

MEDICAL POLICY – 7.01.605


Shoulder Arthrotomy in Adults

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RELATED MEDICAL POLICIES:
7.01.590 Shoulder Arthroplasty in Adults

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Introduction

Shoulder arthrotomy is a type of surgery where a surgeon makes an open incision into the shoulder joint to diagnose or treat a problem. This procedure is usually done when other, less invasive methods like imaging tests or arthroscopy (using a small camera) aren't enough. During the surgery, the surgeon can look directly at the bones, cartilage, muscles, and other tissues in the shoulder. They may remove infected tissue, repair damage, or drain fluid from the joint. It is often used to treat serious infections, injuries, or certain joint diseases. Because it is an "open" surgery (not done through small incisions), recovery may take longer, and individuals may need physical therapy to regain strength and movement in the shoulder. The goal is to relieve pain, treat the underlying problem, and help the shoulder function better. This policy describes when shoulder arthrotomy may be considered medically necessary.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

Policy Coverage Criteria

Note: This policy only applies to individuals aged 19 and older

Hyperlinks to criteria:

Acromioclavicular (AC) separation

AC separation with recent traumatic event, shoulder pain, deformity

Decompression of subacromial space or acromioplasty for rotator cuff tendonitis

Full thickness rotator cuff repair

Partial thickness rotator cuff repair

Removal of intra-articular osteochondral lesion or loose body

Resection of distal clavicle
Shoulder dislocation, initial

Shoulder dislocation, recurrent greater than 2 years

Shoulder dislocation, recurrent less than 2 years

Shoulder dislocation, initial with Bankart, Hill-Sachs, or anterior glenoid rim fracture

Shoulder dislocation, recurrent with Bankart, Hill-Sachs, or anterior glenoid rim fracture

Shoulder fracture repair

Shoulder hardware removal

Synovectomy (major or complete)

Shoulder Arthrotomy

Indication	Medical Necessity
Acromioclavicular (AC) separation (CPT 23550, 23552)	<p>Shoulder arthrotomy for acromioclavicular (AC) separation may be considered medically necessary when ALL of the following criteria are met:</p> <ul style="list-style-type: none"> One or more of the following symptoms is present: <ul style="list-style-type: none"> Recent traumatic event Shoulder pain Deformity <p>AND</p> <ul style="list-style-type: none"> Rockwood type III or higher rated injury (see Related Information) diagnosed by imaging* <p>* Note: Imaging gold standard is X-ray; MRI may be used for soft tissue assessment or if X-ray is inconclusive; ultrasound is not typically used for grading AC separation.</p>
AC separation with recent traumatic event, shoulder pain, deformity (CPT	<p>Shoulder arthrotomy for AC separation with recent traumatic event, shoulder pain, and deformity may be considered medically necessary when ALL of the following criteria are met:</p>

Indication	Medical Necessity
23040, 23044, 23105, 23106)	<ul style="list-style-type: none"> Symptoms of acromioclavicular (AC) separation including ALL of the following: <ul style="list-style-type: none"> Recent traumatic event Shoulder pain Deformity compared to contralateral side <p>AND</p> <ul style="list-style-type: none"> Imaging* shows Rockwood Type III to VI injury (see Related Information) <p>* Note: Imaging gold standard is X-ray; MRI may be used to assess associated soft tissue injury or if X-ray is inconclusive; CT may be considered for complex or high-grade separations.</p> <p>**NSAIDs (non-steroidal anti-inflammatories)</p>
Decompression of subacromial space or acromioplasty for rotator cuff tendonitis (CPT 23130)	<p>Shoulder arthroscopy for decompression of subacromial space or acromioplasty for rotator cuff tendonitis may be considered medically necessary when ALL of the following criteria are met:</p> <ul style="list-style-type: none"> One or more of the following symptoms is present: <ul style="list-style-type: none"> Shoulder or upper arm pain Pain or weakness on resisted shoulder abduction or rotation Passive range of motion (ROM) is normal or greater than active ROM Tenderness over rotator cuff <p>AND</p> <ul style="list-style-type: none"> Imaging* confirms subacromial impingement (Type II or Type III acromion**) <p>AND</p> <ul style="list-style-type: none"> Three months of the following conservative measures have been trialed and failed: <ul style="list-style-type: none"> NSAIDs*** or acetaminophen Subacromial corticosteroid injection as appropriate Physical therapy (PT) or occupational therapy (OT) for at least 6 weeks (which may include PT or OT-directed home exercise) <p>AND</p> <ul style="list-style-type: none"> Arthroscopic surgery is not technically feasible

Indication	Medical Necessity
	<p>Note: *Xray, MRI, or CT showing impingement.</p> <p>**Type II acromion is curved and Type III acromion is hooked; this describes the shape of the acromion bone. These shapes can reduce the space of the rotator cuff tendons and bursa and lead to subacromial impingement.</p> <p>*** NSAIDs (non-steroidal anti-inflammatories)</p>
<p>Full thickness rotator cuff repair (CPT 23410, 23412, 23420)</p>	<p>Shoulder arthrotomy for full thickness rotator cuff repair may be considered medically necessary when ALL of the following criteria are met:</p> <ul style="list-style-type: none"> • Symptomatic full thickness rotator cuff tear confirmed by imaging* and is traumatic injury** <p>OR</p> <ul style="list-style-type: none"> • If atraumatic degenerative cuff repair <p>AND</p> <ul style="list-style-type: none"> ○ Symptoms or findings include ONE of the following: <ul style="list-style-type: none"> ▪ Shoulder tenderness ▪ Restricted active ROM ▪ Pain in deltoid region which may radiate to arm and elbow ▪ Pain worsens with lifting or resistance ▪ Pain occurs at rest or at night ▪ Pain or weakness with abduction or rotation ▪ Painful ROM in the absence of mechanical restriction <p>AND</p> <ul style="list-style-type: none"> ○ Three months of the following conservative measures have been trialed and failed: <ul style="list-style-type: none"> ▪ NSAIDs*** or acetaminophen ▪ Physical therapy (PT) or occupational therapy (OT) for at least 6 weeks (which may include PT or OT-directed home exercise) <p>*Note: Imaging gold standard is MRI, ultrasound is an alternative if MRI is not available, CT arthrogram may be used if MRI is contraindicated.</p> <p>**Conservative measures are not required in an acute traumatic injury with a complete tear with debilitating pain and loss of function</p> <p>***NSAIDs (non-steroidal anti-inflammatories)</p>

