the interior of the joint on a monitor, the surgeon can then determine the amount or type of injury and, if necessary, take a biopsy specimen or repair or correct the problem. These images allow the surgeon to view in detail the inside of the shoulder and its structures. Arthroscopy can be used to diagnose and treat specific shoulder problems such as repairing cartilage or removing damaged tissue.

Arthroscopic surgery to repair a torn rotator cuff usually involves:

- The removal of loose bodies from the space where the rotator cuff moves
- Shaving bone or removing bone spurs from the point of the shoulder blade called subacromial smoothing, which will make more room for the rotator cuff so it's not pinched or irritated
- Sewing the torn edges of the tendon together and to top of the upper arm bone

Literature Review

In a systematic review of 7 articles by Eljabu et al (2015), the authors analyzed the current scientific evidence regarding the natural history of the clinical and anatomical progression of rotator cuff tears.[5,] They concluded that the development of symptoms and anatomical deterioration are often directly correlated. Spontaneous recovery to normal levels of function has been successfully achieved, and standardized non-operative treatment programs are an effective alternative to surgery for many individuals. Follow-up is necessary to avoid irreparable stage.

In a 2015 randomized controlled trial, Kukkonen et al compared the effectiveness of physio-therapy, acromioplasty, and rotator cuff repair for symptomatic, nontraumatic rotator cuff tears.[6,] One hundred and eighty shoulders with symptomatic, nontraumatic, supraspinatus tears were randomized into one of three cumulatively designed intervention groups: the physio-therapy-only group (denoted as Group 1), the acromioplasty and physiotherapy group (denoted as Group 2), and the rotator cuff repair, acromioplasty, and physiotherapy group (denoted as Group 3). The Constant score was the primary outcome measure. Secondary outcome measures were visual analog scale for pain, patient satisfaction, rotator cuff integrity in a control imaging investigation, and cost of treatment. At 2 years, 167 shoulders (160 individuals) were available for analysis. There were no significant differences ($p = 0.38$) in the mean change of Constant score: 18.4 points (95% confidence interval, 14.2 to 22.6 points) in Group 1, 20.5 points (95% confidence interval, 16.4 to 24.6 points) in Group 2, and 22.6 points (95% confidence interval, 18.4 to 26.8 points) in Group 3. There were no significant differences in visual analog scale for pain scores ($p = 0.45$) and patient satisfaction ($p = 0.28$) between the groups. At two years, the mean sagittal size of the tendon tear was significantly smaller ($p < 0.01$) in Group 3 (4.2 mm) compared with Groups 1 and 2 (11.0 mm). The authors concluded that conservative treatment is a reasonable option for the primary initial treatment for isolated, symptomatic, nontraumatic, supraspinatus tears in older individual.

In a systematic review by Seida et al (2010), the authors compared the benefits and harms of nonoperative and operative interventions on clinically important outcomes in adults with rotator cuff tears.[7,] All trials (N=137) had high risk for bias. Cohort and uncontrolled studies were of moderate quality. Reported functional outcomes did not differ between open versus mini-open repair, mini-open versus arthroscopic repair, arthroscopic repair with versus without acromioplasty, or single-row versus double-row fixation. Earlier return to work was reported for mini-open repair versus open repair and for continuous passive motion with physical therapy versus physical therapy alone. Open repairs showed greater improvement in function than did arthroscopic debridement. Complication rates were low across all interventions. The authors concluded that evidence on the comparative effectiveness and harms of various operative and nonoperative treatments for rotator cuff tears is limited and inconclusive.

In 2011, Strauss et al conducted a systematic review regarding the appropriate management of symptomatic partial-thickness rotator cuff tears. Sixteen studies met the inclusion criteria and were included for the final analysis.[8,] Among the 16 studies reviewed, excellent postoperative outcomes were reported in 28.7% to 93% of individuals treated. In all 12 studies with available preoperative baseline data, treatment resulted in significant improvement in shoulder symptoms and function. For high-grade lesions, the data support arthroscopic takedown and repair, transtendon repairs, and transosseous repairs, with all 3 techniques providing a high percentage of excellent results. Debridement of partial-thickness tears of less than 50% of the tendon's thickness with or without a concomitant acromioplasty also results in good to excellent surgical outcomes; however, a 6.5% to 34.6% incidence of progression to full-thickness tears is present. The authors concluded that significant variation is present in the results obtained after the arthroscopic management of partial-thickness rotator cuff tears. What can be supported by the available data is that tears that involve less than 50% of the tendon can be treated with good results by debridement of the tendon with or without a formal acromioplasty, although subsequent tear progression may occur. When the tear is greater than 50%, surgical intervention focusing on repair has been successful.

