

Molina Clinical Policy

Shoulder Arthroscopy: Policy No. 404

Last Approval: 6/8/2022

Next Review Due By: June 2023



DISCLAIMER

This Molina Clinical Policy (MCP) is intended to facilitate the Utilization Management process. Policies are not a supplementation or recommendation for treatment; Providers are solely responsible for the diagnosis, treatment and clinical recommendations for the Member. It expresses Molina's determination as to whether certain services or supplies are medically necessary, experimental, investigational, or cosmetic for purposes of determining appropriateness of payment. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (e.g., will be paid for by Molina) for a particular Member. The Member's benefit plan determines coverage – each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their Providers will need to consult the Member's benefit plan to determine if there are any exclusion(s) or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and a Member's plan of benefits, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of a State, the Federal government or CMS for Medicare and Medicaid Members. CMS's Coverage Database can be found on the CMS website. The coverage directive(s) and criteria from an existing National Coverage Determination (NCD) or Local Coverage Determination (LCD) will supersede the contents of this MCP and provide the directive for all Medicare members. References included were accurate at the time of policy approval and publication.

OVERVIEW

Arthroscopy is a surgical procedure in which a small fiberoptic camera is inserted into the joint through a small incision. In addition to allowing the surgeon to visualize the joint, arthroscopy may also be utilized for treatment of a variety of conditions involving the joint structures. Surgical indications are based on relevant subjective clinical symptoms, objective physical exam & radiologic findings, and response to previous non-operative treatments when medically appropriate. Arthroscopic shoulder repair surgeries are performed as dictated by the type and severity of injury and/or disease.

COVERAGE POLICY

This policy addresses arthroscopic procedures when performed as an elective, non-emergent technique for disease pathology that will cause progressive destruction.

For *Rotator Cuff Repair* criteria, please refer to MCG.

1. Diagnostic arthroscopy may be considered medically necessary when **ALL** of the following criteria are met:
 - a. Severe, disabling pain and/or a documented loss of shoulder function which interferes with the ability to carry out age appropriate activities of daily living; **AND**
 - b. Abnormal, shoulder physical examination findings as compared to the non-involved side that includes any of the following:
 - Functionally limited range of motion (active or passive); **OR**
 - Measurable loss in strength; **OR**
 - Positive impingement signs.

AND

- c. Failure of non-surgical management for at least three (3) months in duration including at least two of the following as appropriate:
 - Activity modification; **OR**
 - Assistive devices (e.g., sling, splint, brace); **OR**
 - Physical therapy; **OR**
 - Physician or physical therapist-supervised therapeutic home exercise program which includes flexibility and muscle strengthening exercises; **OR**
 - Prescription strength anti-inflammatory medications and analgesics; **OR**
 - Intraarticular corticosteroid injection(s);

AND

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- d. Radiographic work-up completed that includes MRI/CT imaging that is inconclusive for internal derangement pathology; **AND**
 - e. Other potential diagnostic conditions (e.g., fracture, thoracic outlet syndrome, brachial plexus disorders, referred neck pain and arthritis) have been excluded.
2. Arthroscopic debridement (limited or extensive) **may be considered medically necessary** when **ALL** of the following criteria have been met:
- a. Severe, disabling pain and/or a documented loss of shoulder function which interferes with the ability to carry out age appropriate activities of daily living; **AND**
 - b. Abnormal, shoulder physical examination findings as compared to the non-involved side that includes **ONE** of the following:
 - Functionally limited range of motion; **OR**
 - Measurable loss of strength.

AND

- c. One or more of the following positive orthopedic tests/signs:
 - Anterior Slide Test
 - Belly-Press Test
 - Biceps Load Test
 - Clunk Test
 - Compression Rotation Test
 - Cross Body Adduction Test
 - Drop Arm Test
 - External Rotation Lag Sign
 - Hawkins-Kennedy Impingement Test
 - Jobe or Empty Can Test
 - Lift-Off Test
 - Neer Impingement Test
 - O'Brien's Test
 - Painful Arc Test
 - Resisted AC Joint Extension Test
 - Speed's Test

AND

- d. Failure of non-surgical management for at least three (3) months in duration including at least two of the following as appropriate:
 - Activity modification; **OR**
 - Assistive devices (e.g., sling, splint, brace); **OR**
 - Physical therapy; **OR**
 - Physician or physical therapist-supervised therapeutic home exercise program which includes flexibility and muscle strengthening exercises; **OR**
 - Prescription strength anti-inflammatory medications and analgesics; **OR**
 - Intraarticular corticosteroid injection(s).

