PREMERA | BLUE CROSS

An Independent Licensee of the Blue Cross Blue Shield Association

MEDICAL POLICY – 7.01.602

Shoulder Arthroscopy in Adults

BCBSA Ref. Policy:	N/A
Effective Date:	Apr. 1, 2026
Last Revised:	Jun. 1, 2026
Replaces:	N/A

RELATED MEDICAL POLICIES:

7.01.165	Radiofrequency Coblation Tenotomy for Musculoskeletal Conditions
7.01.180	Balloon Spacers for Treatment of Irreparable Rotator Cuffs of the Shoulder
7.01.590	Shoulder Arthroplasty
11.01.525	Site of Service Ambulatory Service Center (ASC) Select Surgical Procedures

The Site of Service Medical Necessity criteria within this policy DOES NOT apply to Indian Health Services (IHS) facilities.
Please refer to the medical necessity criteria for the procedure only.

Select a hyperlink below to be directed to that section.

POLICY CRITERIA | DOCUMENTATION REQUIREMENTS | CODING
RELATED INFORMATION | EVIDENCE REVIEW | REFERENCES | APPENDIX | HISTORY

∞ Clicking this icon returns you to the hyperlinks menu above.

Introduction

Shoulder arthroscopy is a minimally invasive surgical procedure used to diagnose and treat problems inside the shoulder joint. During this procedure, a surgeon inserts a small camera and specialized instruments through tiny incisions, allowing them to see and repair damaged tissues without making a large cut. It is commonly used for conditions such as rotator cuff tears, shoulder instability, and cartilage damage. Because it is less invasive than open surgery, patients often experience shorter recovery times and less pain. This medical policy describes when shoulder arthroscopy is 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

We will review for medical necessity this elective surgical procedure.

We also will review the site of service for medical necessity. Site of service is defined as the location where the surgical procedure is performed, such as an off campus-outpatient hospital or medical center, an on campus-outpatient hospital or medical center, an ambulatory surgical center, or an inpatient hospital or medical center.

Site of Service for Elective Surgical Procedures	Medical Necessity
Medically necessary sites of service: • **Ambulatory surgical center**	**Certain elective surgical procedures will be covered in the most appropriate, safe, and cost-effective site. This is the preferred medically necessary site of service for certain elective surgical procedures.**

• **Off campus-outpatient hospital/medical center**
• **On campus-outpatient hospital/medical center**
	Certain elective surgical procedures will be covered in the most appropriate, safe, and cost-effective site. An elective surgical procedure performed in a hospital outpatient department may be considered medically necessary if there is no access to an ambulatory surgical center due to one of the following criteria:
	• There is no qualifying ASC within 30 miles that can provide the necessary care due to one of the following:
	  ○ There is no geographically accessible ASC that has the necessary equipment to perform the procedure; or
	  ○ There is no geographically accessible ASC available at which the individual's physician has privileges; or
	  ○ An ASC's specific guideline prohibits the use of the ASC related to the individual's health condition or weight, or
	• The individual is aged 18 or younger, or
	• The service being performed is in conjunction with an additional service that requires the use of a hospital outpatient department, and the procedures are being performed in the same operative session
	OR

Site of Service for Elective Surgical Procedures	Medical Necessity
	• The individual has a clinical condition which puts them at increased risk for complications including any of the following (this list may not be all inclusive): ○ **Anesthesia Risk** ▪ ASA classification III or higher (see definition) ▪ Personal history of complication of anesthesia ▪ Documentation of alcohol dependence or history of cocaine use ▪ Prolonged surgery (greater than 3 hours) ○ **Cardiovascular Risk** ▪ Uncompensated chronic heart failure (NYHA class III or IV) ▪ Recent history of myocardial infarction (MI) (less than 3 months) ▪ Poorly controlled, resistant hypertension* ▪ Recent history of cerebrovascular accident (less than 3 months) ▪ Increased risk for cardiac ischemia (drug eluting stent placed less than 1 year or angioplasty less than 90 days) ▪ Symptomatic cardiac arrhythmia despite medication ▪ Significant valvular heart disease ○ **Liver Risk** ▪ Advanced liver disease (MELD Score greater than 8)** ○ **Pulmonary Risk** ▪ Chronic obstructive pulmonary disease (COPD) (FEV1 less than 50%) ▪ Poorly controlled asthma (FEV1 less than 80% despite treatment) ▪ Moderate to severe obstructive sleep apnea (OSA)*** ○ **Renal Risk** ▪ End stage renal disease (on dialysis) ○ **Other** ▪ Morbid obesity (BMI greater than or equal to 50) ▪ Pregnancy

Site of Service for Elective Surgical Procedures	Medical Necessity
	▪ Bleeding disorder (requiring replacement factor, blood products, or special infusion product [DDAVP**** does not meet this criterion]) ▪ Anticipated need for transfusion(s) **Note**: * 3 or more drugs to control blood pressure ** https://reference.medscape.com/calculator/meld-score-end-stage-liver-disease *** Moderate-AHI greater than or equal to 15 and less than or equal to 30, Severe-AHI greater than or equal to 30 ****DDAVP-Deamino-Delta-D-Arginine Vasopressin (Desmopressin)
• **Off campus-outpatient hospital/medical center** • **On campus-outpatient hospital/medical center**	**These sites of service are considered not medically necessary for certain elective surgical procedures when the site of service criteria listed above are not met.**
• **Inpatient hospital/medical center**	**This site of service is considered not medically necessary for this elective surgical procedure**

NOTE: This policy only applies to adults aged 19 and older

ROTATOR CUFF REPAIR

LABRAL TEAR OR SUPERIOR LABRAL ANTERIOR POSTERIOR (SLAP) TEAR REPAIR

CAPSULAR RELEASE/ADHESIVE CAPSULITIS (FROZEN SHOULDER)

CAPSULORRHAPHY FOR SHOULDER INSTABILITY AND/OR LAXITY

DISTAL CLAVICULAR EXCISION (AKA MUMFORD PROCEDURE)

LOOSE OR FOREIGN BODY REMOVAL

SUBACROMIAL DECOMPRESSION/ACROMIOPLASTY

SYNOVECTOMY (PARTIAL OR COMPLETE)

THERMAL CAPSULORRHAPHY

ALL OTHER INDICATIONS OR SITUATIONS

Indication	Medical Necessity

Rotator cuff repair (CPT 29827)	**Shoulder arthroscopy for rotator cuff repair (partial or full thickness) may be considered medically necessary when ALL the following criteria are met:**
	• History of disabling shoulder or upper arm pain with loss of shoulder function which interferes with ADLs
	AND
	• Shoulder pain or weakness on resisted abduction or rotation
	AND
	• One of the following positive orthopedic tests (see **Definition of Terms**) is present
	  ○ Drop arm test
	  ○ Painful arc test
	  ○ Empty can test (aka Jobe test)
	  ○ Weakness of external rotation (lag/dropping sign)
	AND
	• Imaging demonstrates partial or full-thickness rotator cuff tear (may be associated with muscle atrophy, fatty replacement, or tendon retraction, if tear is chronic) (see **Definition of Terms** for Ellman and Cofield grade classifications)
	AND
	• Documentation of three months of failed non-operative, conservative management* as demonstrated by a trial of one or more of the following medications:
	  ○ NSAIDs** or acetaminophen
	  ○ Subacromial corticosteroid injection, as appropriate
	AND
	• A trial of the following physical measures:
	  ○ PT for at least 6 weeks (which may include PT-directed home exercise)
	
	Note: *Conservative management is not required in an acute traumatic injury with a complete tear with debilitating pain and loss of function
	
	**NSAIDs (non-steroidal anti-inflammatories)

Indication	Medical Necessity
Superior labral anterior posterior (SLAP) tear repair (CPT 29807)	**Shoulder arthroscopy for repair of a superior labral anterior posterior (SLAP) tear may be considered medically necessary when ALL the following criteria are met:** • History of disabling shoulder pain and loss of shoulder function which interferes with activities of daily living (ADLs) **AND** • Normal or minimally limited active or passive shoulder ROM worsened by heavy lifting, pushing, or overhead movement when compared to unaffected shoulder **AND** • One of the following positive orthopedic tests (see **Definition of Terms**) is present ○ Active Compression Test (aka O'Brien's test) ○ Anterior Slide Test ○ Crank Test (aka Passive Compression Test, Labral Crank Test) **AND** • Imaging demonstrates a SLAP tear **AND** • Documentation of three months of failed non-operative, conservative management as demonstrated by a trial of one or more of the following medications: ○ NSAIDs* or acetaminophen ○ Intra-articular corticosteroid injection, as appropriate **AND** • A trial of the following physical measures: ○ PT for at least 6 weeks (which may include PT-directed home exercise) ***Note:** NSAIDs (non-steroidal anti-inflammatories)
Capsular release/adhesive capsulitis (frozen shoulder) (CPT 29825)	**Shoulder arthroscopy for release of capsular adhesions (e.g., adhesive capsulitis) or lysis of adhesions may be considered medically necessary when ALL the following criteria are met:** • History of disabling shoulder pain and loss of shoulder function which interferes with activities of daily living (ADLs)