Indication	Medical Necessity
Partial thickness rotator cuff repair (CPT 23410, 23412)	<p>Shoulder arthroscopy for partial rotator cuff repair may be considered medically necessary when ALL of the following criteria are met:</p> <ul style="list-style-type: none"> One or more of the following symptoms is present: <ul style="list-style-type: none"> Shoulder or upper arm pain Pain or weakness on resisted abduction or rotation Passive ROM is either normal or greater than active ROM Tenderness over rotator cuff <p>AND</p> <ul style="list-style-type: none"> Partial thickness rotator cuff tear as evidenced by imaging* <p>AND</p> <ul style="list-style-type: none"> Three months of the following conservative measures have been trialed and failed: <ul style="list-style-type: none"> NSAIDS** or acetaminophen Physical therapy (PT) or occupational therapy (OT) for at least 6 weeks (which may include PT or OT-directed home exercise) <p>* Note: Imaging gold standard is MRI, ultrasound is an alternative if MRI is not available, CT arthrogram may be used if MRI is contraindicated.</p> <p>**NSAIDs (non-steroidal anti-inflammatories)</p>
Removal of intra-articular osteochondral lesion or loose body (CPT 23040, 23044, 23107)	<p>Shoulder arthroscopy for removal of intra-articular osteochondral lesion or loose body (see Related Information) may be considered medically necessary when ALL of the following criteria are met:</p> <ul style="list-style-type: none"> Symptoms of intra-articular osteochondral lesion or loose body as evidenced by one of the following: <ul style="list-style-type: none"> Pain localized to the joint interferes with function or ADLs Mechanical symptoms such as clicking, catching locking, or restricted range of motion are attributed to loose body Swelling or effusion is present <p>AND</p> <ul style="list-style-type: none"> Three months of the following conservative measures have been trialed and failed: <ul style="list-style-type: none"> NSAIDS** or acetaminophen

Indication	Medical Necessity
	<ul style="list-style-type: none"> Physical therapy (PT) or occupational therapy (OT) for at least 6 weeks (which may include PT or OT-directed home exercise) <p>AND</p> <ul style="list-style-type: none"> Imaging of intra-articular osteochondral lesion or loose body* as evidenced by X-ray, MRI, or CT <p>AND</p> <ul style="list-style-type: none"> Arthroscopic surgery is not technically feasible. <p>* Note: NSAIDS (non-steroidal anti-inflammatories)</p>
Resection of distal clavicle (CPT 23120)	<p>Shoulder arthrotomy for resection of distal clavicle for AC joint arthritis may be considered medically necessary when ALL of the following criteria are met:</p> <ul style="list-style-type: none"> Both of the following symptoms are present: <ul style="list-style-type: none"> Shoulder pain Tenderness <p>AND</p> <ul style="list-style-type: none"> Arthritis diagnosis in the AC joint by imaging* as demonstrated by two of the following: <ul style="list-style-type: none"> Subchondral cysts (see definition in Related Information section) Subchondral sclerosis (see definition in Related Information section) Periarticular osteophytes (see definition in Related Information section) Shoulder joint subluxation (see definition in Related Information section) Joint space narrowing <p>AND</p> <ul style="list-style-type: none"> Three months of the following conservative measures have been trialed and failed: <ul style="list-style-type: none"> NSAIDS** or acetaminophen Corticosteroid injection as appropriate Physical therapy (PT) or occupational therapy (OT) for at least 6 weeks (which may include PT or OT-directed home exercise)

Indication	Medical Necessity
	<p>* Note: Imaging gold standard is X-ray; MRI may be used if soft tissue assessment is needed or X-ray is inconclusive; CT may be considered if MRI is contraindicated.</p> <p>**NSAIDs (non-steroidal anti-inflammatories)</p>
<p>Shoulder dislocation, initial (CPT 23455, 23450, 23465, 23466)</p>	<p>Shoulder arthrotomy for Initial shoulder dislocation may be considered medically necessary when ALL of the following criteria are met:</p> <ul style="list-style-type: none"> Initial dislocation as evidenced by imaging* <p>AND</p> <ul style="list-style-type: none"> Physical therapy (PT) or occupational therapy (OT) for at least 8 weeks (which may include PT or OT-directed home exercise) <p>* Note: Imaging gold standard is X-ray; MRI may be used to assess associated soft tissue injuries or if X-ray is inconclusive; CT may be considered for complex or recurrent dislocations.</p>
<p>Shoulder dislocation, recurrent greater than 2 years (CPT 23450, 23455, 23465, 23466)</p>	<p>Shoulder arthrotomy for recurrent shoulder dislocation (greater than two years) may be considered medically necessary when ALL of the following criteria are met:</p> <ul style="list-style-type: none"> Recurrent shoulder dislocation as evidenced by imaging* and previous shoulder dislocation was greater than 2 years ago <p>AND</p> <ul style="list-style-type: none"> Physical therapy (PT) or occupational therapy (OT) for at least 8 weeks (which may include PT or OT-directed home exercise) <p>* Note: Imaging gold standard is MRI; X-ray may confirm bony changes or prior dislocations; CT may be used for detailed assessment of glenoid or humeral head defects.</p>
<p>Shoulder dislocation, recurrent less than 2 years (CPT 23450, 23455, 23465, 23466)</p>	<p>Shoulder arthrotomy for recurrent shoulder dislocation (less than two years) may be considered medically necessary when ALL of the following criteria are met:</p> <ul style="list-style-type: none"> Recurrent dislocation as evidenced by imaging* <p>AND</p> <ul style="list-style-type: none"> Previous dislocation was less than two years ago



Indication	Medical Necessity
	<p>* Note: Imaging gold standard is MRI; X-ray may confirm bony changes or prior dislocations; CT may be used for detailed assessment of glenoid or humeral head defects</p>
<p>Shoulder dislocation, initial with Bankart, Hill-Sachs, or anterior glenoid rim fracture (CPT 23040, 23044, 23105, 23106)</p>	<p>Shoulder arthrotomy for Initial shoulder dislocation with Bankart, Hill-Sachs, or anterior glenoid rim fracture may be considered medically necessary when ALL of the following criteria are met:</p> <ul style="list-style-type: none"> Initial dislocation as evidenced by imaging demonstrates at least one of the following: <ul style="list-style-type: none"> Bankart lesion Hill-Sachs lesion Anterior glenoid rim fracture <p>*Note: Imaging gold standard is MRI; X-ray may confirm dislocation and bony injury; CT may be used for detailed evaluation of glenoid or humeral head fractures.</p>
<p>Shoulder dislocation, recurrent with Bankart, Hill-Sachs, or anterior glenoid rim fracture (CPT 23040, 23044, 23105, 23106)</p>	<p>Shoulder arthrotomy for recurrent shoulder dislocation with Bankart, Hill-Sachs, or anterior glenoid rim fracture may be considered medically necessary when ALL of the following criteria are met:</p> <ul style="list-style-type: none"> Previous dislocation was greater than two years ago <p>AND</p> <ul style="list-style-type: none"> Recurrent dislocation as evidenced by imaging* which demonstrates at least one of the following: <ul style="list-style-type: none"> Bankart lesion Hill-Sachs lesion Anterior glenoid rim fracture <p>*Note: Imaging gold standard is MRI; X-ray may confirm dislocation and bony injury; CT may be used for detailed evaluation of glenoid or humeral head fractures.</p>
<p>Shoulder fracture repair (CPT 23660, 23670 23770)</p>	<p>Shoulder arthrotomy for shoulder fracture repair (may also include open reduction and internal fixation (ORIF) may be considered medically necessary when ALL of the following criteria are met:</p> <ul style="list-style-type: none"> One or more of the following symptoms is present:

Indication	Medical Necessity
	<ul style="list-style-type: none"> ○ Shoulder fracture is evidenced by imaging* including ONE of the following: <ul style="list-style-type: none"> ▪ Displaced fracture and reduction not achievable by closed means ▪ Loose fragments within the joint <p>* Note: Imaging gold standard is X-ray; CT may be used for complex or intra-articular fractures; MRI is reserved for cases requiring soft tissue assessment.</p>
Shoulder hardware removal (CPT 20670, 20680)	<p>Shoulder arthrotomy for hardware removal may be considered medically necessary.</p> <ul style="list-style-type: none"> ● One or more of the following symptoms is present: <ul style="list-style-type: none"> ○ Persistent pain localized to the hardware site that interferes with function or activities of daily living (ADLs) ○ Mechanical symptoms such as clicking, catching or restricted range of motion are attributed to hardware position or irritation that causes functional limitations. ○ Infection as evidenced by erythema, swelling, drainage at hardware site or elevated inflammatory markers including white blood cells (WBC), erythrocyte sedimentation rate, (ESR), C-reactive protein (CRP) or positive culture or imaging* consistent with infection ○ X-ray, CT, or MRI show hardware loosening, migration, or breakage <p>*Note: Imaging consistent with infection includes peri-implant lucency or bone erosion on X-ray, marrow edema, soft tissue swelling, or abscess on MRI, bone destruction or gas in soft tissues on CT, and increased uptake around hardware on nuclear scan.</p>
Synovectomy (major or complete) (CPT 23105, 23106)	<p>Shoulder arthrotomy for synovectomy (major or complete) (see Related Information) may be considered medically necessary when ALL of the following criteria are met:</p> <ul style="list-style-type: none"> ● One or more of the following symptoms is present <ul style="list-style-type: none"> ○ Joint pain ○ Limited ROM ○ Joint effusion or swelling <p>AND</p>

Indication	Medical Necessity
	<ul style="list-style-type: none"> Preoperative imaging (MRI, ultrasound, or x-ray) confirms both synovitis and no severe degenerative changes in bone or cartilage. <p>AND</p> <ul style="list-style-type: none"> One of the following applies: <ul style="list-style-type: none"> Disease-specific treatment for at least 12 weeks within the last year (see Table 1) <ul style="list-style-type: none"> Examples: Disease-Modifying Antirheumatic Drugs (DMARDs) for rheumatoid arthritis, corticosteroid injections, biologics, or other targeted therapies Arthroscopic surgery is not technically feasible <p>*Note: major synovectomy is partial removal of the inflamed synovial membrane. Complete synovectomy is total excision of the synovial membrane.</p>

Procedure	Not Medically Necessary
Shoulder arthrotomy	Shoulder arthrotomy for all other indications not listed within this policy including when the above criteria are not met, is considered not medically necessary.

Documentation Requirements
<p>The patient's medical records submitted for review for all conditions should document that medical necessity criteria are met. The record should include the following:</p> <p>For shoulder arthrotomy repair of acromioclavicular (AC) separation documentation should support ALL of the following:</p> <ul style="list-style-type: none"> One or more of the following symptoms is documented: <ul style="list-style-type: none"> Recent traumatic event Shoulder pain Deformity <p>AND</p> <ul style="list-style-type: none"> Rockwood type III or higher rated injury (see Related Information) diagnosed by imaging <ul style="list-style-type: none"> Preferred x-ray

Documentation Requirements

- Acceptable alternatives include MRI if soft tissue assessment is needed or x-ray is inconclusive, ultrasound is not typically used for grading AC separation.

For shoulder arthrotomy repair of AC separation with recent traumatic event, shoulder pain, and deformity documentation should support ALL of the following:

- Recent traumatic event
- Shoulder pain (persistent pain localized to AC joint or superior shoulder region)
- Visible deformity compared to contralateral side

AND

- Imaging report showing Rockwood Type III to VI AC separation (only one is needed, others if clinically indicated)
 - X-ray is preferred
 - MRI may be used if soft tissue injury is suspected or X-ray is inconclusive
 - CT scan may be used for complex or high-grade separations

AND

- Three months of conservative measures have been trialed and failed:
 - NSAIDS
 - Physical therapy (PT) or occupational therapy (OT) for at least 6 weeks (which may include PT or OT-directed home exercise)

For shoulder arthrotomy repair of decompression of subacromial space for acromioplasty for rotator cuff tendonitis documentation should support ALL of the following:

- Documentation of one or more of the following symptoms:
 - Shoulder or upper arm pain
 - Pain or weakness on resisted shoulder abduction or rotation
 - Passive range of motion (ROM) is normal or greater than active ROM
 - Tenderness over rotator cuff

AND

- Imaging confirms subacromial impingement with Type II or Type III acromion
 - X-ray
 - MRI
 - CT scan

AND

- Three months of the following conservative measures have been trialed and failed:
 - NSAIDS (non-steroidal anti-inflammatories) or acetaminophen
 - Subacromial corticosteroid injection

Documentation Requirements

- Physical therapy (PT) or occupational therapy (OT) for at least 6 weeks (which may include PT or OT-directed home exercise)

AND

- Arthroscopic surgery is not technically feasible (e.g., anatomic distortion, dense adhesions, prior failed arthroscopy, other operative limitations)

For shoulder arthrotomy repair of a full thickness rotator cuff documentation should support ALL of the following:

- Diagnosis confirmation of full thickness rotator cuff tear by imaging report (only one is needed, others if clinically indicated)
 - Preferred MRI
 - Acceptable alternatives include ultrasound (if MRI not available), CT arthrogram (if MRI contraindicated)

AND

- If traumatic tear injury documentation of ALL of the following:
 - Acute injury event
 - Debilitating pain and functional loss
 - Note-conservative treatment not required

OR

- If atraumatic tear injury symptoms include at least one of the following:
 - Shoulder tenderness
 - Restricted active ROM
 - Pain in deltoid region which may radiate to arm and elbow
 - Pain worsened by lifting or resistance
 - Pain rest or at night
 - Pain or weakness with abduction or rotation
 - Painful ROM without mechanical restriction

AND

- Three months of the following conservative measures have been trialed and failed:
 - NSAIDS (non-steroidal anti-inflammatories) or acetaminophen
 - Physical therapy (PT) or occupational therapy (OT) for at least 6 weeks (which may include PT or OT-directed home exercise)

For shoulder arthrotomy repair of a partial thickness rotator cuff documentation should support ALL of the following:

- At least one or more of the following clinical symptoms:
 - Shoulder or upper arm pain

Documentation Requirements

- Pain or weakness on resisted abduction or rotation
- Passive ROM is either normal or greater than active ROM
- Tenderness over rotator cuff

AND

- Imaging report confirming partial thickness rotator cuff tear (only one is needed, others if clinically indicated)
 - Preferred MRI
 - Acceptable alternatives include ultrasound (if MRI not available), CT arthrogram (if MRI contraindicated)

AND

- Three months of the following conservative measures have been trialed and failed:
 - NSAIDS (non-steroidal anti-inflammatories) or acetaminophen
 - Physical therapy (PT) or occupational therapy (OT) for at least 6 weeks (which may include PT or OT-directed home exercise)

For shoulder arthrotomy for removal of intra-articular osteochondral lesion or loose body documentation should support ALL of the following:

- Pain localized to the joint which must interfere with function or activities of daily living (ADLs)

OR

- Mechanical symptoms attributed to loose body that must cause function limitations such as:
 - Clicking
 - Catching
 - Locking
 - Restricted ROM

OR

- Swelling or joint effusion documented by physical exam or imaging

AND

- Imaging must confirm presence of an intra-articular osteochondral lesion or loose body (only one is needed, others if clinically indicated)
 - X-ray
 - MRI
 - CT scan

AND

- Three months of conservative measures have been trialed and failed:
 - NSAIDS (non-steroidal anti-inflammatories) or acetaminophen
 - Physical therapy (PT) or occupational therapy (OT) for at least 6 weeks (which may include PT or OT-directed home exercise)

Documentation Requirements

AND

- Arthroscopic surgery is not technically feasible.

For shoulder arthrotomy of resection of distal clavicle for AC joint arthritis documentation should support ALL of the following:

- Documentation of both of the following symptoms:
 - Shoulder pain
 - Tenderness

AND

- Arthritis diagnosis in the AC joint by imaging* confirms at least two of the following:
 - Subchondral cysts
 - Subchondral sclerosis
 - Periarticular osteophytes
 - Joint subluxation
 - Joint space narrowing

AND

- Imaging of AC joint confirms arthritis by:
 - X-ray preferred
 - MRI if soft tissue assessment is needed or x-ray is inconclusive
 - CT (if MRI contraindicated)

AND

- Three months of conservative measures have been trialed and failed:
 - NSAIDS (non-steroidal anti-inflammatories) or acetaminophen
 - Corticosteroid injection as appropriate
 - Physical therapy (PT) or occupational therapy (OT) for at least 6 weeks (which may include PT or OT-directed home exercise)

For shoulder arthrotomy repair of Initial shoulder dislocation documentation should support ALL of the following:

- Imaging report confirms initial shoulder dislocation (only one is needed, others if clinically indicated)
 - X-ray is preferred
 - MRI if soft tissue injury is suspected or X-ray is inconclusive
 - CT scan if fracture complexity or recurrent dislocation is suspected

AND

Documentation Requirements

- Physical therapy (PT) or occupational therapy (OT) for at least 8 weeks (which may include PT or OT-directed home exercise)

For shoulder arthroscopy repair of recurrent shoulder dislocation (greater than 2 years) documentation should support ALL of the following:

- Imaging report confirming recurrent shoulder dislocation (only one is needed, others if clinically indicated)
 - MRI preferred for soft tissue and instability assessment
 - X-ray to confirm prior dislocation or bony changes
 - CT scan for detailed evaluation of glenoid or humeral head defects

AND

- Documentation that the initial shoulder dislocation occurred more than 2 years ago

AND

- Physical therapy (PT) or occupational therapy (OT) for at least 8 weeks (which may include PT or OT-directed home exercise)

For shoulder arthroscopy repair of recurrent shoulder dislocation (less than 2 years) documentation should support ALL of the following:

- Imaging report confirming recurrent shoulder dislocation (only one is needed, others if clinically indicated)
 - MRI preferred for soft tissue and instability assessment
 - X-ray to confirm prior dislocation or bony changes
 - CT scan for detailed evaluation of glenoid or humeral head defects

AND

- Documentation the initial shoulder dislocation occurred less than 2 years ago
 - Include date or approximate timing of first dislocation

For shoulder arthroscopy repair of initial shoulder dislocation arthroscopy with Bankart lesion, Hill-Sachs lesion, or anterior glenoid rim fracture documentation should support ALL of the following:

- Imaging report confirming recurrent initial shoulder dislocation (only one is needed, others if clinically indicated)
 - MRI preferred for soft tissue and labral injuries
 - X-ray to confirm dislocation or bony injury
 - CT scan for detailed evaluation of glenoid or humeral head fractures

AND

Documentation Requirements

- Imaging must clearly demonstrate one of the following:
 - Bankart lesion (detachment of the anterior-inferior labrum from the glenoid rim)
 - Hill-Sachs lesion (compression fracture of the posterior humeral head)
 - Anterior glenoid rim fracture

For shoulder arthrotomy repair of recurrent shoulder dislocation with Bankart lesion, Hill-Sachs lesion, or anterior glenoid rim fracture arthrotomy procedures documentation should support ALL of the following:

- Imaging report confirming recurrent shoulder dislocation (only one is needed, others if clinically indicated)
 - MRI preferred for soft tissue and labral injuries
 - X-ray to confirm prior dislocation and bony changes
 - CT scan for detailed evaluation of glenoid or humeral head fractures

AND

- Imaging must clearly demonstrate at one of the following:
 - Bankart lesion (detachment of the anterior-inferior labrum from the glenoid rim)
 - Hill-Sachs lesion (compression fracture of the posterior humeral head)
 - Anterior glenoid rim fracture

AND

- Provider documentation supporting approximate initial dislocation date

For shoulder arthrotomy for fracture repair (may also include shoulder open reduction and internal fixation (ORIF) documentation should support ALL of the following:

- Imaging report confirms a shoulder fracture (only one is needed, others if clinically indicated)
 - X-ray is preferred
 - CT scan may be used for complex or intra-articular fractures
 - MRI may be used if soft tissue assessment is clinically necessary

AND

- Documentation of at least one of the following
 - Displaced fracture where closed reduction not achievable
 - Presence of loose bone fragments within the joint

For shoulder arthrotomy for hardware removal documentation should support ALL of the following:

- Documentation of at least one of the following
 - Persistent pain at the hardware site which must interfere with function or activities of daily living (ADLs)

Documentation Requirements

- Mechanical symptoms attributed to hardware that must cause function limitations such as:
 - Clicking
 - Catching
 - Restricted ROM
- Signs of infection including any of the following:
 - Erythema, swelling, or drainage at the hardware site
 - Elevated inflammatory markers:
 - White blood cell count (WBC) > 11,000 cells/ μ L (leukocytosis)
 - Erythrocyte sedimentation rate (ESR) > 20 mm/hr (mild elevation); > 40 mm/hr (moderate to significant)
 - C-reactive protein (CRP) > 10 mg/L (acute inflammation); > 3 mg/L (chronic low-grade inflammation)
 - Positive culture (e.g., wound or blood)
 - Imaging consistent with infection (see imaging criteria)