AND

- e. Radiographic work-up completed that includes MRI/CT imaging that demonstrates underlying pathology and correlates with reported symptoms and physical exam findings; **AND**
- f. Other potential diagnostic conditions (e.g., fracture, thoracic outlet syndrome, brachial plexus disorders, referred neck pain and arthritis) have been excluded.

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3. Arthroscopic loose body or foreign body removal **may be considered medically necessary** when **ALL** of the following criteria have been met:
- Severe, disabling pain and/or a documented loss of shoulder function which interferes with the ability to carry out age appropriate activities of daily living; **AND**
 - Mechanical symptoms including painful locking, clicking, catching, or popping; **AND**
 - Failure of non-surgical management for at least three (3) months in duration, except when the loose body or foreign body has caused an acute restriction of shoulder joint range of motion (e.g., locking) including at least two of the following as appropriate:
 - Activity modification; **OR**
 - Assistive devices (e.g., sling, splint, brace); **OR**
 - Physical therapy; **OR**
 - Physician or physical therapist-supervised therapeutic home exercise program which includes flexibility and muscle strengthening exercises; **OR**
 - Prescription strength anti-inflammatory medications and analgesics; **OR**
 - Intraarticular corticosteroid injection(s).

AND

- Radiographic work-up completed that includes MRI/CT imaging that is conclusive for the presence of a loose body or foreign body within the shoulder joint; **AND**
 - Other potential diagnostic conditions (e.g., fracture, thoracic outlet syndrome, brachial plexus disorders, referred neck pain and arthritis) have been excluded.
4. Arthroscopic Synovectomy (partial or complete) **may be considered medically necessary** when **ALL** of the following criteria have been met:
- Severe, disabling pain and/or a documented loss of shoulder function which interferes with the ability to carry out age appropriate activities of daily living; **AND**
 - Demonstration of functionally limited range of motion (active or passive) on physical examination as compared to the non-involved side; **AND**
 - Failure of non-surgical management for at least three (3) months in duration, including at least two of the following as appropriate:
 - Activity modification; **OR**
 - Assistive devices (e.g., sling, splint, brace); **OR**
 - Physical therapy; **OR**
 - Physician or physical therapist-supervised therapeutic home exercise program which includes flexibility and muscle strengthening exercises; **OR**
 - Prescription strength anti-inflammatory medications and analgesics; **OR**
 - Intraarticular corticosteroid injection(s)

AND

- Radiographic work-up completed that includes MRI/CT imaging that demonstrates underlying pathology consistent with the individual's reported medical condition (e.g., synovitis, joint effusion) which correlates with reported symptoms and physical exam findings; **AND**
- Diagnosis of **ONE** of the following conditions:
 - Inflammatory arthritis (i.e., rheumatoid arthritis, gout, pseudogout, psoriatic arthritis); **OR**
 - Hemochromatosis; **OR**
 - Hemophilia; **OR**
 - Lyme synovitis; **OR**

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- Non-specific synovitis (including proliferative synovitis, post-operative synovitis as a sequela from a shoulder replacement, etc.); **OR**
- Other potential pathological conditions have been excluded (e.g.; fracture, thoracic outlet syndrome, brachial plexus disorders, referred neck pain, and arthritis); **OR**
- Pigmented villonodular synovitis (PVNS); **OR**
- Recurrent hemarthrosis secondary to sickle cell anemia, or bleeding diathesis; **OR**
- Synovial chondromatosis.

AND

- f. Other potential diagnostic conditions (e.g., fracture, thoracic outlet syndrome, brachial plexus disorders, referred neck pain and arthritis) have been excluded.
5. Arthroscopic repair of labral tear or superior labral anterior posterior (SLAP) lesion (e.g., Labral repair/biceps tenodesis) **may be considered medically necessary** when **ALL** of the following criteria are met:
- a. Severe, disabling pain and/or a documented loss of shoulder function which interferes with the ability to carry out age appropriate activities of daily living; **AND**
- b. Demonstration of BOTH of the following on physical examination when compared to the non-involved side:
- Minimally limited or full shoulder range of motion aggravated by heavy lifting, pushing, and overhead motion; and
 - One or more of the following positive orthopedic tests:
 - i. Anterior Slide Test; **OR**
 - ii. Biceps Load Test; **OR**
 - iii. Clunk Test; **OR**
 - iv. Compression Rotation Test; **OR**
 - v. O'Brien's Test; **OR**
 - vi. Speed's Test.