Indication	Medical Necessity

	AND
	• History of chronic refractory adhesive capsulitis or arthrofibrosis resulting from disease, injury, or surgery
	AND
	• Limited active and passive shoulder ROM
	AND
	• Documentation of six months of failed non-operative, conservative management as demonstrated by a trial of one or more of the following medications:
	  ○ NSAIDs* or acetaminophen
	  ○ Intra-articular corticosteroid injection, as appropriate
	AND
	• A trial of the following physical measures:
	  ○ PT for at least 12 weeks (which may include PT-directed home exercise)
	
	***Note**: NSAIDs (non-steroidal anti-inflammatories)

Capsulorrhaphy for shoulder instability and/or laxity (CPT 29806)	**Shoulder arthroscopic capsulorrhaphy for shoulder instability and/or laxity may be considered medically necessary when ALL the following criteria are met:**
	• History of shoulder dislocation or subluxation with disabling shoulder pain and loss of shoulder function which interferes with ADLs
	AND
	• Instability found on physical exam demonstrated by any of the following positive orthopedic tests/signs (see **Definition of Terms**)
	  ○ Anterior or posterior apprehension test
	  ○ Load and shift test
	  ○ Sulcus sign
	AND
	• MRI findings demonstrate at least ONE of the following
	  ○ A labral lesion consistent with clinical instability (e.g., Bankart lesion)
	  ○ Hill-Sachs lesion
	  ○ Capsular tear (thickening and edema of the joint)

Indication	Medical Necessity
	○ Capsular redundancy with clinical multidirectional instability (shoulder joint capsule is loose or stretched) **AND** • Documentation of three months of failed non-operative, conservative management* as demonstrated by a trial of one or more of the following medications: ○ NSAIDs** or acetaminophen ○ Intra-articular corticosteroid injection **AND** • A trial of the following physical measures: ○ PT for at least 6 weeks (which may include PT-directed home exercise) **Note:** *Conservative management is not required in an acute traumatic injury when EITHER of the following conditions is present: • Irreducible shoulder dislocation, or • Anterior shoulder instability in competitive contact or collision athletes ** NSAIDs (non-steroidal anti-inflammatories)
Distal clavicular excision (aka Mumford procedure) (CPT 29824)	**Shoulder arthroscopy for clavicular excision may be considered medically necessary when ALL the following criteria are met:** • History of disabling shoulder pain with loss of shoulder function which interferes with activities of daily living (ADLs) **AND** • Localized tenderness to palpation of the acromioclavicular (AC) joint **AND** • At least ONE of the following positive orthopedic tests (see **Definition of Terms**) on physical exam compared to the non-affected shoulder ○ Cross-Body Adduction Test (aka Scarf Test, Cross-Over Adduction Test) ○ Resisted AC Joint Extension Test **AND** • Documentation of three months of failed non-operative,

Indication	Medical Necessity
	conservative management as demonstrated by a trial of one or more of the following medications: ○ NSAIDs* or acetaminophen ○ Subacromial corticosteroid injection, as appropriate **AND** • A trial of the following physical measures: ○ PT for at least 6 weeks (which may include PT-directed home exercise) **AND** • Plain x-rays or imaging (MRI or CT) demonstrate findings consistent with AC joint arthritis **Note**: * NSAIDs (non-steroidal anti-inflammatories)
Loose or foreign body removal (CPT 29819)	**Shoulder arthroscopy for removal of a loose or foreign body is considered medically necessary when ALL the following criteria are met:** • MRI or CT findings demonstrate a loose body or foreign body within the shoulder joint **AND** • Symptoms include BOTH of the following ○ Disabling shoulder pain and loss of shoulder function which interferes with activities of daily living (ADLs), and ○ Mechanical symptoms including any of the following: painful locking, clicking, catching, or popping **AND** • Documentation of three months of failed non-operative, conservative management as demonstrated by a trial of one or more of the following medications: ○ NSAIDs* or acetaminophen ○ Intra-articular corticosteroid injection, as appropriate **AND** • A trial of the following physical measures: ○ PT for at least 6 weeks (which may include PT-directed home exercise) ○

Indication	Medical Necessity
	*__Note:__ NSAIDs (non-steroidal anti-inflammatories)

Subacromial decompression/acromioplasty (CPT 29826)	**Shoulder arthroscopy for subacromial decompression/acromioplasty* may be considered medically necessary when ALL of the following criteria are met:**
	• History of disabling shoulder pain with loss of shoulder function which interferes with activities of daily living (ADLs), and
	• At least ONE of the following positive orthopedic tests (see **Definition of Terms**) on physical exam compared to the
	• non-affected shoulder
	  ○ Hawkins-Kennedy Impingement Test
	  ○ Neer Impingement Test
	AND
	• Documentation of three months of failed non-operative, conservative management as demonstrated by a trial of one or more of the following medications:
	  ○ NSAIDs** or acetaminophen
	  ○ Subacromial corticosteroid injection, as appropriate
	AND
	• A trial of the following physical measures:
	  ○ PT for at least 6 weeks (which may include PT-directed home exercise)
	AND
	• Plain x-rays or imaging (MRI or CT) demonstrate findings consistent with subacromial impingement, (e.g., Type II or III acromions***)
	
	Note: * Arthroscopic subacromial decompression or acromioplasty may be considered medically necessary as an add-on procedure only with other medically necessary primary shoulder surgical procedures
	
	** NSAIDs (non-steroidal anti-inflammatories)
	
	***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.

Indication	Medical Necessity

Synovectomy (partial or complete) (CPT 29820, 29821)	**Shoulder arthroscopic synovectomy (partial or complete) may be considered medically necessary when ALL the following criteria are met:**
	• ONE or more of the following symptoms is present:
	  ○ Joint pain
	  ○ Locking
	  ○ Pain with ROM
	  ○ Limited ROM
	  ○ Crepitus (crackling or crunching sounds in a joint)
	  ○ Joint effusion (accumulation of fluid) or swelling
	AND
	• Imaging or biopsy demonstrates underlying pathology consistent with the reported medical condition (e.g., synovitis, joint effusion)
	AND
	• Documentation of three months of failed non-operative, conservative management as demonstrated by a trial of one or more of the following medications:
	  ○ NSAIDs* or acetaminophen
	  ○ Intra-articular corticosteroid injection, as appropriate
	AND
	• A trial of the following physical measures:
	  ○ PT for at least 6 weeks (which may include PT-directed home exercise)
	AND
	• Diagnosis of ONE of the following conditions is present:
	  ○ Inflammatory arthritis (rheumatoid arthritis, gout, psoriatic arthritis, pseudogout)
	  ○ Hemochromatosis (iron overload)
	  ○ Hemophilia
	  ○ Lyme synovitis
	  ○ Non-specific synovitis (e.g., proliferative synovitis, post-operative synovitis from shoulder replacement, etc.)
	  ○ Pigmented villonodular synovitis (PVNS)- (rare condition of overgrowth of cells within the synovial tissue)

Indication	Medical Necessity
	○ Recurrent hemarthrosis (joint bleeding) secondary to sickle cell anemia, or bleeding diathesis (excessive bleeding) ○ Synovial chondromatosis (a rare condition where cartilage nodules develop within the synovium) *__Note:__ NSAIDs (non-steroidal anti-inflammatories)

Procedure	Not Medically Necessary
Thermal capsulorrhaphy	**Thermal capsulorrhaphy as a treatment of joint instability of the shoulder is considered not medically necessary (e.g., ORA-50 electrothermal system, ArthroCare system, Vulcan electrothermal arthroscopy system, and VAPR II electrosurgical system)**
All other indications or situations	**For all other indications not listed above, or for other situations not described above, including when the above criteria are not met, shoulder arthroscopy is considered not medically necessary**

Documentation Requirements

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:

For arthroscopic rotator cuff repair of the shoulder, documentation should support ALL of the following:

- History of disabling shoulder or upper arm pain with loss of shoulder function which interferes with ADLs, and
- Shoulder pain or weakness on resisted abduction or rotation, and
- Tenderness over rotator cuff

AND

- One of the following positive orthopedic tests is present
  - Drop arm test
  - Painful arc test
  - Empty can test (aka Jobe test)

Documentation Requirements

- Weakness of external rotation (lag/dropping sign)

AND

- Imaging demonstrates partial or full-thickness rotator cuff tear

AND

- Documentation of three months of failed non-operative, conservative management as demonstrated by a trial of one or more of the following medications:
  - NSAIDs* or acetaminophen
  - Subacromial corticosteroid injection, as appropriate

AND

- A trial of the following physical measures:
  - Physical therapy (PT) for at least 6 weeks (which may include PT-directed home exercise)

For arthroscopic repair of a SLAP tear of the shoulder, documentation should support ALL the following:

- History of disabling shoulder pain and loss of shoulder function which interferes with activities of daily living (ADLs), and
- Normal or minimally limited active or passive shoulder ROM worsened by heavy lifting, pushing, or overhead movement when compared to unaffected shoulder

AND

- One of the following positive orthopedic tests is present
  - Active Compression Test (aka O'Brien's test)
  - Anterior Slide Test
  - Crank Test (aka Passive Compression Test, Labral Crank Test)

AND

- Imaging demonstrates a SLAP tear

AND

- Documentation of three months of failed non-operative, conservative management as demonstrated by a trial of one or more of the following medications:
  - NSAIDs* or acetaminophen
  - Intra-articular corticosteroid injection, as appropriate

AND

- A trial of the following physical measures:
  - Physical therapy (PT) for at least 6 weeks (which may include PT-directed home exercise)

Documentation Requirements

For arthroscopic release of shoulder capsular adhesions or lysis of adhesions documentation should support ALL the following:

- History of disabling shoulder pain and loss of shoulder function which interferes with activities of daily living (ADLs), and
- History of chronic refractory adhesive capsulitis or arthrofibrosis resulting from disease, injury, or surgery, and
- Limited shoulder ROM

AND

- Documentation of three months of failed non-operative, conservative management as demonstrated by a trial of one or more of the following medications:
  - NSAIDs* or acetaminophen
  - Intra-articular corticosteroid injection, as appropriate

AND

- A trial of the following physical measures:
  - Physical therapy (PT) for at least 6 weeks (which may include PT-directed home exercise)

For arthroscopic shoulder capsulorrhaphy for instability and/or laxity, documentation should support ALL of the following:

- History of shoulder dislocation or subluxation with disabling shoulder pain and loss of shoulder function which interferes with ADLs, and
- Instability found on physical exam demonstrated by any of the following positive orthopedic tests/signs
  - Anterior or posterior apprehension test
  - Load and shift test
  - Sulcus sign, and
- MRI findings demonstrate at least ONE of the following
  - A labral lesion consistent with clinical instability (e.g., Bankart lesion)
  - Hill-Sachs lesion
  - Capsular tear (thickening and edema of the joint)
  - Capsular redundancy with clinical multidirectional instability (shoulder joint capsule is loose or stretched)

AND

- Documentation of three months of failed non-operative, conservative management as demonstrated by a trial of one or more of the following medications:
  - NSAIDs* or acetaminophen

Documentation Requirements

- Intra-articular corticosteroid injection, as appropriate

AND

- A trial of the following physical measures:
  - Physical therapy (PT) for at least 6 weeks (which may include PT-directed home exercise)

For arthroscopic shoulder distal clavicular excision, documentation should support ALL the following:

- History of disabling shoulder pain with loss of shoulder function which interferes with activities of daily living (ADLs)

AND

- Localized tenderness to palpation of the acromioclavicular (AC) joint

AND

- At least ONE of the following positive orthopedic tests on physical exam compared to the non-affected shoulder
  - Cross-Body Adduction Test (aka Scarf Test, Cross-Over Adduction Test)
  - Resisted AC Joint Extension Test

AND

- Documentation of three months of failed non-operative, conservative management as demonstrated by a trial of one or more of the following medications:
  - NSAIDs* or acetaminophen
  - Subacromial corticosteroid injection, as appropriate

AND

- A trial of the following physical measures:
  - Physical therapy (PT) for at least 6 weeks (which may include PT-directed home exercise)

AND

- Plain x-rays or imaging (MRI or CT) demonstrate findings consistent with AC joint arthritis

For arthroscopic removal of a loose or foreign body from the shoulder, documentation should support ALL the following:

- MRI or CT findings demonstrate a loose body or foreign body within the shoulder joint, and
- Symptoms include BOTH of the following
  - Disabling shoulder pain and loss of shoulder function which interferes with activities of daily living (ADLs), and
  - Mechanical symptoms including any of the following: painful locking, clicking, catching, or popping

AND

Documentation Requirements

- Documentation of three months of failed non-operative, conservative management as demonstrated by a trial of one or more of the following medications:
  - NSAIDs* or acetaminophen
  - Intra-articular corticosteroid injection, as appropriate

AND

- A trial of the following physical measures:
  - Physical therapy (PT) for at least 6 weeks (which may include PT-directed home exercise)

For arthroscopic shoulder subacromial decompression/acromioplasty, documentation should support ALL the following:

- History of disabling shoulder pain with loss of shoulder function which interferes with activities of daily living (ADLs)

AND

- At least ONE of the following positive orthopedic tests (see Definition of Terms) on physical exam compared to the non-affected shoulder
  - Hawkins-Kennedy Impingement Test
  - Neer Impingement Test

AND

- Documentation of three months of failed non-operative, conservative management as demonstrated by a trial of one or more of the following medications:
  - NSAIDs* or acetaminophen
  - Subacromial corticosteroid injection, as appropriate

AND

- A trial of the following physical measures:
  - Physical therapy (PT) for at least 6 weeks (which may include PT-directed home exercise)

AND

- Plain x-rays or imaging (MRI or CT) demonstrate findings consistent with subacromial impingement, (e.g., Type II or III acromions***)

For arthroscopic synovectomy of the shoulder, documentation should support ALL the following:

- ONE or more of the following symptoms is present:
  - Joint pain

Documentation Requirements

- Locking
- Pain with ROM
- Limited ROM
- Crepitus (crackling or crunching sounds in a joint)
- Joint effusion (accumulation of fluid) or swelling

AND

- Imaging or biopsy demonstrates underlying pathology consistent with the reported medical condition (e.g., synovitis, joint effusion)

AND

- Documentation of three months of failed non-operative, conservative management as demonstrated by a trial of one or more of the following medications:
  - NSAIDs* or acetaminophen
  - Intra-articular corticosteroid injection, as appropriate

AND

- A trial of the following physical measures:
  - Physical therapy (PT) for at least 6 weeks (which may include PT-directed home exercise)

AND

- Diagnosis of ONE of the following conditions is present:
  - Inflammatory arthritis (rheumatoid arthritis, gout, psoriatic arthritis, pseudogout)
  - Hemochromatosis (iron overload)
  - Hemophilia
  - Lyme synovitis
  - Non-specific synovitis (e.g., proliferative synovitis, post-operative synovitis from shoulder replacement, etc.)
  - Pigmented villonodular synovitis (PVNS)- (rare condition of overgrowth of cells within the synovial tissue)
  - Recurrent hemarthrosis (joint bleeding) secondary to sickle cell anemia, or bleeding diathesis (excessive bleeding)
  - Synovial chondromatosis (a rare condition where cartilage nodules develop within the synovium)

Coding

Code	Description
CPT	
23929	Unlisted procedure, shoulder
29806	Arthroscopy, shoulder, surgical; capsulorrhaphy
29807	Arthroscopy, shoulder, surgical; repair of SLAP lesion
29819	Arthroscopy, shoulder, surgical; with removal of loose body or foreign body
29820	Arthroscopy, shoulder, surgical; synovectomy, partial
29821	Arthroscopy, shoulder, surgical; synovectomy, complete
29824	Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure)
29825	Arthroscopy, shoulder, surgical; with lysis and resection of adhesions, with or without manipulation
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (i.e., arch) release, when performed (List separately in addition to code for primary procedure)
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
29999	Unlisted procedure, arthroscopy

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.

Active Compression Test: (aka O'Brien's test) is a test used to diagnose labral tears and acromioclavicular (AC) joint injuries in the shoulder. The shoulder is flexed to 90 degrees with slight adduction and internally rotating the arm with the palm facing down. Pain or clicking during internal rotation is considered a positive test, which subsides when the arm is externally rotated with the palm up.

Adhesive Capsulitis/Arthrofibrosis: (aka frozen shoulder) is a condition where the shoulder joint becomes painful and stiff, progressively limiting its range of motion. This occurs when the joint capsule of the shoulder, a connective tissue surrounding the joint, thickens (fibrosis; formation of adhesions) and becomes inflamed, restricting movement.

Anterior Apprehension Test: is a test used to assess anterior instability of the shoulder. An individual lies supine and their arm is abducted to 90 degrees. The arm is slowly rotated pushing the humeral head forward (anteriorly). A positive test is indicated by a sense of impending dislocation of the shoulder.

Anterior Slide Test: is a test used to evaluate SLAP tears in the shoulder. An individual sits or stands with their hand on their hip, thumb pointing backward. An anterior and superior pressure is applied to the humerus while the individual resists the movement. It is considered positive if pain or clicking is reproduced at the front of the shoulder.

Bankart tear: is a specific type of labral tear, often after a shoulder dislocation. It usually occurs in the lower (inferior) part of the labrum and involves the inferior glenohumeral ligament. It commonly occurs in young athletes involved in contact sports.

Biceps tenodesis: is a surgical procedure that involves reattaching the biceps tendon to the upper arm bone (humerus) after it has been detached or damaged at the shoulder joint. It may be performed with an open surgical technique or arthroscopically.