AND

- Imaging must support the diagnosis for need to shoulder hardware removal (only one is needed, others if clinically indicated)
 - X-ray
 - Hardware loosening, migration, breakage
 - Pre-implant lucency or bone erosion (if infection suspected)
 - MRI
 - Marrow edema, soft tissue swelling, abscess
 - CT scan
 - Bone destruction, gas in soft tissues
 - Nuclear scan
 - Increased uptake around hardware

For shoulder arthrotomy for synovectomy (major or complete) documentation should support ALL of the following:

- Documentation must confirm one or more of the following symptoms that must be attributed to synovitis:
 - Joint pain
 - Limited ROM
 - Joint effusion or swelling

AND

- Imaging (only one is needed, others if clinically indicated) must confirm both of the following:
 - Presence of synovitis which may include:

Documentation Requirements

- Synovial thickening
- Hypervascularity
- Joint effusion
- No severe degenerative changes in bone or cartilage

AND

- Imaging may include
 - MRI (preferred for soft tissue detail)
 - Ultrasound (for dynamic assessment of synovial inflammation)
 - X-ray (to rule out advanced osteoarthritis or joint destruction)

AND

- Treatment history documentation must show one of the following:
 - Disease-specific treatment for at least 12 weeks within the last year
 - Examples: Disease-Modifying Antirheumatic Drugs (DMARDs) for rheumatoid arthritis, corticosteroid injections, biologics, or other targeted therapies
 - Must be appropriate to the underlying diagnosis (see [Evidence Review, Table 1](#))

Coding

Code	Description
CPT	
20670	Removal of implant; superficial (e.g., buried wire, pin or rod) (separate procedure) (superficial hardware removal)
20680	Removal of implant; deep (e.g., buried wire, pin, screw, metal band nail, rod, or plate) (deep hardware removal)
23040	Arthrotomy, glenohumeral joint, with exploration, drainage, or removal of foreign body (glenohumeral joint arthrotomy with exploration/drainage)
23044	Arthrotomy, acromioclavicular, sternoclavicular joint, including exploration, drainage, or removal of foreign body (AC/SC joint arthrotomy with exploration/drainage)
23101	Arthrotomy, acromioclavicular joint or sternoclavicular joint, including biopsy and/or excision of torn cartilage (AC/SC joint arthrotomy with biopsy/cartilage excision)
23105	Arthrotomy; glenohumeral joint, with synovectomy, with or without biopsy (glenohumeral synovectomy)
23106	Arthrotomy; sternoclavicular joint, with synovectomy, with or without biopsy (sternoclavicular synovectomy)

Code	Description
23107	Arthrotomy, glenohumeral joint, with removal of loose body or foreign body (glenohumeral loose body removal)
23120	Claviculectomy, partial (partial clavicle resection)
23130	Acromioplasty or acromionectomy, partial, with or without coracoacromial ligament release (decompression of subacromial space / acromioplasty)
23410	Repair of ruptured musculotendinous cuff (e.g., rotator cuff) open, acute (repair of partial or full thickness rotator cuff tear)
23412	Repair of ruptured musculotendinous cuff (e.g., rotator cuff) open chronic (repair of partial or full thickness rotator cuff tear)
23415	Coracoacromial ligament release, with or without acromioplasty
23420	Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)
23450	Capsulorrhaphy, anterior; Putti-Platt procedure or Magnuson type operation
23455	Capsulorrhaphy, anterior; with labral repair (e.g., Bankart procedure)
23460	Capsulorrhaphy, anterior, any type; with bone block
23462	Capsulorrhaphy, anterior, any type; with coracoid process transfer
23465	Capsulorrhaphy, glenohumeral joint, posterior, with or without bone block
23466	Capsulorrhaphy, glenohumeral joint, any type multi-directional instability
23550	Open treatment of acromioclavicular dislocation, acute or chronic (acromioclavicular (AC) separation)
23552	Open treatment of acromioclavicular dislocation, acute or chronic; with fascial graft (includes obtaining graft)
23585	Open treatment of scapular fracture (body, glenoid or acromion), includes internal fixation, when performed
23615	Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s), when performed; (open reduction internal fixation of shoulder) (ORIF of proximal humerus fracture)
23616	Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s), when performed; with proximal humeral prosthetic replacement
23630	Open treatment of greater humeral tuberosity fracture, includes internal fixation, when performed
23660	Open treatment of acute shoulder dislocation (open shoulder dislocation reduction)

Code	Description
23670	Open treatment of shoulder dislocation, with fracture of greater humeral tuberosity, includes internal fixation, when performed
23680	Open treatment of shoulder dislocation, with surgical or anatomical neck fracture, includes internal fixation, when performed
23929	Unlisted procedure, shoulder

Note: CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). HCPCS codes, descriptions and materials are copyrighted by Centers for Medicare Services (CMS).

Related Information

Definition of Terms

Acromioplasty: is a type of shoulder surgery where a portion of the acromion bone is removed to relieve pressure on the rotator cuff by creating more space for tendon movement, which reduces pain and inflammation caused by any impingement in the area.

Anterior glenoid rim fracture: is a break at the front edge of glenoid cavity (shoulder socket) often resulting from traumatic shoulder dislocation and associated with joint instability.

Bankart lesion: is a tear of anteroinferior glenoid labrum (cartilage rim at front of shoulder socket), typically resulting from anterior shoulder dislocation and associated with recurrent joint instability

Hill-Sachs lesion: is a compression fracture of the humeral head (the ball of the shoulder joint) that occurs when the shoulder dislocates. It occurs when the humerus slips out of the shoulder socket and the humeral head slides forward and compresses the glenoid rim, creating a divot or indentation in the bone, which causes pain and limited arm movement.

Intra-articular osteochondral lesion: is a focal injury involving both the articular cartilage and adjacent subchondral bone within the glenohumeral joint (cartilage and underlying bone within the shoulder joint), typically resulting from trauma or degeneration and potentially causing pain, instability, or mechanical symptoms

Loose body: is a free-floating fragment of bone or cartilage within the joint that can cause pain, locking, or restricted motion

Osteochondral lesion: is a fragmentation, tear or fracture covering one of the bones in a joint often caused by trauma or degeneration

Periarticular osteophytes: are bony projections that form around the margins of a joint, typically due to degenerative changes such as osteoarthritis, and may contribute to joint stiffness, impingement, or pain.

