



Shoulder Surgeries

Effective: December 1, 2025

Next Review: December 2026

Last Review: October 2025

IMPORTANT REMINDER

Medical Policies are developed to provide guidance for members and providers regarding coverage in accordance with contract terms. Benefit determinations are based in all cases on the applicable contract language. To the extent there may be any conflict between the Medical Policy and contract language, the contract language takes precedence.

PLEASE NOTE: Contracts exclude from coverage, among other things, services or procedures that are considered investigational or cosmetic. Providers may bill members for services or procedures that are considered investigational or cosmetic. Providers are encouraged to inform members before rendering such services that the members are likely to be financially responsible for the cost of these services.

DESCRIPTION

Shoulder pathology is a common indication and can be treated through surgical and non-surgical methods. Depending on the severity and location of the pathology, a variety of surgical methods may be indicated.

MEDICAL POLICY CRITERIA

Notes: This policy only applies to certain member contracts. Please check the pre-authorization website for the member contract to confirm requirements.

- I. Rotator cuff repair may be considered **medically necessary** when all of the following Criteria are met (A.-D.):
 - A. Documentation of function-limiting pain (e.g., loss of shoulder function which interferes with the ability to carry out activities of daily living and/or demands of employment); and
 - B. Either of the following criteria are met:
 1. Failure to respond to at least three months of non-surgical management which includes documentation of physical therapy or prescribed home exercise program and one or more of the following unless contraindicated:

- a. Trial of anti-inflammatory medication; or
 - b. Cortisone injection; or
 - 2. The individual suffers from a discrete traumatic event that results in an acute full-thickness rotator cuff tear and has associated function limiting pain; and
 - C. Individual meets all of the following Criteria (1. and 2.) on physical examination when compared to the non-involved side:
 - 1. Either of the following:
 - a. Functionally limited active range of motion; or
 - b. Measurable loss of strength of the rotator cuff musculature; and
 - 2. One or more of the following positive orthopedic tests/signs:
 - a. Drop Arm Test; or
 - b. Painful Arc Test; or
 - c. Jobe or Empty Can Test; or
 - d. External Rotation Lag Sign (Dropping Sign); or
 - e. Internal Rotation Lag Sign; or
 - f. Lift-Off Test; or
 - g. Bear Hug Test; or
 - h. Belly-Press Test (Napoleon); or
 - i. Belly-Off Test; or
 - j. Neer Impingement Test; or
 - k. Hawkins-Kennedy Impingement; or
 - l. Hornblower Test (Patte); and
 - D. Advanced diagnostic imaging study (e.g., MRI, CT) demonstrates a partial-thickness rotator cuff tear or a full-thickness rotator cuff tear that correlates with the individual's reported symptoms and physical exam findings.
- II. Labral repair with or without capsulorrhaphy may be considered **medically necessary** when all of the following Criteria are met (A.-D.):
- A. Documentation of function-limiting pain (e.g., loss of shoulder function which interferes with the ability to carry out activities of daily living and/or demands of employment); and
 - B. Either of the following criteria are met:
 - 1. Failure to respond to at least three months of non-surgical management which includes documentation of physical therapy or prescribed home exercise program and one or more of the following unless contraindicated
 - a. Trial of anti-inflammatory medication; or
 - b. Cortisone injection; or
 - 2. The individual suffers from an acute traumatic dislocation with imaging

documenting either acute capsule-labral separation or acute bony Bankart lesion and documented recurrent episodes of instability; and

- C. 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; and
- D. All of the following are met (1. and 2.) based on physical examination when compared to the non-involved side:
 - 1. Normal or minimally limited active or passive shoulder range of motion; and
 - 2. One or more of the following positive orthopedic tests:
 - a. O'Brien's Test; or
 - b. Biceps Load Test; or
 - c. Clunk Test; or
 - d. Anterior Slide Test; or
 - e. Compression Rotation Test; or
 - f. Speed's Test; or
 - g. Modified dynamic labral shear; or
 - h. Apprehension test; or
 - i. Anterior or posterior load and shift test; or
 - j. Positive sulcus sign.

III. Arthroscopic capsular release or lysis of adhesions may be considered **medically necessary** when all of the following criteria are met (A.-D.):

- A. Documentation of chronic refractory adhesive capsulitis or arthrofibrosis which has resulted from disease, injury, or surgery; and
- B. Documentation of function-limiting pain (e.g., loss of shoulder function which interferes with the ability to carry out activities of daily living and/or demands of employment); and
- C. Loss of range of motion in at least one plane of motion of the affected shoulder is reduced by 50% or more; and
- D. Failure to respond to at least three months of non-surgical management including at least two months of physical therapy and one or more of the following unless contraindicated:
 - 1. Trial of anti-inflammatory medication; or
 - 2. Cortisone injection.

