Policy Statement

This policy does not apply to repair of 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

Shoulder Arthroscopy

Arthroscopy of the shoulder for the repair of rotator cuff tears may be considered medically necessary when all of the following criteria are met:

- Patient has painful range of motion, or 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 or duties of employment
- Documentation of a positive result of one or more of the following orthopedic tests when compared to the non-affected side (see Policy Guidelines):
  - Neer Impingement Test
  - Drop Arm Test
  - Hawkins Kennedy Impingement Test
  - Painful Arc Test
  - Full/Empty Can Test
- Documentation including radiological interpretation and report for bony or soft tissue pathology (e.g. ultrasound, CT scan, or MRI) that demonstrates significant rotator cuff tear (Grade II – see Policy Guidelines) that corresponds with the patient’s symptoms and clinical findings
- Exclusion of other possible causative conditions, including, but not limited to severe arthritis, 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*
- The patient has 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

*Prior conservative treatment for at least six weeks is required except for injury caused by acute trauma.

Acromioplasty, Subacromial Decompression

Acromioplasty, subacromial decompression may be considered medically necessary when performed at the same time as a rotator cuff repair when both of the following criteria are met:

- Documentation including radiological interpretation and report for bony or soft tissue pathology (e.g. CT scan and/or MRI) that demonstrates evidence of impingement
- Need for decompression and debridement after massive rotator cuff tear

Shoulder arthroscopy is considered investigational for patients with osteoarthritis of the glenohumeral joint.
Policy Guidelines

Sprains, Strains, and Other Soft-Tissue Injuries
The American Academy of Orthopaedic Surgeons 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”

Shoulder Orthopedic Tests

<table>
<thead>
<tr>
<th>Test</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neer Impingement Test</td>
<td>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.</td>
</tr>
<tr>
<td>Drop Arm Test</td>
<td>Used to assess for 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.</td>
</tr>
<tr>
<td>Hawkins Kennedy Impingement Test</td>
<td>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 or 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.</td>
</tr>
<tr>
<td>Painful Arc Test</td>
<td>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.</td>
</tr>
<tr>
<td>Full/Empty Can Test</td>
<td>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. 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.</td>
</tr>
</tbody>
</table>

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
- Supervised physical therapy which could include an instructed home exercise program, including flexibility and muscle-strengthening exercises. Post-op physical therapy visits will be allowed in addition to the pre-op physical therapy visits.
- Therapeutic injections into the shoulder as appropriate

*Prior conservative treatment for at least six weeks is required except for injury caused by acute trauma.
Patients with relative contraindications should exhaust all appropriate nonsurgical treatment options prior to surgical consideration.

**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 websites: 

**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 is 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
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

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 overall 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 microtearing that will eventually lead to a larger tear or from an injury. If left untreated, rotator cuff tears tend to progress over time.

Arthroscopy is a surgical procedure in which the inside of the joint 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

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. They concluded that recovery to normal levels of function have been
achieved without arthroscopic surgery and that standardized non-operative treatment programs are an effective alternative to surgery for many patients.\textsuperscript{5}

In 2013, Kuhn et al reported on a study (N=452) that assessed the effectiveness of a specific nonoperative physical therapy program in treating atraumatic full-thickness rotator cuff tears using a multicenter prospective cohort study design. Patients were evaluated after 6 and 12 weeks of participating in a physical therapy program. Patients elected to undergo surgery less than 25\% of the time. Patients who decided to have surgery generally did so between 6 and 12 weeks, and few had surgery between 3 and 24 months. The authors concluded that nonoperative treatment using this physical therapy protocol is effective for treating atraumatic full-thickness rotator cuff tears in approximately 75\% of patients followed for 2 years.\textsuperscript{6}

The American Academy of Orthopaedic Surgeons has also recommended that exercise and nonsteroidal anti-inflammatory drugs be used to manage rotator cuff symptoms in the absence of a full-thickness tear.\textsuperscript{3}

Other studies have suggested that routine acromioplasty is not required in the surgical treatment of rotator cuff repair.\textsuperscript{7} The American Academy of Orthopaedic Surgeons recommended that routine acromioplasty is not required at the time of rotator cuff repair.\textsuperscript{3}

\textbf{References}


**Documentation for Clinical Review**

Please provide the following documentation (if/when requested):
- 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
o Documented positive result of one or more orthopedic tests (e.g., Neer Impingement Test, Drop Arm Test, Hawkins Kennedy Impingement Test, Painful Arc Test, Full/Empty Can Test)

o 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 physician and patient
  • Completed and signed CollaborATE survey by the patient

Post Service
  • 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. Inclusion or exclusion of codes does not constitute or imply member coverage or provider reimbursement.

MN/NMN
The following services may be considered medically necessary when policy criteria are met. Services may be considered not medically necessary when policy criteria are not met.

<table>
<thead>
<tr>
<th>Type</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT®</td>
<td>29826</td>
<td>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)</td>
</tr>
<tr>
<td></td>
<td>29827</td>
<td>Arthroscopy, shoulder, surgical; with rotator cuff repair</td>
</tr>
<tr>
<td>HCPCS</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>ICD-10 Procedure</td>
<td>0LQ14ZZ</td>
<td>Repair Right Shoulder Tendon, Percutaneous Endoscopic Approach</td>
</tr>
<tr>
<td></td>
<td>0LQ24ZZ</td>
<td>Repair Left Shoulder Tendon, Percutaneous Endoscopic Approach</td>
</tr>
<tr>
<td></td>
<td>0RJ4ZZ</td>
<td>Inspection of Right Shoulder Joint, Percutaneous Endoscopic Approach</td>
</tr>
<tr>
<td></td>
<td>0RJK4ZZ</td>
<td>Inspection of Left Shoulder Joint, Percutaneous Endoscopic Approach</td>
</tr>
<tr>
<td></td>
<td>0RQJ4ZZ</td>
<td>Repair Right Shoulder Joint, Percutaneous Endoscopic Approach</td>
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</tbody>
</table>

Policy History

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

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Action</th>
<th>Reason</th>
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</thead>
<tbody>
<tr>
<td>06/01/2018</td>
<td>Custom Policy</td>
<td>Medical Policy Committee</td>
</tr>
</tbody>
</table>
Definitions of Decision Determinations

**Medically Necessary:** A treatment, procedure, or drug is medically necessary only when it has been established as safe and effective for the particular symptoms or diagnosis, is not investigational or experimental, is not being provided primarily for the convenience of the patient or the provider, and is provided at the most appropriate level to treat the condition.

**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. Please call (800) 541-6652 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.