Rockwood classification of AC injuries:

Type I: Minor sprain of the acromioclavicular ligament; intact joint capsule; intact coracoclavicular ligament; intact deltoid and trapezius

Type II: Rupture of the acromioclavicular ligament and joint capsule; sprain of the coracoclavicular ligament but intact coracoclavicular interspace; minimal detachment of the deltoid and trapezius

Type III: Rupture of the acromioclavicular ligament, joint capsule, and coracoclavicular ligament; elevated clavicle (100% or less displacement); detachment of the deltoid and trapezius

Type IV: Rupture of the acromioclavicular ligament, joint capsule, and coracoclavicular ligament; posteriorly displaced clavicle into the trapezius; detachment of the deltoid and trapezius

Type V: Rupture of the acromioclavicular ligament, joint capsule, and coracoclavicular ligament; elevated clavicle (greater than 100% displacement); detachment of the deltoid and trapezius

Type VI (rare): Rupture of acromioclavicular ligament, joint capsule, and coracoclavicular ligament; the clavicle is displaced behind the tendons of the biceps and coracobrachialis.

Shoulder dislocation: is a displacement of the humeral head from the glenoid fossa of the scapula, resulting in loss of normal articulation within the glenohumeral joint

Shoulder subluxation: is a partial dislocation of the shoulder joint, where the head of the upper arm bone (humerus) slips out of the shoulder socket (glenoid) but does not completely dislocate. This condition may be caused by traumatic injuries such as a fall or a direct blow to the shoulder, or from non-traumatic causes like repetitive movements that occur during sports. Symptoms may include pain, looseness or instability in the shoulder, limited range of motion, and possibly a popping or clicking sensation. It is less severe than full dislocation. It may resolve on its own, be treated with conservative care, or require surgery to repair damaged tissues.

Synovectomy: is an open surgical excision of inflamed synovial tissue from the glenohumeral joint, typically indicated for chronic synovitis unresponsive to conservative treatment. Procedures may include open glenohumeral synovectomy, subacromial synovectomy, or posterior capsular synovectomy.

Subchondral cyst: is a fluid filled pocket beneath joint cartilage within the subchondral bone, commonly associated with degenerative joint conditions such as osteoarthritis.

Subchondral sclerosis: is a thickening and increased density of the bone beneath joint cartilage, commonly seen in degenerative joint conditions such as osteoarthritis.

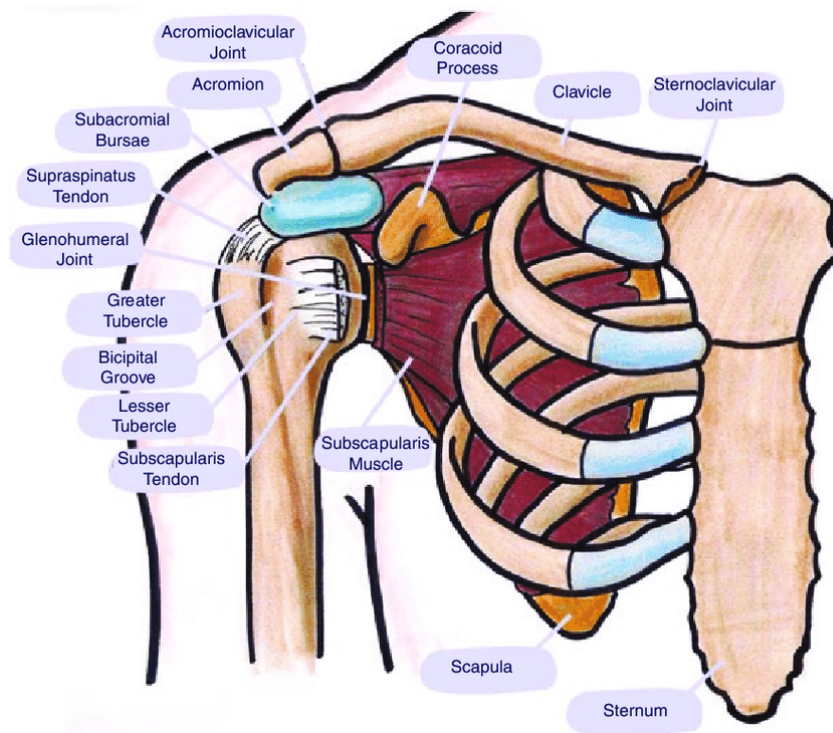
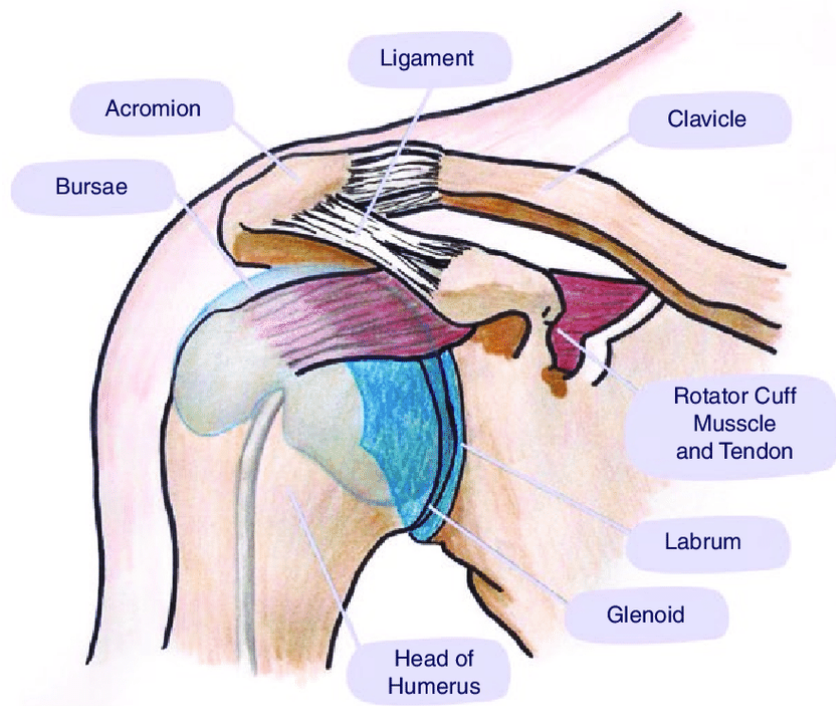
Table 1. Disease-Specific Treatments Required Within One year of Major or Complete Synovectomy

Disease	Pre-Synovectomy Treatments (within prior year)
Rheumatoid Arthritis (RA)	DMARDs (methotrexate, hydroxychloroquine), biologic DMARDs (TNF inhibitors), NSAIDs, corticosteroids, physical therapy
Psoriatic Arthritis	DMARDs, (methotrexate, sulfasalazine) biologic DMARDs (IL-17 or IL-12/23 inhibitors), NSAIDs, corticosteroids
Juvenile Idiopathic Arthritis	NSAID, DMARDs (e.g., methotrexate), biologics DMARDs, (etanercept), physical therapy
Tenosynovial Giant Cell Tumor (TGCT)	Targeted therapy (e.g., CSF1R inhibitors), radiation therapy, observation if asymptomatic
Synovial Chondromatosis	Observation if mild, arthroscopic removal of loose bodies, NSAIDs
Hemophilia (with recurrent hemarthrosis)	Factor replacement therapy, radiosynovectomy (e.g., Yttrium-90), physical therapy
Septic Arthritis	Antibiotic therapy (IV and oral), joint aspiration or lavage, surgical debridement if needed
Pigmented Villonodular Synovitis (PVNS)	Radiation therapy, observation if minimal symptoms
Lyme Arthritis	Antibiotics (e.g., doxycycline, amoxicillin), NSAIDs, DMARDs if persistent inflammation (methotrexate, hydroxychloroquine, sulfasalazine, and biologic DMARDs such as TNF inhibitors like infliximab (Remicade®), IL-1 blockers like anakinra (Kineret®), B-cell monoclonal antibodies like rituximab, and T-cell costimulation blockers like abatacept (ORENCIA®).