IV. Distal clavicle excision may be considered **medically necessary** when all of the following criteria are met (A.-D.):

- A. Documentation of function-limiting pain (e.g., loss of shoulder function which interferes with the ability to carry out activities of daily living and/or demands of employment); and

- B. Documentation of one or more of the following positive orthopedic findings on physical examination:
 - 1. Localized tenderness to palpation of the acromioclavicular (AC) joint; or
 - 2. Cross Body Adduction Test; or
 - 3. Resisted AC Joint Extension Test; or
 - 4. Neer Impingement Test; or
 - 5. Hawkins-Kennedy Impingement Test; and
- C. Failure to respond to at least three months of non-surgical management which includes documentation of physical therapy or prescribed home exercise program and one or more of the following unless contraindicated:
 - 1. Trial of anti-inflammatory medication; or
 - 2. Cortisone injection; and
- D. Diagnostic imaging study (e.g., MRI, CT, plain radiographs) demonstrating underlying pathology (e.g., AC joint arthritis, impingement, etc.) which correlates with the individual's reported symptoms and physical exam findings.
- V. Subacromial decompression or acromioplasty may be considered **medically necessary** as an add-on procedure only when performed with other medically necessary primary shoulder surgical procedures and when all of the following criteria are met (A.-D.):
 - A. Documentation of function-limiting pain (e.g., loss of shoulder function which interferes with the ability to carry out activities of daily living and/or demands of employment); and
 - B. Documentation of one or more of the following positive orthopedic tests on physical examination:
 - 1. Cross Body Adduction Test; or
 - 2. Resisted AC Joint Extension Test; or
 - 3. Neer Impingement Test; or
 - 4. Hawkins-Kennedy Impingement Test; and
 - C. Failure to respond to at least three months of non-surgical management which includes documentation of physical therapy or prescribed home exercise program and one or more of the following unless contraindicated:
 - 1. Trial of anti-inflammatory medication; or
 - 2. Cortisone injection; and
 - D. Diagnostic imaging study (e.g., MRI, CT, plain radiographs) demonstrating underlying pathology (e.g., AC joint arthritis, impingement, etc.) which correlates with the individual's reported symptoms and physical exam findings.
- VI. Biceps tenodesis may be considered **medically necessary** when all of the following Criteria are met (A.-D.):

- A. Documentation of function-limiting pain (e.g., loss of shoulder function which interferes with the ability to carry out activities of daily living and/or demands of employment); and
- B. Failure to respond to at least three months of non-surgical management which includes documentation of physical therapy or prescribed home exercise program and one or more of the following unless contraindicated:
 - 1. Trial of anti-inflammatory medication; or
 - 2. Cortisone injection; and
- C. 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; and
- D. Documentation of one or more of the following positive orthopedic tests on physical examination:
 - a. O'Brien's Test; or
 - b. Biceps Load Test; or
 - c. Clunk Test; or
 - d. Anterior Slide Test; or
 - e. Compression Rotation Test; or
 - f. Speed's Test; or
 - g. Upper cut test; or
 - h. Popeye sign; or
 - i. Yergason's test; or
 - j. Proximal biceps (groove) tenderness.

VII. Arthroscopic loose body or foreign body removal may be considered **medically necessary** when all of the following criteria are met (A.-D.):

- A. Documentation of function-limiting pain (e.g., loss of shoulder function which interferes with the ability to carry out activities of daily living and/or demands of employment); and
- B. Mechanical symptoms including painful locking, clicking, catching, and/or popping; and
- C. Failure to respond to at least three months of non-surgical management which includes documentation of physical therapy or prescribed home exercise program and one or more of the following unless contraindicated:
 - 1. Trial of anti-inflammatory medication; or
 - 2. Cortisone injection; and
- D. Advanced diagnostic imaging study (e.g., MRI, CT) is conclusive for the presence of a loose body or foreign body within the shoulder joint.

VIII. Diagnostic arthroscopy of the shoulder may be considered **medically necessary** as a separate procedure when all of the following criteria have been met (A.-C.):

- A. Documentation of function-limiting pain (e.g., loss of shoulder function which interferes with the ability to carry out activities of daily living and/or demands of employment); and
- B. Failure to respond to at least three months of non-surgical management which includes documentation of physical therapy or prescribed home exercise program and one or more of the following unless contraindicated:
 - 1. Trial of anti-inflammatory medication; or
 - 2. Cortisone injection; and
- C. Advanced diagnostic imaging study (e.g., MRI, CT) is inconclusive for internal derangement/pathology.