Capsulorrhaphy: is a surgical procedure that stabilizes a loose or unstable shoulder joint by tightening the shoulder capsule (the tissue surrounding the joint) and ligaments, reducing the space around the joint, to prevent excessive movement. It is usually done to address shoulder instability or dislocations. It may be performed through an open surgical technique or arthroscopically.

Cofield Classification of Full-Thickness Rotator Cuff Tears:

- **Small**: Less than 1 cm
- **Medium**: 1-3 cm
- **Large**: 3-5 cm
- **Massive**: Greater than 5 cm

Coracoacromial ligament: is a strong, triangular band of tissue in the shoulder connecting the coracoid process and the acromion of the scapula forming a protective arch over the head of the humerus. It helps with stability of the shoulder joint and protects the rotator cuff tendons.

Crank Test: (aka Passive Compression Test, Labral Crank Test) is a test used to assess for glenoid labral tears, particularly SLAP tears, in the shoulder. It involves applying compression to

the shoulder of an individual either seated or lying supine with the affected arm abducted to 90 degrees with the elbow flexed to 90 degrees while rotating the humerus. The test is considered positive if pain or clicking associated with a labral tear is reproduced with this maneuver.

Cross-Body Adduction Test: (aka Scarf Test, Cross-Over Adduction Test) is a test used to assess potential injuries to the acromioclavicular (AC) joint. It involves passively adducting an individual's arm across the body, compressing the AC joint. A positive test produces pain, possibly indicating AC joint arthritis or subluxation.

Drop arm test: is a test used to identify a significant rotator cuff tear, particularly of the supraspinatus muscle. The individual is seated or standing. The examiner lifts the individual's affected arm out to the side (abducts it) to 90 degrees while supporting the arm at the elbow. The examiner then removes their arm of support. The test is considered positive if the arm drops suddenly without support or if the individual cannot hold the arm in the 90-degree position or cannot control a smooth, slow descent. A positive test is indicative of a full-thickness rotator cuff tear.

Ellman Classification of Partial-Thickness Rotator Cuff Tears

- **Grade 1**: Less than 3mm deep
- **Grade 2**: 3-6 mm deep
- **Grade 3**: Greater than 6 mm deep

Empty can test: (aka Jobe test) is a test used to assess the function of the supraspinatus muscle in the shoulder. The individual stands with their arms at their sides. The individual raises both arms to 90 degrees abduction with their palms facing forward. The individual internally rotates their arms so that their thumbs point towards the floor (like they are emptying a can). The examiner applies downward pressure on the individual's arms, asking them to resist. A test is considered positive when there is pain in the shoulder, weakness or instability to resist the downward pressure, or dropping of the affected arm. A positive test is indicative of a supraspinatus injury such as a tear, rotator cuff impingement, or nerve damage.

External rotation lag sign: is a test used to assess the integrity of the infraspinatus and teres minor muscles, which are part of the rotator cuff. It is used to help diagnose full-thickness tears of these tendons. An individual sits with their back to the examiner. The examiner flexes the individual's elbow to 90 degrees. The examiner positions the shoulder to 20 degrees abduction (external rotation) while supporting the individual's elbow and wrist. The individual is instructed to hold the arm in this position while the examiner releases support at the wrist but maintains support at the elbow. A positive test is when the individual's arm drops back into internal rotation.

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.

Hawkins-Kennedy impingement test: is a test used to assess for subacromial impingement syndrome in the shoulder. An individual's arm while they are standing or seated is passively internally rotated while it is flexed to 90 degrees with the elbow flexed to 90 degrees. A positive test is when this maneuver reproduces pain.

Load and Shift test: is a test used to assess the stability of the glenohumeral joint (shoulder joint). An individual is usually seated with their arm relaxed. The examiner stabilizes the scapula and clavicle with one hand and grasps the humeral head with the other hand and guides it into a neutral position within the glenoid. The examiner applies a gentle pressure to the humeral head either anteriorly (pushing forward) or posteriorly (pushing backward) to assess the joint stability in those directions (the load phase). For the shift phase, the examiner guides the humeral head within the glenoid fossa (glenoid cavity). The movements on the affected side are compared to the other healthy shoulder. The test is considered positive if pain or instability is reproduced during the movements.

The Mumford Procedure: (aka distal clavicle excision) is a surgical procedure where a small portion of the end of the clavicle (collarbone) is removed. It is used to treat pain and dysfunction in the acromioclavicular (AC) joint of the shoulder by reducing any bone-on-bone contact that may be causing inflammation by creating more space, which relieves pain brought about by the two bones (acromion and clavicle) rubbing together. It may be performed by an open surgical technique or arthroscopically.

Neer impingement test: is a test used to assess the presence of subacromial impingement syndrome. An examiner passively flexes an individual's arm forward while internally rotating it with the thumb facing down, all while stabilizing the scapula. A positive test is indicated when pain is reproduced in the shoulder, suggesting impingement of the supraspinatus tendon, long head of the biceps tendon, or subacromial bursa.

Painful arc test: identifies subacromial impingement syndrome in the shoulder suggesting irritation of the rotator cuff tendons or subacromial bursa. The individual sits or stands with their arms at their sides. The individual is instructed to slowly abduct their arm in the scapular plane with their thumb pointing upwards. A test is considered positive if pain is present when the arm is abducted to around 60 degrees and resolves after around 120 degrees of abduction. When the individual slowly brings their arm down again (adduction), the pain should reappear at the

same arc. There should be no pain felt during the initial and final parts of the movement. The test is indicative of impingement syndrome of the supraspinatus tendon.

Popeye sign: is a visible bulging, ball-shaped deformity in the upper arm of the biceps muscle that occurs when its tendon, particularly the long head of the tendon, tears from the bone. This rupture causes the muscle to contract and bunch up, creating a bulge similar to the cartoon character Popeye's famously muscular arm.

Posterior Apprehension test: is a test used to assess posterior shoulder instability. An individual lies supine or sits upright and their arm is abducted to 90 degrees with the elbow bent at 90 degrees. A slight pressure is applied to the humerus, pushing down on the elbow while simultaneously adducting (moving towards the body) and internally rotating the arm. The test is considered positive with a sense of the humeral head moving out of place posteriorly

Resisted AC Joint Extension test: (aka the AC resisted extension test) is a test used to assess for problems in the AC joint, such as arthritis or ligament injuries. An individual is seated with their arm flexed to 90 degrees and internally rotated with the elbow flexed to 90 degrees. The examiner applies resistance to the individual's arm as the individual attempts to extend their arm horizontally away from their body. The test is considered positive if the individual experiences pain near the AC joint during the resisted movement.

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.

Speed's test: is a test used to assess for pain and tenderness in the biceps tendon and superior labrum (SLAP) lesion in the shoulder. The individual stands with their arms at their side. The examiner places their hand on the individual's forearm, just below the elbow. The individual flexes their shoulder to 90 degrees keeping their elbow straight. The examiner applies downward pressure on the individual's forearm while the individual resists. The test is considered positive if the individual experiences pain in the anterior shoulder or bicipital groove (an indentation on the upper part of the humerus [upper arm bone]).

Strength Scale:

- **0:** No visible muscle contraction
- **1:** Visible muscle contraction with no or trace movement
- **2**: Limb movement, but not against gravity
- **3**: Movement against gravity but not resistance
- **4:** Movement against at least some resistance supplied by the examiner
- **5**: Full strength

Source: **https://www.merckmanuals.com/professional/neurologic-disorders/neurologic-examination/how-to-assess-muscle-strength** Accessed October 15, 2025.

Subacromial decompression: is a surgical procedure used to treat shoulder impingement where the tendons and bursa become compressed, causing pain and limited movement. The procedure increases room in the subacromial space by removing bone spurs or inflamed tissue, allowing the tendons and bursa to move more freely. The procedure can be performed with an open surgical technique or arthroscopically.

Subscapularis tear: is a shoulder injury involving a tear of the subscapularis tendon (muscle), a key part of the rotator cuff. The damage can range from minor fraying of the tendon to a complete rupture of the fibers. Symptoms include pain in the front of the shoulder and weakness during internal rotation or lifting of the arm. The subscapularis muscle helps with internal rotation and stabilizing of the shoulder joint. These tears can occur due to acute injuries, such as falls or sudden forceful movements, or from chronic wear and tear.

