

BSC7.14	Partial Thickness Rotator Cuff Tears and Acromioplasty/ Subacromial Decompression		
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Section:	7.0 Surgery	Page:	Page 1 of 15

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](#)
- 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.
- 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.
- 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

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

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 Surgeons¹ 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 patient's scapula with one hand, while passively flexing the arm while it is internally rotated. If the patient 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 patient'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 patient reports pain between 60 degrees and 120 degrees of abduction. Pain should reduce after 120 degrees of abduction. If the patient 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 patient 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 Infrapinatus and Supraspinatus Maneuvers	Examples of tests used to diagnose pain or weakness in the infrapinatus and supraspinatus, which are muscles in the rotator cuff: <ul style="list-style-type: none"> • <i>External Lag Sign at 90 Degrees Test:</i> The patient is asked to sit with his back to the clinician who holds the patient'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 patient to maintain this position. The test is positive if a lag or drop occurs as the infrapinatus is responsible for holding the arm in external rotation in this position. The magnitude of the lag is recorded. • <i>Infrapinatus Test:</i> The patient stands with their shoulder fully adducted and their arm in neutral and the elbow flexed to 90 degrees. The

Test	Description
	<p>shoulder is internally rotated to 45 degrees. The clinician then applies an internal rotation force to the forearm which the patient resists. Pain or weakness compared to the contralateral shoulder indicate infraspinatus pathology.</p> <ul style="list-style-type: none"> • <i>Empty Can Test (or the similar Jobe's Test)</i>: The patient 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 patient point their thumb down at the floor. The patient 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 patient to bring the arm behind their lower back with the palm facing outwards. The clinician applies resistance during this maneuver. If the patient exhibits pain or weakness, the test is considered positive. In the modified liftoff test, the clinician holds the patient's thumb in this position off the patient's back and then asks the patient to maintain the position. If the patient 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 patients who may have difficulty reaching behind their back. The patient 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 patient's stomach while the patient 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 patient 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.

Shoulder Arthroscopy Decision Aid

Use of decision aids can promote shared decision making, and may improve patients understanding and enable them to make decisions that are more fully informed and consistent with their preferences, values and goals. A decision aid is a tool used to inform patients about available treatments, along with potential benefits, risks and costs, during clinical encounters.

The decision aid is intended for use following the patient pre-operative education course. The resulting decision aid is intended to be nondirective, encouraging clinicians to create a conversation with patients using their own communication styles, while simultaneously ensuring that key information is conveyed and that patient preferences are elicited. Blue Shield of California considers the use of decision aids as a higher level of informed consent and requires patients to acknowledge receipt, review, and sign the Enhanced Clinical Programs (ECP) Shoulder Arthroscopy decision aid as a pre-authorization requirement.

Shared Decision Making

Shared Decision Making (SDM) is a process in which patients openly explore with the aid of their physician both the available evidence supporting each therapeutic intervention, and also determine what matters most to the patient. This allows both the physician and the patient to reach agreed-upon treatment decisions reflecting mutual goals and expected outcomes. The completion of the CollaboRATE survey and signing of the appropriate shoulder surgery decision aid by the member helps to assure the member's personal preferences have been considered.

CollaboRATE

Patient-centered health care is a central component of current health policy agendas. CollaboRATE is a 3-Item questionnaire that measures the level of shared decision making in the clinical encounter from the patient's perspective. In the questionnaire, the patient rates, on a scale of 1 to 9, the provider's efforts to understand the surgical plan of care from the patient's perspective. The CollaboRATE SDM tool has demonstrated discriminative validity, concurrent validity, intra-rater reliability, and sensitivity to change.

To access further information, please visit the following website: <http://www.jmir.org/2014/1/e2/>.

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.

Effective January 1, 2021, the following CPT codes have been **revised**:

- **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])

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 patient who undergoes this treatment knows exactly what to expect from the procedure chosen. A decision aid and a shared decision making tool have been incorporated to improve the knowledge, adjust unrealistic expectations, and elicit values about the benefit desired and the degree of acceptable risks for the patient contemplating the procedure.

Determining how to help physicians better incorporate clinical guidelines and evidence-based medicine into this decision-making has important implications for successful patient outcomes after an arthroscopic procedure for partial thickness rotator cuff tears. Therefore, reducing the incidence of “inappropriate” shoulder arthroscopy procedures and eliminating overuse helps to ensure that the most appropriate care to Blue Shield members is being delivered.

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 patients. Follow-up is necessary to avoid irreparable stage.

In a 2015 randomized controlled trial, Kukkonen et al compared the effectiveness of physiotherapy, 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 physiotherapy-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 patients) 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 patients.