IX. Synovectomy (partial or complete) is considered **medically necessary** when all of the following criteria have been met (A.-E.):

- A. Documentation of function-limiting pain (e.g., loss of shoulder function which interferes with the ability to carry out activities of daily living and/or demands of employment); and
- B. Individual demonstrates functionally limited range of motion (active or passive) on physical examination as compared to the non-involved side; and
- C. Failure to respond to at least three months of non-surgical management which includes documentation of physical therapy or prescribed home exercise program and one or more of the following unless contraindicated:
 - 1. Trial of anti-inflammatory medication; or
 - 2. Cortisone injection; and
- D. 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; and
- E. Presence of ONE of the following:
 - 1. Inflammatory arthritis (i.e., rheumatoid arthritis, gout, pseudogout, psoriatic arthritis); or
 - 2. Pigmented villonodular synovitis; or
 - 3. Synovial chondromatosis; or
 - 4. Lyme synovitis; or
 - 5. Hemophilia; or
 - 6. Hemochromatosis; or
 - 7. Non-specific synovitis (including proliferative synovitis, post-operative synovitis as a sequela from a shoulder replacement, etc.); or
 - 8. Recurrent hemarthrosis (i.e., secondary to sickle cell anemia, bleeding diathesis, etc.).

X. Debridement (limited or extensive) with or without removal of subdeltoid calcareous deposits is considered **medically necessary** when all of the following criteria have been met (A.-D.):

A. Documentation of function-limiting pain (e.g., loss of shoulder function which interferes with the ability to carry out activities of daily living and/or demands of employment); and

B. Physical exam findings include all of the following:

1. Functionally limited range of motion or measurable loss of strength; and

2. Documentation of one or more of the following positive orthopedic tests:

a. Drop Arm Test; or

b. Painful Arc Test; or

c. Jobe or Empty Can Test; or

d. External Rotation Lag Sign; or

e. Lift-Off Test; or

f. Belly-Press Test; or

g. Cross Body Adduction Test; or

h. Resisted AC Joint Extension Test; or

i. Neer Impingement Test; or

j. Hawkins-Kennedy Impingement Test; or

k. O'Brien's Test; or

l. Biceps Load Test; or

m. Clunk Test; or

n. Anterior Slide Test; or

o. Compression Rotation Test; or

p. Speed's Test; and

C. Failure to respond to at least three months of non-surgical management which includes documentation of physical therapy or prescribed home exercise program and one or more of the following unless contraindicated:

1. Trial of anti-inflammatory medication; or

2. Cortisone injection; and

D. Advanced diagnostic imaging study (e.g., MRI, CT) demonstrates underlying pathology which correlates with the individual's reported symptoms and physical exam findings.

XI. Rotator cuff repair is considered **not medically necessary** in all other scenarios including but not limited to when Criterion I. is not met.

XII. Labral repair with or without capsulorrhaphy is considered **not medically necessary** in all other scenarios including but not limited to when Criterion II. is not met.

- XIII. Arthroscopic capsular release or lysis of adhesions is considered **not medically necessary** in all other scenarios including but not limited to when Criterion III. is not met.
- XIV. Distal clavicle excision is considered **not medically necessary** in all other scenarios including but not limited to when Criterion IV. is not met.
- XV. Subacromial decompression or acromioplasty is considered **not medically necessary** in all other scenarios including but not limited to when Criterion V. is not met or as a stand-alone procedure.
- XVI. Biceps tenodesis is considered **not medically necessary** in all other scenarios including but not limited to when Criterion VI. is not met.
- XVII. Loose body or foreign body removal is considered **not medically necessary** in all other scenarios including but not limited to when Criterion VII. is not met.
- XVIII. Diagnostic arthroscopy is considered **not medically necessary** in all other scenarios including but not limited to when Criterion VIII. is not met.
- XIX. Synovectomy is considered **not medically necessary** in all other scenarios including but not limited to when Criterion IX. is not met.
- XX. Debridement is considered **not medically necessary** in all other scenarios including but not limited to when Criterion X. is not met.

NOTE: A summary of the supporting rationale for the policy criteria is at the end of the policy.

LIST OF INFORMATION NEEDED FOR REVIEW

REQUIRED DOCUMENTATION:

The information below **must** be submitted for review to determine whether policy criteria are met. If any of these items are not submitted, it could impact our review and decision outcome.