Sulcus sign: is a test used to assess inferior shoulder instability, such as a laxity or subluxation of the glenohumeral joint in the inferior direction (downwards). An individual is seated or standing with their arm relaxed at their side. The examiner stabilizes the shoulder and grasps the individual's forearm or elbow and then pulls the arm downwards. The test is considered positive if there is the appearance of a visible, palpable groove or depression (the "sulcus") below the acromion (the bony prominence at the top of the shoulder) as the humeral head pulls away from the shoulder socket

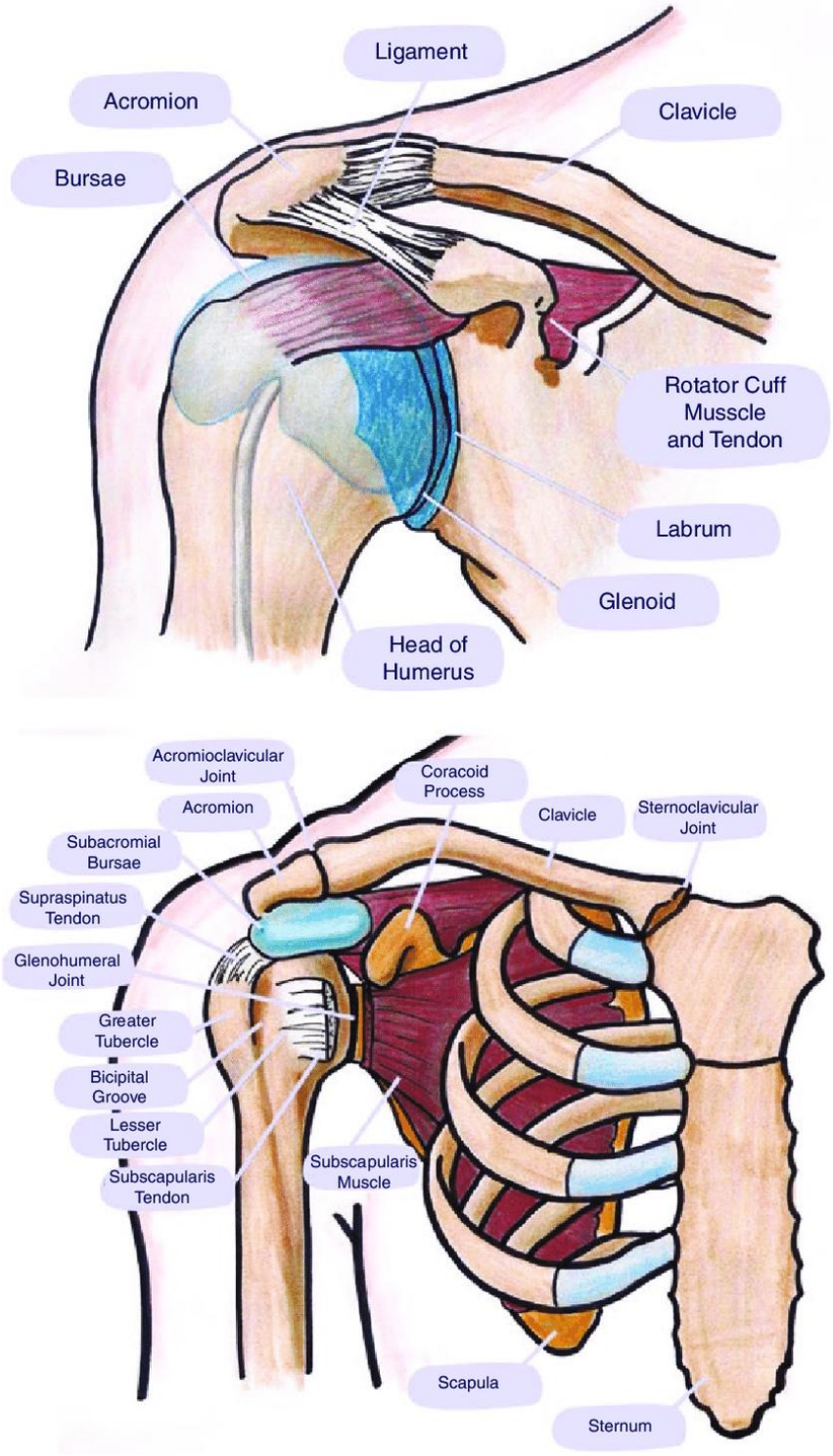
Superior labral anterior posterior (SLAP) tear: is a shoulder injury involving the labrum, a ring of cartilage surrounding the shoulder socket. It affects the labrum where the biceps tendon attaches, causing pain, potential instability, clicking, catching, or popping, and decreased range of motion or weakness in the shoulder. It can result from a forward fall onto an outstretched

hand, a direct blow to the shoulder, or repetitive overhead motions like throwing or weightlifting.

Thermal capsulorrhaphy: uses thermal energy to restructure or "shrink" collagen in the shoulder capsule to decrease the capsule size to improve shoulder joint instability and laxity by tightening the capsule and ligaments. (devices used include ORA-50 electrothermal system, ArthroCare system, Vulcan electrothermal arthroscopy system, and VAPR II electrosurgical system)

Yergason's test: is a test used to assess for pain and instability of the long head of the biceps tendon. The individual bends their elbow to 90-degrees with their forearm partially pronated (palm down). The examiner then resists the individual's attempt to supinate (turn palm up) and externally rotate their forearm, while palpating the bicipital groove and stabilizing their forearm above the individual's wrist. A test is considered positive if the individual experiences pain in the bicipital groove or there is a popping sensation or clicking sound as the tendon moves out of its groove. The test is indicative of a bicipital tendonitis, a SLAP tear, or a biceps tendon subluxation/dislocation.

Shoulder Anatomy



Source: **https://www.researchgate.net/figure/Anatomy-of-the-shoulder-joint_fig5_348256306**. Accessed September 4, 2025.

Evidence Review

Description

Shoulder arthroscopy is a minimally invasive surgical procedure whereby a physician inserts a small camera (arthroscope) and surgical instruments through small incisions around the shoulder joint. The camera projects images to a monitor where the physician can better visualize and examine the anatomy of the shoulder and repair or remove damaged tissue. The procedure enables a physician to diagnose and treat a myriad of shoulder problems such as rotator cuff tears, labral tears, removal of loose tissue, or repair an unstable shoulder joint, usually with a much shorter recovery time and less pain than traditional open surgery. This procedure is generally performed as an outpatient procedure.

Background

Shoulder arthroscopy began being performed in the 1970's. The American Academy of Orthopaedic Surgeons (AAOS) estimates that 8% of all American adults have been affected by chronic shoulder pain, second only to chronic knee pain as a cause of musculoskeletal disability.[1] Arthroscopy is a procedure used to examine, diagnose, and treat problems with the shoulder joint. It may be needed when shoulder pain or limited movement is not helped by conservative care (non-surgical treatment) such as rest, anti-inflammatories, steroid injections, or physical therapy. Injury, overuse, and age-related wear and tear are common causes for most shoulder problems. Shoulder arthroscopy may relieve many of the symptoms caused by these problems that lead to damage of the rotator cuff tendons, labrum, articular cartilage, and other soft tissues surrounding the shoulder joint

The shoulder joint is complex and incurs more motion than any other joint in the human body. It consists of three bones: the humerus (upper arm bone), the scapula (shoulder blade), and the clavicle (collarbone). It is a ball and socket joint where the head of the upper arm bone (humerus) fits into the socket of the shoulder blade (the glenoid). Articular cartilage covers the surface of the ball and socket to enable the bones to glide smoothly across one another. The glenoid is surrounded by a strong fibrous cartilage called the labrum. The labrum forms a seal around the socket to add stability and cushioning. The shoulder capsule is formed by bands of tissue called ligaments surrounding the joint. The capsule is lined with a thin membrane called the synovium. Synovial fluid which is produced by the synovium is what lubricates the shoulder

joint. There are four tendons that surround the shoulder capsule called the rotator cuff. The rotator cuff helps keep the arm bone centered in the shoulder socket. The rotator cuff covers the head of the humerus and attaches it to the shoulder blade. There is also a lubricating sac called a bursa that sits between the rotator cuff and the top bone of the shoulder (acromion). It is what helps the rotator cuff tendons glide smoothly with arm movement.[2]

The small instruments that are inserted during the arthroscopy procedure are used to shave, cut, grasp, suture passing, knot tying, and use special devices that are able to anchor stitches to a bone, or insert anchors. All of these measures are used in an attempt to repair or remove damaged tissue.

Summary of Evidence

Rotator Cuff Repair

For individuals who have rotator cuff tears who receive a shoulder arthroscopy repair the evidence is mixed and includes RCTS, systematic reviews and meta-analyses. Kuhn (2013) reported on a multicenter prospective cohort study of 452 individuals who had atraumatic full-thickness rotator cuff tears (confirmed by physical exam and MRI) who began a physical therapy program developed from a systematic review and were evaluated at 6 and 12 weeks [20]. At 6 weeks the participants chose if they were "cured" and not to proceed further, if they were improved, they could continue with 6 more weeks of physical therapy, or if they were no better, they could elect to have surgery. It was noted that 70% had supraspinatus involvement only, with 48% with minimal retraction and 33.5% with mid-humeral retraction per the MRI. At two years of follow-up, 82 participants of 422 had decided to have surgery (26%). The authors concluded that physical therapy is effective in the nonoperative treatment of atraumatic full-thickness rotator cuff tears as validated by outcome scores (American Shoulder and Elbow Surgeons [ASES], Western Ontario Rotator Cuff Index [WORC], and Single Assessment Numeric Evaluation [SANE]) and documented improvements in range of motion.