AND

- c. Failure of non-surgical management for at least three (3) months in duration, including at least two of the following as appropriate:
- Activity modification
 - Assistive devices (e.g., sling, splint, brace)
 - Physical therapy
 - Physician or physical therapist-supervised therapeutic home exercise program which includes flexibility and muscle strengthening exercises
 - Prescription strength anti-inflammatory medications and analgesics
 - Intraarticular corticosteroid injection(s); and
- d. Radiographic work-up completed that includes MRI/CT imaging that demonstrates labral tear/biceps tendon pathology (e.g., SLAP, Bankart) and correlates with reported symptoms and physical exam findings; **AND**
- e. Other potential diagnostic conditions (e.g., fracture, thoracic outlet syndrome, brachial plexus disorders, referred neck pain and arthritis) have been excluded.
6. Arthroscopic distal clavicle excision and subacromial decompression/acromioplasty **may be considered medically necessary** when **ALL** of the following criteria have been met:
- a. Severe, disabling pain and/or a documented loss of shoulder function which interferes with the ability to carry out age appropriate activities of daily living; **AND**
- b. Demonstration of localized tenderness to palpation of the acromioclavicular (AC) joint (not required for subacromial decompression/acromioplasty); **AND**

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- c. One or more of the following positive orthopedic tests on physical examination when compared to the non-involved side:
 - Cross Body Adduction Test; **OR**
 - Hawkins-Kennedy Impingement Test; **OR**
 - Neer Impingement Test; **OR**
 - Resisted AC Joint Extension Test.

AND

- d. Failure of non-surgical management for at least three (3) months in duration, including at least two of the following as appropriate:
 - Activity modification; **OR**
 - Assistive devices (e.g., sling, splint, brace); **OR**
 - Physical therapy; **OR**
 - Physician or physical therapist-supervised therapeutic home exercise program which includes flexibility and muscle strengthening exercises; **OR**
 - Prescription strength anti-inflammatory medications and analgesics; **OR**
 - Intraarticular corticosteroid injection(s).

AND

- e. Plain radiographs demonstrate findings consistent with pathology in the subacromial space and/or at the AC joint; **AND**
 - f. Radiographic work-up completed that includes MRI/CT imaging that demonstrates underlying pathology (e.g., AC joint arthritis, impingement, etc.) which correlates with reported symptoms and physical exam findings. *NOTE: Advanced diagnostic imaging is not required for isolated distal clavicle excision when not associated with subacromial decompression/acromioplasty surgery;* **AND**
 - g. Other potential diagnostic conditions (e.g., fracture, thoracic outlet syndrome, brachial plexus disorders, referred neck pain and arthritis) have been excluded.
7. Arthroscopic capsulorrhaphy (Bankart procedure) for shoulder instability and/or laxity **may be considered medically necessary** when **ALL** of the following criteria have been met:
- a. Documented history of “post-traumatic” or “atraumatic” instability and/or laxity that has resulted in severe, disabling pain and/or a documented loss of shoulder function which interferes with the ability to carry out age appropriate activities of daily living; **AND**
 - b. Demonstration of one or more of the following positive orthopedic tests on physical examination when compared to the non-involved side:
 - Anterior or Posterior Apprehension Test; **OR**
 - Load and Shift Test; **OR**
 - Sulcus Sign.

AND

- c. Failure of non-surgical management for at least three (3) months in duration that includes shoulder stabilization/strengthening exercises except when met in an acute traumatic injury setting for irreducible shoulder dislocation or anterior shoulder instability in competitive contact or collision athletes; **AND**
- d. Radiographic work-up completed that includes MRI/CT imaging that demonstrates labral tear/biceps tendon pathology (e.g., SLAP, Bankart) and correlates with reported symptoms and physical exam findings; **AND**
- e. Other potential diagnostic conditions (e.g., fracture, thoracic outlet syndrome, brachial plexus disorders, referred neck pain and arthritis) have been excluded.

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8. Arthroscopic capsular release/lysis of adhesions/manipulation under anesthesia (MUA) for an individual with documented chronic refractory adhesive capsulitis/arthrofibrosis (frozen shoulder) which has resulted from disease, injury or surgery **may be considered medically necessary** when **ALL** of the following are met:
- Severe, disabling pain and/or a documented loss of shoulder function which interferes with the ability to carry out age appropriate activities of daily living; **AND**
 - Demonstration of functional limitations and painful loss of active and passive range of motion of at least 50% when compared to the non-involved side; **AND**
 - Failure of non-surgical management for at least three (3) months in duration that includes **ALL** of the following as appropriate:
 - Anti-inflammatory medication; **AND**
 - Cortisone injection; **AND**
 - At minimum of two (2) months of physical therapy (i.e., active exercise and manual therapy designed to increase joint mobility and range of motion).