- History and physical/chart notes
- Non-surgical management provided
- Diagnostic imaging reports
- Documentation of function-limiting pain
- Applicable physical examination findings including but not limited to orthopedic tests performed, pain scale(s), range of motion, and/or loss of strength.

CROSS REFERENCES

None

BACKGROUND

According to The American Academy of Orthopaedic Surgeons^[1]:

Shoulder disease is a major cause of musculoskeletal disability in the United States. Chronic shoulder pain has been estimated to affect approximately 8% of all American adults, second only to chronic knee pain in our society's burden of musculoskeletal disease. Rotator cuff pathology is the leading cause of shoulder-related disability seen

by orthopaedic surgeons, and surgical volume is on the rise. One study, for example, notes a 141% increase in rotator cuff repairs from 1996 to 2006 in the United States. Societal costs of a medical condition include direct and indirect costs. Direct costs are those associated with diagnosis and treatment, whereas indirect costs include lost income due to inability to work or lower wages, missed workdays, and disability payments. Approximately 4.5 million patient visits related to shoulder pain occur each year in the United States.

EVIDENCE SUMMARY

Systematic reviews (SRs) have evaluated the accumulated evidence for the shoulder procedures addressed in this policy. Therefore, this evidence review focuses on the most recent systematic reviews.

ROTATOR CUFF REPAIR

Systematic Reviews

Longo (2021) published a systematic review comparing conservative therapy and surgical management in patients with rotator cuff tears.^[2] The primary outcomes were Constant-Murley score (CMS) and visual analog scale (VAS) pain scores. Six studies were included in the review and the average CMS score at 12 months of follow up was 77.6 in the surgery group and 72.8 in the conservative group. The mean of VAS pain score at 12 months of follow-up was 1.4 ± 1.6 in the surgery group and 2.4 ± 1.9 in the conservative group. Quantitative synthesis showed better results in favor of the surgical group in terms of VAS pain score one year after surgery (-1.08 , 95% CI -1.58 to -0.58 ; $p < 0.01$).

Ryosa (2017) published a systematic review to assess the evidence on effectiveness of surgical repair or conservative treatment for rotator cuff tears.^[3] Three RCTs were included involving 252 patients with primary outcomes of pain and function scores. At one year follow, there was no significant difference in constant scores but there was a significant difference in VAS score in the surgery group. The authors concluded that conservative management should be the first line therapy in patients with rotator cuff tears and that surgery plays an important role for those who fail conservative management.

Gombera (2014) published a systematic review of rotator cuff repairs and glenohumeral instability to better understand when surgery is indicated and what type of procedure should be performed.^[4] The authors included 11 studies evaluating patients with rotator cuff tears resulting from shoulder dislocations. Across the included studies, surgical repair of the rotator cuff resulted in improved pain relief and patient satisfaction when compared to conservative therapy.

Section Summary

There is enough research to show that surgical repair of the rotator cuff can be a safe and effective treatment option in patients where conservative management has failed. It is important that conservative management is attempted as it may provide similar outcomes in pain and function scores in certain patient populations. For those who failed conservative management, surgical repair can play an important role in treatment. Additional systematic reviews support the surgical repair of rotator cuff tears.^[5 6]

LABRAL REPAIR

Systematic Reviews

Civan (2021) published a review of the treatment of SLAP tears to determine which modality was most effective in different clinical scenarios.^[7] Six studies were included and SLAP repair and biceps tenodesis (BT) were the two primary surgeries that were compared. The use of BT showed superior results in four of the six studies, but the difference was not statistically significant. Additionally, functional scoring outcomes were not statistically significant between groups. Overall, the return to report and previous level were higher in the BT group. The authors concluded that both surgical treatments may be effective in repairing SLAP tears, reducing pain, and improving function.

De Sa (2020) published a systematic review comparing labral repairs and BT for the management of SLAP tears across 23 studies. Isolated type II SLAP tears were treated via SLAP repair in 781 patients with a mean age of 35 years and a mean postoperative follow-up of 35 months. BT was performed in 100 patients with a mean age of 44 years and a mean postoperative follow-up of 32 months. Similar postoperative scores were noted in both the SLAP repair and BT groups for American Shoulder and Elbow Surgeons, Constant, UCLA, and VAS pain scores. The authors concluded that both SLAP repairs and BT are acceptable treatments for type II SLAP tears and that labral repair remains the most commonly performed procedure for this indication.