Kukkonen (2015), likewise compared 180 shoulders with symptomatic, nontraumatic, supraspinatus tears randomized to three groups: 1) physiotherapy, 2) acromioplasty and physiotherapy, and 3) rotator cuff repair, acromioplasty, and physiotherapy.[22] The primary outcome was the Constant score. One hundred sixty-seven shoulders from 160 participants were followed for two years. There were no significant differences in the mean change of Constant score: 18.4 (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 the secondary outcome

of visual analog scale for pain scores (p=0.45) and patient satisfaction (p=0.28) between the groups. The mean size of the tendon tear at two years was significantly smaller, (4.2 mm) ($p < 0.01$) in Group 3 compared to Groups 1 and 2 (11.0 mm). The authors concluded that there was no significant difference in clinical outcome between the three interventions at two years of follow-up. Thus, conservative treatment is a reasonable option for primary initial treatment of isolated, symptomatic, nontraumatic, supraspinatus tears.

A Cochrane Review in 2019 reviewed 9 RCTs including adults (1007 participants with a mean age between 56 and 68 years) with full-thickness rotator cuff tears assessing the effect of rotator cuff repair with or without subacromial decompression compared to nonoperative treatment (exercises with or without glucocorticoid injection).[17] The primary analysis was of three trials with 339 participants who received surgery or non-operative therapy. The results demonstrated that surgery resulted in little or no benefit in individuals with rotator cuff tears for up to one year. The authors acknowledge methodology concerns as there was no placebo control and most of the participants had small degenerative tears of the supraspinatus tendon so the conclusions may not be generalizable to traumatic tears, large tears, or to young people

Longo (2021) in a systematic review and meta-analysis compared conservative versus surgical management of full-thickness rotator cuff tears from six RCTs with a primary outcome measure of Constant-Murley score (CMS) and visual analog scale (VAS) score.[24] Three trials recorded CMS scores at 12 months from 257 individuals, 126 in the surgical group and 131 in the conservative group. The average score was 77.6 ± 14.4 in the surgery group and 72.8 ± 16.5 in the conservative group. Thus, there were no statistically significant differences between the two groups. (4.42, 95% CI- 5.52 to 14.36; p= 0.38, I^2= 84%) at one year, nor was there any statistically significant differences between the CMS measured at two years of follow-up (0.40, 95% CI −4.55 to 5.35; P = 0.87, I^2 = 0%). However, the VAS pain score in 2 trials for the surgery group provided superior results compared to the conservative group at 12 months of follow-up for 147 participants (71 in the surgical group and 76 in the conservative group). The mean of VAS pain score was 1.4 ± 1.6 in the surgery group and 2.4 ± 1.9 in the conservative group. The authors concluded that at 2-year follow-up there was not significant improvement in terms of the CMS score and that further well-designed RCTS with longer follow-up were needed to evaluate if surgical versus conservative treatment provide comparable long-term results.

However, with fifteen-year follow-up, Moosmayer (2024) found that for small-to-medium-sized rotator cuff tears there were significant and increasing differences favoring tendon repair.[29] 103 participants with ≤ 3 cm full-thickness rotator cuff tears were randomized to tendon repair or physiotherapy. Shoulder function measurements (Constant score) were performed by the same blinded assessor at 6 months, 1, 2, 5, 10 and 15 years. Tear size in unrepaired tears was assessed by ultrasonography. Eighty-three of the 103 (81%) participants were available for the 15-year

follow-up (43 in the primary tendon repair group and 40 in the physiotherapy with optional secondary repair). Fifteen of 51 participants in the physiotherapy group had crossed over to secondary surgery because of lack of progress with physiotherapy alone. Results demonstrated that primary tendon repair was superior by a mean difference of 11.8 points for the Constant score (p=0.001), secondary outcomes demonstrated 13.9 points for the American Shoulder and Elbow Surgeons (ASES) score (p < 0.001), 1.8 cm on a 10-cm visual analog scale for pain (p < 0.001), and 16.2 and 22.4, respectively, for pain-free abduction and flexion (p = 0.04 and 0.001). Twenty-six tears treated by physiotherapy alone had a mean tear size increase from 16.2 to 31.6 mm in the anterior-posterior direction.

Labral Tears

One systematic review by Erickson (2015) reported that individuals with type II or IV superior labrum anterior-posterior (SLAP) tears who had undergone arthroscopic repair and were over 40 years demonstrated higher failure rates at 2-year follow-up, while in some studies those participants older than 40 years and those younger than 40 years had similar outcomes.[9] Findings suggested that as the participants aged, their satisfaction decreased and their complication rate increased, including postoperative stiffness. Reoperations also occurred at a higher rate as the participants aged. The author concluded that biceps tenotomy and tenodesis are alternatives to SLAP repair or revision for failed SLAP repair. If there is an associated rotator cuff tear, the author concluded the evidence favors debridement or biceps tenotomy over SLAP repair.

Schrøder (2017) reported on a double-blind, sham-controlled trial of 118 participants with an isolated type II SLAP lesion and mean age of 40.[32] Participants were randomly assigned to 1) labral repair, n=40, 2) biceps tenodesis, n=39, and 3) sham surgery, n=39. The sham surgery consisted of a 5 mm skin incision, and the individual was kept in the operating room for the time required to perform an actual arthroscopic surgery. All three groups received standardized postoperative rehabilitation. All participants were followed for 24 months. Primary outcomes were clinical ROWE score with 100 being best possible and Western Ontario Sholder Instability Index (WOSI) with 0 being the best possible. The results showed there were no significant differences between groups at 6 months or 24 months follow-up in any outcome. Between-group differences in Rowe scores at 2 years were: biceps tenodesis versus labral repair: 1.0 (95% CI -5.4 to 7.4), p=0.76; biceps tenodesis versus sham surgery: 1.6 (95% CI -5.0 to 8.1), p=0.64; and labral repair versus sham surgery: 0.6 (95% CI -5.9 to 7.0), p=0.86. There were similar findings for, between group differences in the WOSI score as well. The authors concluded

"neither labral repair nor biceps tenodesis had any significant clinical benefit over sham surgery for individuals with SLAP II lesions in the population studied."

Biceps Tenodesis

Gurnani (2016) performed a systematic review and meta-analysis to compare clinical outcomes of tenodesis and tenotomy in the surgical treatment of long head of the biceps brachii. 9 studies including 650 participants undergoing long head biceps brachii tenodesis or tenotomy were reviewed.[13] The results showed there was no significant difference in the post-operative Constant score (mean difference 1.77), elbow flexion strength (mean difference 0), and forearm supination strength (mean difference 0.01). A Popeye deformity (odds ratio 0.17) and cramping pain (odds ratio 0.38) in the bicipital groove muscle were seen less in the individuals treated with tenodesis. The authors concluded that based on these findings there were no differences in post-operative functional outcomes between tenodesis and tenotomy for the treatment of long head of the biceps brachii.

MacDonald (2020) performed an RCT to compare approaches in the treatment of biceps pathology (lesions of the long head of the biceps brachii) between biceps tenodesis and tenotomy.[26] One-hundred fourteen participants (with a mean age of 57.7 years) were randomized intraoperatively while undergoing diagnostic arthroscopic surgery and found to have a lesion of the long head of the biceps tendon. The primary outcome measure was the American Shoulder and Elbow Surgeons (ASES) score, secondary outcomes were the Western Ontario Rotator Cuff Index (WORC) score, elbow and shoulder strength, operative time, complications, and revision surgery incidence. MRI was performed at 12 months to evaluate the integrity of the procedure in the tenodesis group. ASES and WORC scores improved significantly, with a mean difference of 32.3% ($P < .001$) and 37.3% ($P < .001$), respectively, with no difference between groups in either outcome from baseline to 24 months follow-up. There was no difference between the two groups related to pain, cramping, elbow flexion strength or supination strength. There were 4 occurrences of cosmetic deformity in the tenodesis group and 15 in the tenotomy group at 24 months. MRI findings at 12 months demonstrated that the tenodesis was intact for all participants. The authors concluded that tenodesis and tenotomy for lesions of the long head of biceps tendon both have good subjective outcomes noting that there is a higher rate of Popeye deformity in the tenotomy group.