Summary of Evidence

Shoulder arthroscopy for the repair of rotator cuff tears and acromioplasty, subacromial decompression when performed at the same time as a rotator cuff repair is supported with sufficient clinical evidence in the published scientific literature as safe and effective when the medical necessity criteria is met.

Supplemental Information

Practice Guidelines and Position Statements

American Academy of Orthopaedic Surgeons (AAOS)

According to the 2010 AAOS Guideline and Evidence Report for Optimizing the Management of Rotator Cuff Problems (2010), the following is suggested[3,]:

Rotator Cuff Tears and Exercise

3. a. We cannot recommend for or against exercise programs (supervised or unsupervised) for individuals with rotator cuff tears.
Strength of Recommendation: Inconclusive

Rotator Cuff Related Symptoms and Exercise or Nonsteroidal Anti-Inflammatory Medication

4. a. We suggest that individuals who have rotator cuff-related symptoms in the absence of a full thickness tear be initially treated non-operatively using exercise and/or non-steroidal anti-inflammatory drugs.
Strength of Recommendation: Moderate

Surgery - Acromioplasty

8. We suggest that routine acromioplasty is not required at the time of rotator cuff repair.
Strength of Recommendation: Moderate

The Canadian Orthopaedic Association

According to The Canadian Orthopaedic Association's Preliminary Report – "Choosing Wisely." Identifying Musculoskeletal Interventions with Limited Levels of Efficacy in the Shoulder & Elbow, the following was mentioned regarding acromioplasty for the treatment of rotator cuff tears[25,]:

"1.3.2. Acromioplasty

- The addition of acromioplasty to rotator cuff repair has limited efficacy, as this procedure does not appear to improve pain or quality of life of individuals. Further studies are needed to conclusively determine the effect of acromioplasty on re-tear rate.

Impingement of the rotator cuff tendons has been identified as a potential contributor to the etiology of rotator cuff tears, leading to an increase in the adoption of acromioplasty as part of many rotator

cuff repair procedures. While removal of the acromion may, in theory, reduce the potential for re-tear, reduce pain and improve function, there is still a lack of compelling evidence to support this claim."

Medicare National Coverage

There is no national coverage determination (NCD). In the absence of an NCD, coverage decisions are left to the discretion of local Medicare carriers.