Gorantla (2010) published a systematic review of arthroscopic repair of type II SLAP lesions in patients with a minimum of two years of follow-up.^[8] Of the included studies, the percentage of good and excellent results ranged from 40-94% and return to previous level of play ranged from 20%-94% with overhead athletes being the most challenging population to return to previous levels. The authors concluded that arthroscopic repair of type II SLAP lesions resulted in overall excellent results for those not involved in overhead sports, which were much less predictable.

Section Summary

There is enough research to show that surgical repair of labral tears is a safe and effective treatment option for SLAP lesions or tears. The procedure has a good safety profile and allows patients to return to prior functioning with reduced pain. Biceps tenodesis may be an effective alternative treatment method in certain populations. Additional systematic reviews support the use of these techniques in individuals with labral tears.^[9-10]

ARTHROSCOPIC CAPSULAR RELEASE AND LYSIS OF ADHESIONS

Systematic Reviews

Rex (2021) published a systematic review evaluating nine RCTs in patients with primary frozen shoulder.^[11] The review compared the effectiveness of pre-specified physiotherapy techniques with a steroid injection (PTSI), manipulation under anesthesia (MUA) with a steroid injection, and arthroscopic capsular release (ACR). Results from the analysis showed the following comparisons between treatment types: ACR versus MUA: 0.21 (95% CI 0.00 to 0.42), ACR versus supportive care: -0.13 (95% CI -1.10 to 0.83), and ACR versus PTSI: 0.33 (95% CI 0.07 to 0.59) and 0.25 (95% CI -0.34 to 0.85), all favoring ACR; MUA versus supportive care: 0 (95% CI -0.44 to 0.44); and MUA versus PTSI: 0.12 (95% CI -0.14 to 0.37) favoring MUA. These results indicate that there is no clinically superior treatment option between ACR, MUA, and PTSI and all may serve an important clinical use.

Forsythe (2021) published a review on the efficacy of arthroscopic shoulder surgery for the treatment of adhesive capsulitis.^[12] A total of 66 studies were included with comparisons across a variety of interventions including physical therapy, shoulder injections, MUA, and ACR. A network meta-analysis demonstrated that ACR was the most effective treatment for increasing range of motion. Additionally, the most effective interventions for functional status were PT, MUA, injections, and ACR. There is no single treatment method that emerges as superior in regard to outcomes like ROM, pain, and functional status. Surgical techniques including ACR and MUA were effective in improving pain and ROM when conservative management failed.

Section Summary

There is enough research to show that arthroscopic capsular release and lysis of adhesions are safe and effective treatment options for frozen shoulder when conservative management fails. There is no clinically superior option for all scenarios although each of them has shown efficacy in reducing pain and improving range of motion.

DISTAL CLAVICLE EXCISION

Systematic Reviews

According to a review by Rabalais (2007), excision of the distal clavicle has become a standard surgical treatment option for AC joint arthritis and osteolysis refractory to conservative therapy.^[13] The review assessed whether other treatment options such as direct (superior) arthroscopic excision or indirect (bursal) arthroscopic excision provided superior results compared to distal clavicle excision. The literature supports surgical excision, but the reports are all Level III or IV evidence consisting largely of retrospective case series. Arthroscopic distal clavicle resection has provided more "good or excellent" results than has the open procedure. Distal clavicle resection has provided satisfactory results when combined with other procedures.

SUBACROMIAL DECOMPRESSION AND ACROMIOPLASTY

Systematic Reviews

A Cochrane review of subacromial decompression surgery for rotator cuff disease was published in 2019 reviewing the benefits and harms of the procedure.^[14] A total of eight trials were included with 1,062 patients with subacromial impingement. Two trials (506 participants) compared arthroscopic subacromial decompression with arthroscopy only (placebo surgery), with all groups receiving postoperative exercises. These trials included a third treatment group: no treatment (active monitoring) in one and exercises in the other. Six trials (556 participants) compared arthroscopic subacromial decompression followed by exercises with exercises alone. Two of these trials included a third arm: sham laser in one and open subacromial decompression in the other. Trial size varied from 42 to 313 participants. Participant mean age ranged between 42 and 65 years. Only two trials reported mean symptom duration (18 to 22 months in one trial and 30 to 31 months in the other), two did not report duration and four reported it categorically. Both placebo-controlled trials were at low risk of bias for the comparison of surgery versus placebo surgery. The other trials were at high risk of bias for several criteria, most notably at risk of performance or detection bias due to lack of participant and personnel blinding.