Arthroscopic Capsular Release, Lysis of Adhesions, Manipulation Under Anesthesia

Rangan (2020) performed a multicenter, pragmatic, three-arm, superiority RCT comparing 1) manipulation under anesthesia (MUA) and 2) arthroscopic capsular release (ACR) with 3) early structured physical therapy (PT) plus steroid injection randomized 2:2:1, n=503 for the treatment of frozen shoulder.[31] Both forms of surgery were followed by PT. Early structured PT consisted of mobilization techniques and a home exercise program supplemented by a steroid injection. Both forms of PT (postoperative and early structured) were 12 sessions up to 12 weeks. The primary outcome was the Oxford Shoulder Score (OSS) (0-48) at 12 months. At 12 months, OSS data was available for 189 of 201 participants assigned to MUA (mean estimate 38·3 points, 95% CI 36·9 to 39·7), 191 (94%) of 203 participants assigned to capsular release (40·3 points, 38·9 to 41·7), and 93 (94%) of 99 participants assigned to physiotherapy (37·2 points, 35·3 to 39·2). The mean group differences were 2·01 points (0·10 to 3·91) between the capsular release and manipulation groups, 3·06 points (0·71 to 5·41) between capsular release and physiotherapy, and 1·05 points (-1·28 to 3·39) between manipulation and physiotherapy. All mean differences at12 months were less than the target differences of 5 OSS points between PT and either form of surgery or 4 points between MUA and ACR. Thus, none of the three interventions were clinically superior.

Forsythe (2021) performed a network meta-analysis of 66 RCTs including 4042 shoulders to determine which interventions had the best clinical outcomes in adhesive capsulitis.[11] Arthroscopic surgical capsular release had the most effective treatment in improving ROM. The most effective pain relief interventions were physical therapy (PT) with medical or ultrasound therapy. Interventions that were the most effective in improving functional status were PT, manipulation under anesthesia (MUA), intra-articular or subacromial steroid injections, surgical capsular release, and PT supplemented with alternative therapy.

Arthroscopic Capsulorrhaphy for Shoulder Instability

Jaggi (2023) performed a randomized, placebo-controlled RCT with 68 participants with apprehension in their shoulder joint with damage to the joint capsule and labrum on an arthroscopic examination randomized to diagnostic arthroscopy followed by arthroscopic capsular shift or diagnostic arthroscopy alone.[15] Participants were excluded if they had a high velocity shoulder injury, bone or neural damage, a rotator cuff or labral tear, or previous surgery on the same shoulder. The primary outcome was pain and functional impairment as measured by the Western Ontario Shoulder Instability Index prespecified to a 10.4-point reduction in pain

and disability for a minimum clinically important effect. The results demonstrated that the mean reduction in pain and functional impairment was similar for both groups. The authors concluded that arthroscopically capsular shift confers only minimal clinical benefit over diagnostic arthroscopy alone.

Subacromial Decompression

Beard (2018) performed a multicenter, pragmatic, parallel group, placebo-controlled RCT of 313 participants randomized (1:1:1) to 3 treatment groups: 1) decompression surgery, n=106, 2) arthroscopy only, n=103 (essentially a placebo as surgical bone and soft tissue removal was omitted), and 3) no treatment, n=104, which included a reassessment appointment with a shoulder specialist 3 months after study entry with follow-up for all three groups at 6 and 12 months. Participants had subacromial pain for three months with intact rotator cuff tendons and had completed non-operative management which included exercise therapy and at least one steroid injection. Full rotator cuff tears were excluded. The primary outcome was the Oxford Shoulder Score (OSS) 0-48, (48 best) at 6 months. At 6 months data was available for 90 participants in group 1, 94 in group 2, and 90 in group 3. Mean OSS did not differ between the two surgical groups at 6 months (decompression mean 32·7 points [SD 11·6] versus arthroscopy mean 34·2 points [9·2]; mean difference -1·3 points (95% CI -3·9 to 1·3, p=0·3141). Both surgical groups showed a small benefit over no treatment (mean 29·4 points [SD 11·9], mean difference versus decompression 2·8 points [95% CI 0·5-5·2], p=0·0186; mean difference versus arthroscopy 4·2 [1·8-6·6], p=0·0014) but these differences were not clinically important. The authors concluded that surgical decompression appeared to offer no benefit over arthroscopy alone.

A 2019 Cochrane systematic review included 8 RCTs with a total of 1062 participants with rotator cuff disease with subacromial impingement. Two trials compared arthroscopic subacromial decompression with arthroscopy placebo surgery, with all groups receiving postoperative exercises, plus a third group of active monitoring which received no treatment and the other trial had a third group which included exercises. Six trials (556 participants) compared arthroscopic subacromial decompression followed by exercises versus exercises alone. Two of these trials included a third group: sham laser in one trial and open subacromial decompression in the other trial. Trial size varied from 42 to 313 participants with a mean age of 42 to 65 years and duration to a maximum of 31 months. The authors note the reporting results are only from the two placebo-controlled trials as they were the only ones that were at low risk of bias.

At one-year of follow-up mean pain (0-10, 0 is best) was 2.9 points after placebo surgery and 0.26 better after subacromial decompression (284 participants), an absolute difference of 3% and relative difference of 4%. Mean function at one year (0-100, 100 is best) was 69 points after

placebo surgery and 2.8 better after surgery (274 participants), an absolute difference of 3%, and relative difference of 9%. Global success rate was 97/148 after placebo and 101/142 after surgery corresponding to Relative Risk (RR)1.08 (95% CI 0.93 to 1.27). Quality of life was 0.73 units (-0.59 to 1, 1 is best) after placebo and 0.03 units worse after subacromial decompression (285 participants), an absolute difference of 1.3%, and relative difference of 4%.

The authors concluded that the data from this review does not support the use of subacromial decompression in the treatment of rotator cuff disease manifest as painful shoulder impingement. They note, "High-certainty evidence shows that subacromial decompression does not provide clinically important benefits over placebo in pain, function or health-related quality of life."

Lähdeoja (2020) conducted a systematic review with meta-analysis to determine the benefits and harms of subacromial decompression surgery in 30 adults with subacromial pain syndrome lasting greater than three months. The authors reported "there was a high certainty of evidence of no additional benefit of subacromial decompression surgery over placebo surgery in reducing pain at one year following surgery" (mean difference [MD] -0.26, 95% CI -0.84 to 0.33), minimally important difference [MID] 1.5) or improving physical function at 1-2 years (MD 2.8, 95% CI -1.4 to 6.9, MID 8.3). The authors concluded that subacromial decompression surgery provided no important benefit compared with placebo surgery or exercise therapy.

Thermal Capsulorrhaphy

The literature does not support use of thermal capsulorrhaphy. The few available comparative studies do not support the theory that this procedure is an efficacious treatment for shoulder instability. The case series report a high rate of unsatisfactory results and complications, raising the potential for a net harm. Because of the lack of efficacy and potential for harm, this procedure is considered not medically necessary.

Ongoing and Unpublished Clinical Trials

Some currently ongoing trials that might influence this policy are listed in **Table 1**.

Table 1. Summary of Key Trials

NCT No.	Trial Name	Planned Enrollment	Completion Date
Ongoing			
NCT05807854	Treatment of Degenerative Massive Rotator Cuff Tears: a Multicenter, Randomized Comparative Surgical Trial	160	Mar 2027

NCT National Clinical Trial.

Practice Guidelines and Position Statements

American Academy of Orthopaedic Surgeons (AAOS)

In 2019, the AAOS Clinical Practice Guidelines for the Management of Rotator Cuff Injuries strongly recommended the following:

- Surgery is recommended for patients with symptomatic full-thickness rotator cuff tears who have not responded to conservative treatments such as physical therapy.
- The guideline discusses various surgical techniques, including arthroscopic, mini-open, and open repair methods. Arthroscopic repair is often preferred due to its minimally invasive nature and quick recovery times.
- Strong evidence supports that surgical repair of rotator cuff tears results in significant improvement in patient-reported outcomes, including pain relief and functional recovery.

Medicare National Coverage

There is no national coverage determination.