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 patients 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.

Shared Decision Making (SDM)

Shared decision making (SDM) is promoted as an ideal model to incorporate in the treatment plan between patient and physician. This is based on the premise that the best medical decision for an individual patient incorporates the patient's preferences and values through the process of information sharing and planning. This idea involves at least two participants; the clinician and the patient.⁹⁻¹⁴ It represents the optimal physician-patient communication. Patients most likely to perceive their physicians as providing excellent care are those experiencing their preferred decision-making style with their primary physicians.¹⁵⁻¹⁶ Studies show that patient satisfaction, medication compliance, and health outcomes are improved by shared decision making.¹⁷⁻¹⁹

On July 19, 2015, the first joint International Shared Decision-Making/International Society for Evidence-Based Health Care (ISDM/ISEHC) Conference met in Sydney, Australia with over 300 people from around the globe to share knowledge and inspire action to improve the entire health care experience. Highlights of this meeting included:

- Informed consents is gaining importance connected with the use of the SDM, which includes a collaborative conversation around the patient's informed preferences and the best available scientific evidence.
- Aligned incentives are necessary to maximize SDM, but not necessarily monetary.
- Increasing in interest and gaining support is the inclusion of family engagement in the decision-making process with the patient/family/care team (called a triad) rather than the patient/care team (called a dyad). The discussion was how to make this a reality, as it has long been felt the family needed to be part of the SDM, but not easily implemented.
- Development of learning programs/greater communication skills for medical students was repeatedly discussed, looking for ways to include training for these as learned skills to build conversations around patient preferences and evidence-based scientific medicine/practice.²⁰

According to author David Arterburn, a general Internist, associate investigator at Group Health Research Institute, and affiliate associate professor at the University of Washington:

"Decision aids are evidence-based sources of health information that can help patients make informed treatment decisions. However, little is known about how decision aids affect health care use when they are conducted an observational study to examine the associations between introducing decision aids for hip and knee osteoarthritis and rates of joint replacement surgery and costs in a large health system in Washington State. Consistent with prior randomized trials, our introduction of decision aids was associated with 26 percent fewer hip replacement surgeries, 38 percent fewer knee replacements, and 12-21 percent lower costs over six months. These findings support the concept that patient decision aids for some health conditions, for which treatment decisions are highly sensitive to both patients' and physicians' preferences, may reduce rates of elective surgery and lower costs."²¹

He includes a recent review of 86 RCTs of decision aides which found that:

"These aids consistently increase patients' knowledge; improve treatment expectations; increase active participation in decision making; reduce decisional

conflict or uncertainty about the appropriate course of action; decrease the proportion of people remaining undecided about treatment; and help patients reach decisions that are more aligned with their stated values."²¹.

CollaboRATE

Patient-centered health care is a central component of current health policy agendas. Shared decision making (SDM) is considered to be the pinnacle of patient engagement and methods to promote this are becoming commonplace. However, the measurement of SDM continues to prove challenging. Reviews have highlighted the need for a patient-reported measure of SDM that is practical, valid, and reliable to assist implementation efforts. In consultation with patients, CollaboRATE was developed, a 3-item measure of the SDM process.²² Barr et al (2014) completed a study identifying the need for scalable patient-reported measure of the SDM process. In the current project, the study assessed the psychometric properties of CollaboRATE. A representative sample of the US population was recruited online and was randomly allocated to view 1 of 6 simulated doctor-patient encounters in January 2013. Three dimensions of SDM were manipulated in the encounters: (1) explanation of the health issue, (2) elicitation of patient preferences, and (3) integration of patient preferences. Participants then completed CollaboRATE (possible scores 0-100) in addition to 2 other patient-reported measures of SDM: the 9-item Shared Decision Making Questionnaire (SDM-Q-9) and the Doctor Facilitation subscale of the Patient's Perceived Involvement in Care Scale (PICS). A subsample of participants was resurveyed between 7 and 14 days after the initial survey. This study assessed CollaboRATE's discriminative, concurrent, and divergent validity, intrarater reliability, and sensitivity to change. The final sample consisted of 1341 participants. CollaboRATE demonstrated discriminative validity, with a significant increase in CollaboRATE score as the number of core dimensions of SDM increased from zero (mean score: 46.0, 95% CI: 42.4-49.6) to 3 (mean score 85.8, 95% CI: 83.2-88.4). CollaboRATE also demonstrated concurrent validity with other measures of SDM, excellent intrarater reliability, and sensitivity to change; however, divergent validity was not demonstrated. The fast and frugal nature of CollaboRATE lends itself to routine clinical use. Further assessment of CollaboRATE in real-world settings is required.²³.