References

1. The American Academy of Orthopaedic Surgeons. Diseases and Conditions: Sprains, Strains and Other Soft-Tissue Injuries. June 2020. Accessed March 31, 2023 from https://orthoinfo.aaos.org/en/diseases--conditions/sprains-strains-and-other-soft-tissue-injuries/.
2. Weinstein SI, Yelin EH, Watkins-Castillo SI. United States Bone and Joint Initiative. The Burden of Musculoskeletal Diseases in the United States 3rd Edition. Chronic Joint Pain. 2014. Rosemont, IL. Accessed March 31, 2023 from http://www.boneandjointburden.org/2014-report/ib2/chronic-joint-pain.
3. American Academy of Orthopaedic Surgeons (AAOS). Guideline and Evidence Report. Appropriate Use Criteria for Optimizing the Management of Full-Thickness Rotator Cuff Tears. 2013. Accessed March 31, 2023 from https://www.aaos.org/globalassets/quality-and-practice-resources/rotator-cuff/auc-optimizing-management-full-thickness-rotator-cuff-tears.pdf.
4. U.S. Department of Labor Bureau of Labor Statistics. Case and Demographic Characteristics for Work-related Injuries and Illnesses Involving Days Away From Work: Calendar Year 2016 Survey Results. 2019. Accessed April 22, 2022 from https://www.bls.gov/iif/oshcdnew2016.htm.
5. Eljabu W, Klinger HM, von Knoch M. The natural history of rotator cuff tears: a systematic review. Archives of Orthopaedic and Trauma Surgery. 2015;135(8):1055-1061.
6. Kukkonen J, Joukainen A, Lehtinen J et al. Treatment of Nontraumatic Rotator Cuff Tears: A Randomized Controlled Trial with Two Years of Clinical and Imaging Follow-up. Journal of Bone and Joint Surgery. 2015;97(21):1729-1737.
7. Agency for Healthcare Research and Quality. Comparative Effectiveness of Nonoperative and Operative Treatment for Rotator Cuff Tears. Comparative Effectiveness Review No. 22. 2010. Accessed March 31, 2023 from https://effectivehealthcare.ahrq.gov/products/rotator-cuff-tear/research.
8. Strauss EJ, Salata MJ, Kercher J et al. The Arthroscopic Management of Partial-Thickness Rotator Cuff Tears: A Systematic Review of the Literature. Arthroscopy. 2011;27(4):568-580.
9. Elwyn G, Edwards A, Kinnersley P. Shared decision-making in primary care: the neglected second half of the consultation. Br J Gen Pract. 1999;49(443):477-482.
10. Elwyn G, Edwards A, Kinnersley P et al. Shared decision making and the concept of equipoise: the competences of involving patients in healthcare choices. Br J Gen Pract. 2000;50(460):892-899.
11. Gwyn R and Elwyn G. When is a shared decision not (quite) a shared decision? Negotiating preferences in a general practice encounter. Soc Sci Med. 1999;49(4):437-447.
12. Elwyn G, Edwards A, Wensing M et al. Shared decision making: developing the OPTION scale for measuring patient involvement. Qual Saf Health Care. 2003;12(2):93-99.
13. Charles C, Gafni A, Whelan T. Shared decision-making in the medical encounter: What does it mean? (or it takes at least two to tango) Soc Sci Med. 1997;44(5):681-692.
14. Charles CA, Whelan T, Gafni A. Shared treatment decision making: What does it mean to physicians? J Clin Oncol. 2003;21(5):932-936.
15. Murray E, Pollack L, White M et al. Clinical decision-making: Patients' preferences and experiences. Patient Educ Couns. 2007;65(2):189-196.

16. Braddock CH, 3rd, Fihn SD, Levinson W et al. How doctors and patients discuss routine clinical decisions. Informed decision making in the outpatient setting. J Gen Intern Med. 1997;12(6):339-345.
17. Wilson SR, Strub P, Buist AS et al. Shared treatment decision making improves adherence and outcomes in poorly controlled asthma. Am J Respir Crit Care Med. 2010;181(6):566-577.
18. Urowitz S, Deber R. How Consumerist Do People Want to Be? Preferred Role in Decision-Making of Individuals with HIV/AIDS. Healthc Policy. 2008;3(3):e168-e182.
19. White DB, Braddock CH, 3rd, Bereknyei S et al. Toward shared decision making at the end of life in intensive care units: opportunities for improvement. Arch Intern Med. 2007;167(5):461-467.
20. Informed Medical Decisions Foundation. Shared Decision Making and Evidence-Based Practice Unite in Sydney. 2015. Accessed April 07, 2021 from http://www.informedmedicaldecisions.org/2015/08/20/shared-decision-making-and-evidence-based-practice-unite-in-sydney/.
21. Arterburn D, Wellman R, Westbrook E et al. Introducing Decision Aids At Group Health Was Linked To Sharply Lower Hip And Knee Surgery Rates And Costs. Health Aff. 2012;31(9):2094-2104.
22. Elwyn G, Frosch D, Thomson R et al. Shared Decision Making: A Model for Clinical Practice. J Gen Intern Med. 2012;27(10):1361-7.
23. Barr PJ, Thompson R, Walsh T et al. The Psychometric Properties of CollaboRATE: A Fast and Frugal Patient-Reported Measure of the Shared Decision-Making Process. J Med Internet Res. 2014;16(1). Accessed March 31, 2023 from https://www.jmir.org/2014/1/e2/.
24. Elwyn G, Barr PJ, Grande SW et al. Developing CollaboRATE: a fast and frugal patient-reported measure of shared decision making in clinical encounters. Patient Educ Couns. 2013;93(1):102-7.
25. Canadian Orthopaedic Association. Identifying Musculoskeletal Interventions with Low or Limited Levels of Efficacy - 2016. Accessed April 22, 2022 from http://coa-aco.org/position-statements/knowledge-transfer-pillar/identifying-musculoskeletal-interventions-with-low-or-limited-levels-of-efficacy-2016/.