Compared with placebo, high-certainty evidence indicates that subacromial decompression provides no improvement in pain, shoulder function, or health-related quality of life up to one year, and probably no improvement in global success (moderate-certainty evidence, downgraded due to imprecision). At one year, mean pain (on a scale zero to 10, higher scores indicate more pain), was 2.9 points after placebo surgery and 0.26 better (0.84 better to 0.33 worse), after subacromial decompression (284 participants), an absolute difference of 3% (8% better to 3% worse), and relative difference of 4% (12% better to 5% worse). At one year, mean function (on a scale 0 to 100, higher score indicating better outcome), was 69 points after placebo surgery and 2.8 better (1.4 worse to 6.9 better), after surgery (274 participants), an absolute difference of 3% (7% better to 1% worse), and relative difference of 9% (22% better to 4% worse). Global success rate was 97/148 (or 655 per 1000), after placebo and 101/142 (or 708 per 1000) after surgery corresponding to RR 1.08 (95% CI 0.93 to 1.27). Health-related quality of life was 0.73 units (European Quality of Life EQ-5D, -0.59 to 1, higher score indicating better quality of life), after placebo and 0.03 units worse (0.011 units worse to 0.06 units better), after subacromial decompression (285 participants), an absolute difference of 1.3% (5% worse to 2.5% better), and relative difference of 4% (15% worse to 7% better).

Adverse events including frozen shoulder or transient minor complications of surgery were reported in approximately 3% of participants across treatment groups in two randomized controlled trials, but due to low event rates we are uncertain if the risks differ between groups: 5/165 (37 per 1000) reported adverse events with subacromial decompression and 9/241 (34 per 1000) with placebo or non-operative treatment, RR 0.91 (95% CI 0.31 to 2.65) (moderate-certainty evidence, downgraded due to imprecision). The trials did not report serious adverse events. Based upon moderate-certainty evidence from two observational trials from the same prospective surgery registry, which also included other shoulder arthroscopic procedures (downgraded for indirectness), the incidence proportion of serious adverse events within 30 days following surgery was 0.5% (0.4% to 0.7%; data collected 2006 to 2011), or 0.6% (0.5 % to 0.7%; data collected 2011 to 2013). Serious adverse events such as deep infection, pulmonary embolism, nerve injury, and death have been observed in participants following shoulder surgery.

Section Summary

There is enough evidence to show that subacromial decompression as a standalone procedure in the treatment of rotator cuff pathology, including but not limited to subacromial impingement, does not result in improved health outcomes and may be of harm to patients undergoing the treatment. The use of subacromial decompression may be used as an adjunct procedure during other treatments for rotator cuff pathology such as tears, but not as a standalone procedure.

BICEPS TENODESIS

Systematic Reviews

Creech (2016) published a systematic review on the surgical indications for biceps tenodesis which included 39 studies.^[15] The most common indications for long head biceps tenodesis were partial tearing, instability, tenosynovitis, labral tear, or general positive clinical exams for long head biceps pain.

Frantz (2021) published a systematic review on the use of biceps tenodesis for superior labrum anterior-posterior tears in overhead athletes.^[16] A total of eight articles were included

and type II SLAP tears were the most common diagnosis. Combined reported postoperative functional scores were as follows: American Shoulder and Elbow Surgeons, 81.7 to 97; 12-Item Short Form Health Survey physical, 50 to 54; visual analog scale for pain, 0.8-1.5; Kerlan Jobe Orthopaedic Clinic, 66 to 79; and satisfaction, 80% to 87%. The overall return-to-sports rate for overhead athletes was 70%. For studies that clearly delineated outcomes based on level of play/athlete, the combined return-to-sports rate was 69% for recreational overhead athletes, 80% for competitive/collegiate athletes, and 60% for professionals. The authors concluded that biceps tenodesis in the overhead athlete has important functional and return to play outcomes.

Belk (2021) published a systematic review comparing biceps tenodesis to tenotomy in five RCTs including 236 patients.^[17] No differences in Constant-Murley, visual analog scale, or American Shoulder and Elbow Surgeons scores were found between groups in any study, and of all the studies evaluating strength and range of motion at latest follow-up, only 1 found a significant difference between groups, in which tenodesis patients demonstrated significantly increased forearm supination strength ($P = .02$). One study found tenodesis patients to experience significantly more biceps cramping at six-month follow-up compared with tenotomy patients ($P = .04$), although no differences in complication rates at latest follow-up were found in any study. The study concluded that treatment of these pathologies with either surgical technique can lead to similar improvements in patient-reported and functional outcomes.