Regulatory Status

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

References

1. American Academeny of Orthopaedic Surgeons (AAOS). Management of rotator cuff injuries. Evidenced-Based Clinical Practice Guideline. Published March 11, 2019. Rosemont, IL, American Academy of Orthopaedic Surgeons. Available at URL: **https://www.aaos.org/globalassets/quality-and-practice-resources/rotator-cuff/rotator-cuff-cpg-final-12-20-19.pdf.** Accessed September 4, 2025.
2. American Academy of Orthopaedic Surgoens (AAOS). OrthoInfo. Gregory JM, Aibinder WR, Athwal GS. Shoulder Arthroscopy. December 2023. Available at URL: **https://orthoinfo.aaos.org/en/treatment/shoulder-arthroscopy/**. Accessed September 4, 2025.
3. Abrams GD, Gupta AK, Hussey KE, et al. Arthroscopic repair of full-thickness rotator cuff tears with and without acromioplasty: randomized prospective trial with 2-year follow-up. Am J Sports Med. 2014;42(6):1296-1303. PMID: 24733157.
4. Altintas B, Anderson N, Pitta R, et al. Repair of rotator cuff tears in the elderly: does it make sense? a systematic review. Am J Sports Med. 2019;48(3):744-753. PMID: 31038992.
5. Beard DJ, Rees JL, Cook JA, et al. Arthroscopic subacromial decompression for subacromial shoulder pain (CSAW): a multicentre, pragmatic, parallel group, placebo controlled, three-group, randomised surgical trial. Lancet. 2018;391(10118):329-338. PMID: 29169668.
6. Cheng C, Chen B, Xu H, et al. Efficacy of concomitant acromioplasty in the treatment of rotator cuff tears: A systematic review and meta-analysis. PLoS ONE. 2018;13(11): e0207306. PMID: 30439995.
7. Dong W, Goost H, Lin XB, et al. Treatments for shoulder impingement syndrome: a PRISMA systematic review and network meta-analysis. Medicine (Baltimore). 2015;94(10): e510. PMID: 25761173.
8. Dunn WR, Kuhn JE, Sanders R, et al. 2013 Neer Award: Predictors of failure of nonoperative treatment of chronic, symptomatic, full-thickness rotator cuff tears. J Shoulder Elbow Surg. 2016; 25:1303-1311. PMID: 27422460.
9. Erickson J, Lavery K, Monica J, et al. Surgical treatment of symptomatic superior labrum anterior-posterior tears in patients older than 40 years: a systematic review. Am J Sports Med. 2015; 43(5): 1274-1282. PMID: 24961444.
10. Farfaras S, Sernert N, Rostgard Christensen L, et al. Subacromial decompression yields a better clinical outcome than therapy alone: a prospective randomized study of patients with a minimum 10-year follow-up. Am J Sports Med. 2018;46(6):1397-1407. PMID: 29543510.
11. Forsythe B, Lavoie-Gagne O, Patel BH, et al. Efficacy of arthroscopic surgery in the management of adhesive capsulitis: a systematic review and network meta-analysis of randomized controlled trials. Arthroscopy. 2021;37(7):2281-2297. PMID: 33221429.
12. Ge H, Zhang Q, Sun Y, et al. Tenotomy or tenodesis for the long head of biceps lesions in shoulders: a systematic review and meta-analysis. PLoS ONE. 2015;10(3): e0121286. PMID: 25786125.
13. Gurnani N, van Deurzen DF, Janmaat VT, et al. Tenotomy or tenodesis for pathology of the long head of the biceps brachii: a systematic review and meta-analysis. Knee Surg Sports Traumatol Arthrosc. 2016;24(12):3765-3771. PMID: 25975753.
14. Haahr JP, Østergaard S, Dalsgaard J, et al. Exercises versus arthroscopic decompression in patients with subacromial impingement: a randomised, controlled study in 90 cases with a one year follow up. Ann Rheum Dis. 2005;64(5):760-764. PMID: 15834056.
15. Jaggi A, Herbert RD, Alexander S, et al. Arthroscopic capsular shift surgery in patients with atraumatic shoulder joint instability: a randomised, placebo-controlled trial. Br J Sports Med. 2023;57(23):1484-1489. PMID: 37308285.
16. Karjalainen TV, Jain NB, Heillinen J., et al. Surgery for rotator cuff tears. Cochrane Database Syst Rev. 2019; 12(12): CD013502. PMID: 31813166.

17. Karjalainen TV, Jain NB, Page CM, et al. Subacromial decompression surgery for rotator cuff disease. Cochrane Database Syst Rev. 2019;1:CD005619. PMID: 30707445.

18. Ketola S, Lehtinen JT, Arnala I. Arthroscopic decompression not recommended in the treatment of rotator cuff tendinopathy: a final review of a randomised controlled trial at a minimum follow-up of ten years. Bone Joint J. 2017;99-B(6):799-805. PMID: 28566400.

19. Khatri C, Ahmed I, Parsons H, et al. The natural history of full-thickness rotator cuff tears in randomized controlled trials: a systematic review and meta-analysis. Am J Sports Med. 2019; 47(7): 1734-1743. PMID: 29963905.

20. Kuhn JE, Dunn WR, Sanders R, et al. Effectiveness of physical therapy in treating atraumatic full-thickness rotator cuff tears: a multicenter prospective cohort study. J Shoulder Elbow Surg. 2013;22(10):1371-1379. PMID: 23540577.

21. Kuhn JE, Dunn WR, Sanders R, et al. 2024 Kappa Delta Ann Doner Vaughan Award: Nonsurgical treatment of symptomatic, atraumatic full-thickness rotator cuff tears-a prospective multicenter cohort study with 10-year follow-up. J Am Acad Orthop Surg. 2024;32(23):1061-1073. PMID: 39325825.

22. Kukkonen J, Joukainen A, Lehtinen J, et al. Treatment of nontraumatic rotator cuff tears: a randomized control trial with two years of clinical and imaging follow-up. J Bone Joint Surg Am. 2015; 97:1729-1737. PMID: 26537160

23. Lähdeoja T, Karjalainen T, Jokihaara J, et al. Subacromial decompression surgery for adults with shoulder pain: a systematic review with meta-analysis. Br J Sports Med. 2020;54(11):665-673. PMID: 30647053.

24. Longo UG, Risi Ambrogioni L, Candela V., et al. Conservative versus surgical management for patients with rotator cuff tears: a systematic review and meta-analysis. BMC Musculoskelet Disord. 2021; 22(1): 50. PMID: 33419401.

25. MacDonald P, McRae S, Leiter J, et al. Arthroscopic rotator cuff repair with and without acromioplasty in the treatment of full-thickness rotator cuff tears: a multicenter, randomized controlled trial. J Bone Joint Surg Am. 2011;93(21):1953-1960. PMID: 22048089.

26. MacDonald P, Verhulst F, McRae S, et al. Biceps tenodesis versus tenotomy in the treatment of lesions of the long head of the biceps tendon in patients undergoing arthroscopic shoulder surgery: a prospective double-blinded randomized controlled trial. Am J Sports Med. 2020;48(6):1439-1449. PMID: 32223645.

27. Moosmayer S, Lund G, Seljom U, et al. Comparison between surgery and physiotherapy in the treatment of small and medium-sized tears of the rotator cuff; A randomized controlled study of 103 patients with one-year follow-up. J Bone Joint Surg Br. 2010;92(1):83–91. PMID: 20044684.

28. Moosmayer S, Lund G, Seljom US, et al. Tendon repair compared with physiotherapy in the treatment of rotator cuff tears: a randomized controlled study in 103 cases with a five-year follow-up. J Bone Joint Surg Am. 2014; 96(18): 1504-1514. PMID: 25232074.

29. Moosmayer S, Lund G, Seljom US, et al. At a 10-year follow-up, tendon repair is superior to physiotherapy in the treatment of small and medium-sized rotator cuff tears. J Bone Joint Surg. 2019;101(12):1050-1060. PMID: 31220021.

30. Moosmayer S, Lund G, Seljom US et al. Fifteen-year results of a comparative analysis of tendon repair versus physiotherapy for small-to-medium-sized rotator cuff tears: a concise follow-up of previous reports. J Bone Joint Surg Am. 2024; 106(19): 1785-1796. PMID: 39197154.

31. Oh LS, Wolf BR, Hall MP, et al. Indications for rotator cuff repair. A systematic review. Clin Ortho and Rel Res. 2006; 455:52–63. PMID: 17179786.

32. Rangan A, Brealey SD, Keding A, et al. Management of adults with primary frozen shoulder in secondary care (UK FROST): a multicentre, pragmatic, three-arm, superiority randomised clinical trial. Lancet. 2020; 396(10256): 977-989. PMID: 33010843.

33. Schrøder CP, Skare Ø, Reikerås O, et al. Sham surgery versus labral repair or biceps tenodesis for type II SLAP lesions of the shoulder: a three-armed randomised clinical trial. Br J Sports Med. 2017;51(24):1759-1766. PMID: 28495804.

History

Date	Comments
11/01/25	New policy, approved October 14, 2025, effective for dates of service on or after February 6, 2026, following 90-day provider notification. Add to Surgical section. Shoulder arthroscopy in adults is considered medically necessary for the indications noted when criteria are met. Site of Service Ambulatory Service Center (ASC) Select Surgical Procedures criteria added Thermal capsulorrhaphy is considered not medically necessary.
04/01/26	Interim Review, approved March 10, 2026. Minor formatting changes made. Modified conservative management to require where noted for each indication both a medication trial and failure as well as a trial and failure of physical measures. Removed policy criteria for diagnostic arthroscopy, debridement arthroscopy, and biceps tenodesis. Removed policy criterion under Rotator cuff arthroscopy "Tenderness over rotator cuff." Separated out distal clavicular excision arthroscopy criteria and subacromial decompression/acromioplasty criteria for greater clarity only, policy intent unchanged. Removed CPT codes 29805, 29822, 29823, 29828 to align with changes in criteria.
04/09/26	Minor update correction. Removed header hyperlinks to diagnostic arthroscopy, debridement arthroscopy, and biceps tenodesis and separated out subacromial decompression/acromioplasty that were inadvertently missed at the above interim review.
06/01/26	Minor update. Added header to indicate that site of service review does not apply to Indian Health Services (IHS) facilities.

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.