DMARDs: Disease-Modifying Antirheumatic Drugs.

DMARDs are medications used to treat autoimmune and inflammatory conditions like rheumatoid arthritis, psoriatic arthritis, and juvenile idiopathic arthritis.

There are two main types of DMARD: traditional DMARDs (e.g., methotrexate, hydroxychloroquine, sulfasalazine), and biologic DMARDs (e.g., TNF inhibitors, IL-17 blockers, JAK inhibitors).



Source: https://www.researchgate.net/figure/Anatomy-of-the-shoulder-joint_fig5_348256306. Accessed August 21, 2025

Description

Shoulder arthrotomy refers to a surgical incision into the glenohumeral joint, typically performed as part of open procedures for diagnostic exploration, removal of intra-articular loose bodies, or treatment of structural instability. While arthroscopic techniques are preferred for many shoulder conditions, open procedures involving arthrotomy are for select non-emergent cases, particularly when anatomical complexity, failed prior surgery, or surgeon expertise favor an open approach. Open shoulder procedures involving arthrotomy may be appropriate across age groups but are most commonly indicated in adolescents and young adults, particularly males under 30, who have high recurrence risk, failed prior stabilization, or significant bone loss.

Background

Shoulder instability is a common orthopedic condition, particularly among young, active individuals. It refers to the inability of the glenohumeral joint to maintain its normal alignment, often due to trauma, ligamentous laxity, or repetitive overhead activity. Instability may present as subluxation, dislocation, or a sensation of the shoulder “giving way,” and can lead to chronic pain, functional impairment, and progressive joint damage if left untreated. The incidence of shoulder dislocation in the United States is approximately 23.9 per 100,000 person-years, with higher rates in young males aged 15 to 29.¹ Between 60% and 91.3% of all shoulder dislocations occur in males, with a male-to-female ratio of 2.6:1.¹ Shoulder instability affects approximately 2% of the general population. Among individuals who experience a dislocation before age 20, the recurrence rate is as high as 80%, compared to 20% in those over age 40.²

Open shoulder procedures, particularly arthrotomy, remain critical in complex, high-risk, or revision cases where precise anatomical restoration is required. By providing direct visualization of intra-articular structures such as the capsule, labrum, and glenoid rim, arthrotomy enables secure repair in scenarios involving large bony defects, extensive cartilage injury, or failed prior stabilization. Techniques like the Latarjet (used for recurrent shoulder locations with significant bone loss) and open Bankart repair (used to restore shoulder stability after recurrent anterior dislocations) employ arthrotomy and are well-supported in the literature as effective

interventions for recurrent anterior instability and structural compromise. These approaches are especially valuable when arthroscopic methods prove insufficient. In non-urgent cases, clinical guidelines recommend a stepwise treatment strategy beginning with physical therapy, pharmacologic management, and activity modification before progressing to surgical intervention.

Open shoulder procedures show superior performance in both elderly and high-demand populations. High-risk populations include contact athletes such as football and wrestling players, overhead athletes such as baseball and volleyball players, military personnel, manual laborers, and individuals with generalized ligamentous laxity or connective tissue disorders. Open procedures involving arthrotomy are most often medically necessary in young males under 30 with recurrent anterior instability and bone loss, individuals with failed prior arthroscopic stabilization, individuals with multidirectional instability unresponsive to conservative care, and individuals with intra-articular loose bodies or unexplained joint pathology requiring direct visualization.

Recurrent shoulder instability can lead to secondary intra-articular damage, including labral tears, cartilage degeneration, and bony lesions such as Hill-Sachs and glenoid defects. These structural changes often develop over time due to repeated subluxation or dislocation events and may complicate both diagnosis and treatment. Chronic instability is also associated with reduced proprioception and altered shoulder kinematics, which can impair function and increase the risk of osteoarthritis. Early recognition and appropriate intervention are essential to prevent progression and preserve joint integrity.

Open anterior shoulder stabilization should be considered primarily when critical glenoid bone loss is present, especially when recurrent shoulder dislocations occur, or when other factors like failed arthroscopic repair, engaging Hill-Sachs lesions, additional shoulder pathologies, and high likelihood of instability increase the risk of recurrent instability. These criteria help surgeons select individuals who are most likely to benefit from durable outcomes with open procedures.³

Summary of Evidence

Rotator Cuff Tears

A systematic review of the literature by Mohammed et. al., (2021) discussing the relevance of open rotator cuff repair concluded that the open rotator cuff repair is advantageous for larger tears and the increased ease of repair. The author summarizes that an open repair is preferred in these situations over an arthroscopic approach: L shaped tears, which are significantly longer medial to lateral as compared to anterior to posterior, massive and large tears, complete tear of

the subscapularis, poor tissue quality and extensive lamination, previously failed arthroscopic revision repairs, reconstruction of the superior capsule with long head of biceps in conjunction with a partial repair of a massive rotator cuff tear.⁴

A prospective cohort study by Zarezadeh et al., (2020) comparing clinical outcomes between open and arthroscopic rotator cuff repair in individuals with rotator cuff repair were followed for 3 years. The mean tear size in both surgical groups were similar, and all individuals improved in pain, active abduction, active forward flexion, and function. The open surgery group showed superior outcomes in 44% increased function over the arthroscopic surgery group at the follow up.⁵

An Austin Orthopedic Institute (2025) report emphasized that while arthroscopy offers shorter recovery times and less postoperative pain, open surgery provides better access and precision for complex repairs, such as total shoulder replacements and extensive rotator cuff tears. Open procedures remain essential for anatomical correction and structural durability in high-demand or revision cases.⁶