Section Summary

There is enough research to show that biceps tenodesis is a safe and effective treatment option for different shoulder pathologies including SLAP tears and long head biceps tearing, pain, and/or instability when conservative management fails. The shoulder joint and treatments of pathologies in this area are complex and have a variety of clinically successful outcomes that should consider the unique anatomy and pathology of each scenario.

ARTHROSCOPY: DIAGNOSTIC, LOOSE BODY/FOREIGN BODY REMOVAL, SYNOVECTOMY (PARTIAL OR COMPLETE) OR DEBRIDEMENT (LIMITED OR EXTENSIVE)

Shoulder arthroscopy is a common orthopaedic procedure used for diagnostics and surgical treatment for some pathologic shoulder conditions.^[18] Shoulder arthroscopy has been recognized as both a diagnostic and therapeutic technique with a low incidence of complications. Arthroscopy has several advantages compared to open surgery, including a more comprehensive view of intra-articular pathology, smaller incisions with decreased morbidity, the potential for a more rapid rehabilitation, and a faster return to work.

Systematic Reviews

Acosta-Olivo (2021) published a SR evaluating the efficacy of arthrotomy, when compared with arthroscopy, in the treatment of adults with septic arthritis of any joint.^[19] Twenty studies (10,249 patients) were included in the analysis. The authors reported a significant lower risk of re-infection (odds ratio [OR], 1.35 [95% CI, 1.16-1.58]; $p = 0.0002$) and complications (OR, 1.32 [95% CI, 1.12-1.55]; $p = 0.001$) rate as well as less hospital stay (mean difference [MD], 0.57 days [95% CI, 0.10-1.05]; $p = 0.02$) favoring arthroscopic intervention. The subanalysis for shoulder septic arthritis intervened by arthrotomy had a higher risk of re-infection (OR, 1.24 [95% CI, 1.00-1.53]; $p = 0.04$). The authors conclude that patients with septic arthritis of the knee and shoulder treated by arthroscopy have less risk of re-infection than those treated by

arthrotomy. They also note that the quality of the body of evidence is still insufficient to reach reliable conclusions.

Williams (2020) published a SR describing outcomes, surgical procedures, and rates of conversion to arthroplasty after arthroscopic debridement of symptomatic primary glenohumeral osteoarthritis.^[20] A total of 371 patients (382 shoulders) in 8 studies were included in the analysis. Sample sizes ranged from 8 patients (9 shoulders) to 98 patients (107 shoulders), and the samples were predominantly comprised of male patients (range, 57.1%-100%). There was significant heterogeneity ($I^2 = 75\%$) in the rates of conversion to shoulder arthroplasty, which ranged from 4% to 42.4%, with the mean time to conversion ranging from 9 to 56 months. The authors conclude that Arthroscopic treatment of glenohumeral osteoarthritis provides improvements in ROM and patient-reported outcomes with minimal complications.

Despite variability in procedures and rates of subsequent conversion to arthroplasty, arthroscopic treatment appears to provide symptom relief and functional improvements in carefully selected patients. However, the longevity of improvement remains unclear, with studies including a longer duration of follow-up showing potential regression of symptom relief and increased rates of conversion to arthroplasty.

Section Summary

There are a few SRs on arthroscopy for specific procedures or injuries. Most studies are observational or case studies. Shoulder arthroscopy for diagnostics, loose body/foreign body removal, synovectomy and debridement, including removal of subdeltoid calcareous may be beneficial in certain conditions or procedures.

PRACTICE GUIDELINE SUMMARY

American Academy of Orthopaedic Surgeons^[1]

The American Academy of Orthopaedic Surgeons (AAOS) guidelines for the management of rotator cuff injuries provides moderate to strong recommendation based on the depth and quality of evidence for the following shoulder procedures: physical therapy and surgical management including acromioplasty, cuff repair, distal clavicle resection, and corticosteroid injections. The recommendations were established using methods of evidence-based medicine that rigorously control for bias, enhance transparency, and promote reproducibility.

SUMMARY

The current research for rotator cuff repair has shown improvement in health outcomes resulting in reduced pain and improved function in select individuals. Therefore, rotator cuff surgery is considered medically necessary in individuals who meet the policy criteria.

In those individuals who don't meet policy criteria, rotator cuff repair is considered not medically necessary because the procedure is not considered clinically effective or appropriate for these individuals.

The current research for labral tear repair has shown improvement in health outcomes resulting in reduced pain and improved function in select individuals. Therefore, labral repair surgery is considered medically necessary in individuals who meet the policy criteria.