Elwyn et al (2013) completed a study with an objective of measuring the process of shared decision making is a challenge, which constitutes a barrier to research and implementation. The aim of the study was to report the development of CollaboRATE, brief patient-reported measure of shared decision making. The following stages were utilized: (1) item formulation; (2) cognitive interviews; (3) item refinement; and (4) pilot testing of final items. Participants were over 18 years old and recruited from the public areas of the Dartmouth-Hitchcock Medical Center. The key finding of this study is that developing a brief patient-reported measure of shared decision making requires a move away from terms such as 'decisions', 'options' and 'preferences'. Although technically correct, these terms act as barriers. They are often unfamiliar, and they also implicitly assume that patients are willing to take active roles in decision making; whereas patients are often unaware that decisions are required, or have taken place, never mind feel that they could or should have participated in them. The outcome of this study concluded that these methods have allowed the development of a brief, patient-reported measure of shared decision making that is highly accessible to intended users.²⁴.

The principles of shared decision making are well documented but there is a lack of guidance about how to accomplish the approach in routine clinical practice. The aim is to translate existing conceptual descriptions into a three-step model that is practical, easy to remember, and can act as a guide to skill development. Achieving shared decision making depends on building a good relationship in the clinical encounter so that information is shared and patients are supported to deliberate and express their preferences and views during the decision making process. To accomplish these tasks, a model was proposed of how to do shared decision making that is based on choice, option and decision talk. The model has three steps: a) introducing choice, b) describing options, often by integrating the use of patient decision support, and c) helping patients explore preferences and make decisions. This model rests on supporting a process of deliberation, and on understanding that decisions should be influenced

by exploring and respecting “what matters most” to patients as individuals, and that this exploration in turn depends on them developing informed preferences.²²

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 suggested³:

Rotator Cuff Tears and Exercise

3. a. We cannot recommend for or against exercise programs (supervised or unsupervised) for patients with rotator cuff tears.

Strength of Recommendation: Inconclusive

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

4. a. We suggest that patients 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 tears²⁵:

“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 patients. 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.

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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, Liffoff/Modified Liffoff 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
- Completed and signed Shoulder Arthroscopy Surgery Decision Aid by the patient
- Completed and signed CollaboRATE survey by the patient

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]) (Code revision effective 1/1/2021)
	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]) (Code revision effective 1/1/2021)
	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.

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.

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 (No changes)	
BEFORE	AFTER
<p>Partial Thickness Rotator Cuff Tears and Acromioplasty/ Subacromial Decompression BSC7.14</p> <p>Policy Statement: Shoulder Arthroscopy</p> <p>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:</p> <ul style="list-style-type: none"> • The patient and provider have reviewed, completed, and signed the Shoulder Arthroscopy Surgery Decision Aid, ensuring shared decision making has occurred (see Policy Guidelines) • The patient has reviewed, completed, and signed the "CollaboRATE" survey • 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 • Documentation of a positive result of one or more of the following orthopedic tests when compared to the non-affected side (see Policy Guidelines): <ul style="list-style-type: none"> ○ Neer Impingement Test ○ Hawkins Kennedy Impingement Test ○ Painful Arc Test ○ Full/Empty Can Test ○ Pain or weakness with infraspinatus and supraspinatus maneuvers such as: <ul style="list-style-type: none"> ▪ External Lag Sign at 90 Degrees Test ▪ Infraspinatus Test ▪ Empty Can Test (or the similar Jobe’s Test) ○ Liftoff/Modified Liftoff Test ○ Belly-Press Test ○ Drop Arm Test • 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 	<p>Partial Thickness Rotator Cuff Tears and Acromioplasty/ Subacromial Decompression BSC7.14</p> <p>Policy Statement: Shoulder Arthroscopy</p> <p>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:</p> <ol style="list-style-type: none"> 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): <ol style="list-style-type: none"> 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: <ol style="list-style-type: none"> 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 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

POLICY STATEMENT (No changes)	
BEFORE	AFTER
<p>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.</p> <ul style="list-style-type: none"> • 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. • 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 <p>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:</p> <ul style="list-style-type: none"> • Documentation, including radiological interpretation and report of bony or soft tissue pathology (e.g., CT scan and/or MRI) demonstrating evidence of impingement • Intra-operative decision based on subacromial space available after repair of a rotator cuff tear to avoid secondary mechanical impingement 	<p>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.</p> <ul style="list-style-type: none"> 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. 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 <p>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:</p> <ul style="list-style-type: none"> 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