AND

- Other potential diagnostic conditions (e.g., fracture, thoracic outlet syndrome, brachial plexus disorders, referred neck pain and arthritis) have been excluded.

Limitations and Exclusions

Arthroscopic shoulder procedures are considered not medically necessary for any other indication or condition not detailed above.

DOCUMENTATION REQUIREMENTS. Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.

SUMMARY OF MEDICAL EVIDENCE

There is an abundance of lower quality literature in the peer reviewed medical journals regarding arthroscopic shoulder procedures as a treatment for disease and injury. The majority of the literature does not compare one procedure to other and consists of observational case studies based on disease or illness. There are a few systematic reviews on specific disease or injury. These studies generally demonstrated a reduction in pain, and an increase in functional ability including activities of daily living for arthroscopic shoulder procedures as a treatment for disease and injury.

For a list of evidence-based literature used in the creation and review of this policy, please see the references section.

SUPPLEMENTAL INFORMATION

Definitions

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

Adhesive Capsulitis – also called frozen shoulder, is a disabling and sometimes severely painful condition resulting from excessive scar tissue or adhesions across the glenohumeral joint capsule, leading to stiffness, pain, and limited passive and active range of motion in shoulder and is clinically divided into classes:

- Primary adhesive capsulitis is characterized by a significant limitation of both active and passive motions on the shoulder; individuals are typically unable to recall a possible cause of the condition (idiopathic adhesive capsulitis).

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- Secondary adhesive capsulitis is characterized by a trauma or a possible cause prior to the onset of the symptoms, such as fracture of the humerus, rotator cuff repair, shoulder girdle injury/surgery, or prolonged immobilization.

Distal Clavicle Excision – the removal of the end of the clavicle at the acromioclavicular (AC) joint. The superior AC ligament remains intact so that the joint remains stable.

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

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

- **Bankart Tear** is a tear in the labrum located in the front, lower (anterior, inferior) part of the glenoid. This type of tear occurs most commonly during a shoulder dislocation and makes the shoulder more prone to recurrent dislocations.
- **SLAP Tear (Superior Labral, Anterior and Posterior tear)** A SLAP tear is an injury to the superior labrum, extending anterior to posterior of the biceps tendon attachment, which may include disruption of the origin of the long head of biceps brachii. SLAP tears are commonly found in athletes involved in overhead activities (such as baseball pitchers), and range of motion deficits. Scapula dyskinesia may increase risk of SLAP tears.

Shoulder Dislocation – the complete loss of the humeral articulation with the glenoid fossa, usually as a result of acute trauma.

Shoulder Instability/Laxity – a partial loss of the glenohumeral articulation. Two categories are identified: Post traumatic shoulder instability includes an individual with a previous injury that has stretched or torn the ligaments of the shoulder. A traumatic instability/loose shoulder joint includes an individual with generalized looseness of the joints “double-jointed” or “multi-directional instability” usually representing a type of congenital ligamentous laxity.

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

Subacromial Decompression – the removal of bone or other abnormality to enlarge the space between the rotator cuff musculature and the acromion.

Synovitis – common in many shoulder conditions and typically resolves when the primary pathology is treated. Most commonly, this includes loose bodies, inflammatory arthritis or degenerative arthritis, labral tears and adhesive capsulitis.

CODING & BILLING INFORMATION

CPT Codes

CPT	Description
29805	Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure)
29806	Arthroscopy, shoulder, surgical; capsulorrhaphy
29807	Arthroscopy, shoulder, surgical; repair of SLAP lesion
29819	Arthroscopy, shoulder, surgical; with removal of loose body or foreign body
29820	Arthroscopy, shoulder, surgical; synovectomy, partial
29821	Arthroscopy, shoulder, surgical; synovectomy, complete
29822	Arthroscopy, shoulder, surgical; debridement, limited, 1 or 2 discrete structures (e.g., humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies])
29823	Arthroscopy, shoulder, surgical; debridement, extensive, 3 or more discrete structures (e.g., humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator

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	cuff, subacromial bursa, foreign body[ies])
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

CODING DISCLAIMER. Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does not guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.

APPROVAL HISTORY

06/08/2022 Policy reviewed, no changes.
06/09/2021 New policy.

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APPENDIX

Reserved for State specific information. Information includes, but is not limited to, State contract language, Medicaid criteria and other mandated criteria.