In those individuals who don't meet policy criteria, labral repair is considered not medically necessary because the procedure is not considered clinically effective or appropriate for these individuals. The current research for arthroscopic capsular release or lysis of adhesions for treatment of shoulder pathologies has shown improvement in health outcomes resulting in reduced pain and improved function in select individuals. Therefore, arthroscopic capsular release or lysis of adhesions is considered medically necessary in individuals who meet the policy criteria.

In those individuals who don't meet policy criteria, arthroscopic capsular release or lysis of adhesions is considered not medically necessary because the procedure is not considered clinically effective or appropriate for these individuals.

The current research for distal clavicle excision for AC joint pathology has shown improvement in health outcomes resulting in reduced pain and improved function in select individuals. Therefore, distal clavicle excision is considered medically necessary in individuals who meet the policy criteria.

In those individuals who don't meet policy criteria, distal clavicle excision is considered not medically necessary because the procedure is not considered clinically effective or appropriate for these individuals.

Subacromial decompression or acromioplasty may be considered medically necessary as an add-on procedure only when performed with other medically necessary primary shoulder surgical procedures and policy criteria are met.

There is enough evidence to show that subacromial decompression as a standalone procedure in the treatment of rotator cuff pathology, including but not limited to subacromial impingement, does not result in improved health outcomes and may be of harm to individuals undergoing the treatment. Therefore, subacromial decompression or acromioplasty is considered not medically necessary when policy criteria are not met or as a standalone procedure. The use of subacromial decompression may be used as an adjunct procedure during other treatments for rotator cuff pathology such as tears, but not as a standalone procedure.

The current research for biceps tenodesis has shown improvement in health outcomes resulting in reduced pain and improved function in select individuals. Therefore, biceps tenodesis is considered medically necessary in individuals who meet the policy criteria.

In those individuals who don't meet policy criteria, biceps tenodesis is considered not medically necessary because the procedure is not considered clinically effective or appropriate for these individuals.

Arthroscopy for the purpose of diagnostics in shoulder injuries/pathology can result in improved health outcomes in select populations. Therefore, diagnostic arthroscopy of the shoulder is considered medically necessary in individuals who meet the policy criteria.

In those individuals who don't meet policy criteria, arthroscopy for the purpose of diagnostics in the shoulder is considered not medically necessary because the procedure is not considered clinically effective or appropriate for these individuals.

Arthroscopic removal of loose body or foreign bodies in the shoulder joint can result in improved health outcomes in select populations. Therefore, loose body or foreign body arthroscopic removal in the shoulder joint is considered medically necessary in individuals who meet the policy criteria.

In those individuals who don't meet policy criteria, arthroscopic loose body or foreign body removal in the shoulder joint is considered not medically necessary because the procedure is not considered clinically effective or appropriate for these individuals.

Synovectomy (partial or complete) in the shoulder joint using arthroscopy can result in improved health outcomes in select populations. Therefore, arthroscopic synovectomy (partial or complete) in the shoulder joint is considered medically necessary in individuals who meet the policy criteria.

In those individuals who don't meet policy criteria, arthroscopic synovectomy (partial or complete) is considered not medically necessary because the procedure is not considered clinically effective or appropriate for these individuals.

Debridement (limited or extensive) in the shoulder joint using, including removal of subdeltoid calcareous deposits, can result in improved health outcomes in select populations. Therefore, arthroscopic debridement (limited or extensive) in the shoulder joint, with or without removal of subdeltoid calcareous deposits, is considered medically necessary in individuals who meet the policy criteria.

In those individuals who don't meet policy criteria, arthroscopic debridement (limited or extensive) in the shoulder joint with or without removal of subdeltoid calcareous deposit is considered not medically necessary because the procedure is not considered clinically effective or appropriate for these individuals.

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CODES

Codes	Number	Description
CPT	23000	Removal of subdeltoid calcareous deposits, open
	23020	Capsular contracture release (eg, Sever type procedure)
	23120	Claviculectomy; partial

Codes	Number	Description
	23130	Acromioplasty or acromionectomy, partial, with or without coracoacromial ligament release
	23410	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute
	23412	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; chronic
	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
	23455	Capsulorrhaphy, anterior; with labral repair (eg, Bankart procedure)
	23462	Capsulorrhaphy, anterior, any type; with coracoid process transfer
	23466	Capsulorrhaphy, glenohumeral joint, any type multi-directional instability
	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
	29823	Arthroscopy, shoulder, surgical; debridement, extensive
	29824	Arthroscopy, shoulder, surgical; distal claviclectomy 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
HCPCS	None	

Date of Origin: December 2022