Documentation for Clinical Review

Please provide the following documentation:

- History and physical and/or consultation notes including:
  - Type of procedure
  - Reason for procedure
  - Clinical records indicating pain, loss of muscle strength of the rotator cuff musculature, and/or functional disability that interferes with ADLs
  - Documented positive result of one or more orthopedic tests (e.g., Neer Impingement Test, Hawkins Kennedy Impingement Test, Painful Arc Test, Full/Empty Can Test, External Lag Sign at 90 Degrees Test, Infraspinatus Test, Liftoff/Modified Liftoff Test, Belly-Press Test, Drop Arm Test)
  - Treatment plan
- Radiology reports (e.g., ultrasound, CT, MRI) used to make surgical decision
- Documented exclusion of other possible causative conditions
- Prior conservative treatments, duration, and response or reason conservative treatment is inappropriate
- Past and present diagnostic testing and results
- Pertinent past procedural and surgical history

Post Service (in addition to the above, please include the following):

- Procedure report(s)

Coding

This Policy relates only to the services or supplies described herein. Benefits may vary according to product design; therefore, contract language should be reviewed before applying the terms of the Policy.

The following codes are included below for informational purposes. Inclusion or exclusion of a code(s) does not constitute or imply member coverage or provider reimbursement policy. Policy Statements are intended to provide member coverage information and may include the use of some codes for clarity. The Policy Guidelines section may also provide additional information for how to interpret the Policy Statements and to provide coding guidance in some cases.

Type	Code	Description
CPT®	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])
	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
HCPCS	None	

Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

Effective Date	Action
06/01/2018	Custom Policy
12/01/2018	Policy revision without position change
07/01/2019	Administrative update
10/01/2019	Administrative update
05/01/2020	Annual review. Policy statement and guidelines updated.
01/01/2021	Coding update
05/01/2021	Annual review. No change to policy statement.
06/01/2022	Annual review. No change to policy statement.
05/01/2023	Annual review. Policy statement, guidelines and literature updated.

Definitions of Decision Determinations

Medically Necessary: Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by Blue Shield, are: (a) consistent

with Blue Shield medical policy; (b) consistent with the symptoms or diagnosis; (c) not furnished primarily for the convenience of the patient, the attending Physician or other provider; (d) furnished at the most appropriate level which can be provided safely and effectively to the patient; and (e) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's illness, injury, or disease.

Investigational/Experimental: A treatment, procedure, or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

Split Evaluation: Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a split evaluation, where a treatment, procedure, or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

Prior Authorization Requirements (as applicable to your plan)

Within five days before the actual date of service, the provider must confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department at (800) 541-6652, or the Transplant Case Management Department at (800) 637-2066 ext. 3507708 or visit the provider portal at www.blueshieldca.com/provider.

We are interested in receiving feedback relative to developing, adopting, and reviewing criteria for medical policy. Any licensed practitioner who is contracted with Blue Shield of California or Blue Shield of California Promise Health Plan is welcome to provide comments, suggestions, or concerns. Our internal policy committees will receive and take your comments into consideration.

For utilization and medical policy feedback, please send comments to: MedPolicy@blueshieldca.com

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.