Shoulder Dislocation Stabilization

Open shoulder procedures involving arthrotomy are supported by a substantial body of evidence, including randomized controlled trials (RCTs), systematic reviews, and long-term cohort studies. These procedures remain essential in the management of recurrent anterior instability, multidirectional instability (MDI), intra-articular pathology, and failed prior repairs—particularly in high-risk or anatomically complex cases. A 15-year prospective RCT by Bottoni et al. compared open and arthroscopic anterior stabilization and found no significant difference in long-term recurrence or functional outcomes. However, individuals with “off-track” Hill-Sachs lesions had significantly higher failure rates, highlighting the importance of glenoid track assessment and the potential need for open procedures in cases of substantial bone loss (Bottoni et al., 2021).⁷

Shoulder arthrotomy remains a clinically validated intervention for managing complex glenohumeral pathology in adult populations, particularly in cases involving recurrent instability, glenoid bone loss, multidirectional laxity, and revision scenarios. Meta-analyses and randomized controlled trials (Hurley 2019; Bottoni 2021) consistently report lower recurrence rates, higher return-to-sport percentages, and sustained satisfaction in open procedures versus arthroscopy:^{7, 8} Hurley et al. conducted a systematic review and meta-analysis comparing open and arthroscopic Latarjet procedures. Both approaches demonstrated similar rates of recurrent instability and complications, but open procedures were associated with lower rates of

persistent apprehension in some subgroups, suggesting a role for open techniques in individuals with high functional demands or failed prior stabilization (Hurley et al., 2019).⁸

Gao et al. (2020) reviewed multiple RCTs on Bankart repair (used to restore shoulder stability after recurrent anterior dislocations) and concluded that recurrence rates in arthroscopic cases remained static over time, while open Bankart procedures maintained superior outcomes in contact athletes and revision scenarios. Gao et al. concluded that open Bankart repair remains a viable and effective option, particularly in high-risk individuals or those with failed arthroscopic repairs. Despite the increasing use of arthroscopy, open procedures continue to yield favorable outcomes in appropriately selected individuals.⁹ Harris et al. (2021) synthesized 26 studies totaling 1,781 individuals and found recurrence rates of 8% for open stabilization versus 11% for arthroscopic methods. The return-to-sport rate was significantly higher in the open group (89% vs. 74%), suggesting superior biomechanical durability.¹⁰

In high-demand populations such as overhead athletes and military personnel, open procedures have demonstrated superior durability. A retrospective cohort study with 106 athletes under age 30 years undergoing an open Latarjet procedure for anterior shoulder instability by Bavarel et. al, (2018), showed net improvement of 27.95 in Rowe score (postoperative assessment of shoulder stability, motion, and function on a scale of maximum score 100) in the competitive athletes with a 14.5% improvement in the recreational athletes in a mean follow up of 46 months. The repair was durable and 100% of all participants resumed their previous sport at an identical or an increased level prior to their shoulder injury. The open Latarjet is concluded to be considered as the primary choice for shoulder stabilization for the highly active populations including athletes to allow for higher functional demands and to reduce the greater risks of dislocation possible in an arthroscopic repair.¹¹

Mohtadi et. al., (2014) reported that for open and arthroscopic repair for shoulder stabilization in a 1:1 randomized controlled trial with 196 individuals, at two years there was no difference between open and arthroscopic repair for quality of life. However, there was a significant difference in recurrence rates of dislocation, with 52% less recurrence of shoulder instability in the open shoulder repair group at two years compared to the arthroscopically repaired shoulder instability. This data suggests that an open surgical repair for shoulder instability is recommended to reduce the recurrence risk of instability in younger males with a Hills-Sachs lesion.¹²

Open Capsular Shift

A systematic review by Jacobsen et al., (2012) with a total of 197 individuals who had open capsular shift surgery, or to arthroscopic capsular plication, concluded that in the case of either traumatic or atraumatic shoulder instability onset in 2 directions in the absence of structural lesions, similar results are seen with either open or arthroscopic surgery when examining the recurrence of instability, complications, loss of external rotation, and return to sport. Both procedures were demonstrated to be dependable and safe with minimal complications.¹³

A systematic review by Huerta et al., (2017) examining management of shoulder instability and comparing open vs. arthroscopic procedures in the setting without bone loss, showed similar outcomes for both procedures. The authors state that if the glenoid bone loss is greater than 25%, the open procedure is the superior choice for repair.¹⁴

Subacromial Decompression

An open subacromial decompression procedure is preferred in severe cases which need a bigger incision to directly access the shoulder joint, especially with large rotator cuff tears or in the case of shoulder damage presenting as higher complexity.¹⁵ In a prospective randomized study by Farfaras et al., (2014) of 87 individuals with subacromial impingement syndrome, the study compared open and arthroscopic acromioplasty with physiotherapy. The open acromioplasty group demonstrated the greatest improvement over the follow up at three years.¹⁶

Ongoing and Unpublished Clinical Trials

Table 2. Summary of Key Trials

NCT No.	Trial Name	Planned Enrollment	Completion Date
Ongoing			
NCT06360887	Management of Proximal Humerus Fractures in Elderlies: a Clinical Trial	351	Jan 2028
NCT04809064	Open Versus Arthroscopic Stabilization of Shoulder Instability with Subcritical Bone Loss: the OASIS Trial	400	Sep 2027

NCT No.	Trial Name	Planned Enrollment	Completion Date
NCT05705479	Shoulder Instability Trial Comparing Arthroscopic Stabilization Benefits Compared with Latarjet Procedure Evaluation	114	May 2027

NCT: national clinical trial.

^a Denotes industry-sponsored or cosponsored trial.

Practice Guidelines and Position Statements

Guidelines or position statements will be considered for inclusion if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

American Academy of Orthopaedic Surgeons (AAOS)

The American Academy of Orthopaedic Surgeons (AAOS) has issued a strong recommendation in 2025 that supports open surgical procedures, including arthrotomy, for managing rotator cuff repairs. The AAOS stated that there is not a difference in patient reported outcomes between open or arthroscopic procedures.¹⁷

Medicare National Coverage

There is no national coverage determination.

Regulatory Status

Shoulder arthrotomy is a surgical procedure and as such, is not subject to regulation by the FDA.

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History

Date	Comments
12/01/25	New policy, approved November 11, 2025, effective for dates of service on or after March 4, 2026, following 90-day provider notification. Add to Surgical section. Shoulder arthrotomy in adults is considered medically necessary for the indications noted when criteria are met. The following CPT codes will apply to this policy when it becomes effective March 4, 2026: 20670, 20680, 23040, 23044, 23101, 23105, 23106, 23107, 23120, 23130, 23410, 23412, 23415, 23420, 23450, 23455 , 23460, 23462 , 23465, 23466, 23550, 23552, 23585, 23615, 23616, 23630, 23660, 23670, 23680, and 23939.

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. The Company adopts policies after careful review of published peer-reviewed scientific literature, national guidelines and local standards of practice. Since medical technology is constantly changing, the Company reserves the right to review and update policies as appropriate. Member contracts differ in their benefits. Always consult the member benefit booklet or contact a member service representative to determine coverage for a specific medical service or supply. CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). ©2026 Premera All Rights Reserved.

Scope: Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.