Appendix A

POLICY STATEMENT	
BEFORE Red font: Verbiage removed	**AFTER** Blue font: Verbiage Changes/Additions
Partial Thickness Rotator Cuff Tears and Acromioplasty/ Subacromial Decompression BSC7.14 **Policy Statement:** **Shoulder Arthroscopy** Arthroscopy of the shoulder for the repair of partial thickness rotator cuff tears may be considered **medically necessary** when **all** of the following criteria are met: I. The patient and provider have reviewed, completed, and signed the Shoulder Arthroscopy Surgery Decision Aid, ensuring shared decision making has occurred (see Policy Guidelines) II. The patient has reviewed, completed, and signed the "CollaboRATE" survey III. Patient has painful range of motion, documented loss of muscle strength of the rotator cuff musculature, or documented shoulder function disability, **any** of which significantly interferes with the ability to perform activities of daily living, duties of employment, athletic participation, or sleep IV. Documentation of a positive result of **one or more** of the following orthopedic tests when compared to the non-affected side (see Policy Guidelines): A. Neer Impingement Test B. Hawkins Kennedy Impingement Test C. Painful Arc Test D. Full/Empty Can Test E. Pain or weakness with infraspinatus and supraspinatus maneuvers such as: 1. External Lag Sign at 90 Degrees Test 2. Infraspinatus Test 3. Empty Can Test (or the similar Jobe's Test) F. Liftoff/Modified Liftoff Test G. Belly-Press Test H. Drop Arm Test	**Partial Thickness Rotator Cuff Tears and Acromioplasty/ Subacromial Decompression BSC7.14** **Policy Statement:** **Shoulder Arthroscopy** I. Arthroscopy of the shoulder for the repair of partial thickness rotator cuff tears may be considered **medically necessary** when **all** of the following criteria are met: A. Individual has painful range of motion, documented loss of muscle strength of the rotator cuff musculature, or documented shoulder function disability, **any** of which significantly interferes with the ability to perform activities of daily living, duties of employment, athletic participation, or sleep B. Documentation of a positive result of **one or more** of the following orthopedic tests when compared to the non-affected side (see Policy Guidelines): 1. Neer Impingement Test 2. Hawkins Kennedy Impingement Test 3. Painful Arc Test 4. Full/Empty Can Test 5. Pain or weakness with infraspinatus and supraspinatus maneuvers such as: a. External Lag Sign at 90 Degrees Test b. Infraspinatus Test c. Empty Can Test (or the similar Jobe's Test) 6. Liftoff/Modified Liftoff Test 7. Belly-Press Test 8. Drop Arm Test

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V. Documentation, including formal radiological interpretation and detailed report of bony or soft tissue pathology or abnormality (e.g., ultrasound, CT scan, or MRI) that demonstrates rotator cuff pathology (Grade II – see Policy Guidelines) that corresponds with the patient's symptoms and clinical findings. In-office reports (ultrasound and x-rays) should include a comprehensive description of the radiographic findings. In rare instances where the imaging is normal and does not support the need for this procedure, the history, physical exam, and MD rationale need to clearly show why surgery is indicated on exception, including why another cause is less likely.	C. Documentation, including formal radiological interpretation and detailed report of bony or soft tissue pathology or abnormality (e.g., ultrasound, CT scan, or MRI) that demonstrates rotator cuff pathology (Grade II – see Policy Guidelines) that corresponds with the individual's symptoms and clinical findings. In-office reports (ultrasound and x-rays) should include a comprehensive description of the radiographic findings. In rare instances where the imaging is normal and does not support the need for this procedure, the history, physical exam, and MD rationale need to clearly show why surgery is indicated on exception, including why another cause is less likely.
VI. When present, other possible causative conditions of shoulder pain are documented to have been excluded, less likely, or mild in nature. These conditions may include but are not limited to glenohumeral arthritis, frozen shoulder/adhesive capsulitis, brachial plexus disorders, fracture, referred neck pain, and thoracic outlet syndrome.	D. When present, other possible causative conditions of shoulder pain are documented to have been excluded, less likely, or mild in nature. These conditions may include but are not limited to glenohumeral arthritis, frozen shoulder/adhesive capsulitis, brachial plexus disorders, fracture, referred neck pain, and thoracic outlet syndrome.
VII. Documentation of unsuccessful conservative therapy for at least six weeks (non-surgical medical management, see Policy Guidelines), or documentation of rationale if conservative therapy is considered inappropriate	E. Documentation of unsuccessful conservative therapy for at least six weeks (non-surgical medical management, see Policy Guidelines), or documentation of rationale if conservative therapy is considered inappropriate
Acromioplasty, Subacromial Decompression Acromioplasty and/or subacromial decompression may be considered **medically necessary** when performed at the same time as a rotator cuff repair when **either** of the following criteria are met: I. Documentation, including radiological interpretation and report of bony or soft tissue pathology (e.g., CT scan and/or MRI) demonstrating evidence of impingement II. Intra-operative decision based on subacromial space available after repair of a rotator cuff tear to avoid secondary mechanical impingement	**Acromioplasty, Subacromial Decompression** II. Acromioplasty and/or subacromial decompression may be considered **medically necessary** when performed at the same time as a rotator cuff repair when **either** of the following criteria are met: A. Documentation, including radiological interpretation and report of bony or soft tissue pathology (e.g., CT scan and/or MRI) demonstrating evidence of impingement B. Intra-operative decision based on subacromial space available after repair of a rotator cuff tear to avoid secondary mechanical impingement