# Clinical Policy: Acromioplasty and Rotator Cuff Repair

Reference Number: PA.CP.MP.OR.1018 Coding Implications
Effective Date: 04/01/2020 Revision Log
Last Review Date: NEW POLICY

**See** Important Reminder **at the end of this policy for important regulatory and legal information.**

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**Common Name:** Acromioplasty and Rotator Cuff Repair

**Definition:** The rotator cuff is a network of four muscles that come together as tendons to form a covering around the head of the humerus to help lift and rotate the arm. A tear to one or more of the tendons can cause pain and disability that requires surgical repair and reattachment of the rotator tendon to the upper arm bone.

**I. Criteria for Inclusion**

A. Acromioplasty is considered medically necessary for any of the following:
   1. MRI or other imaging evidence of impingement, chronic fibrosis or tendonitis, or acromion abnormalities (e.g. type III acromion) when all of the following are met:
      a. Pain or functional impairment that has failed to improve with at least 3 months of conservative treatment including at least 2 of the following:
         i. NSAIDs and/or analgesics
         ii. Local modalities such as ice or heat
         iii. Physical therapy, or detailed professionally-directed home exercise program
         iv. Intra-articular corticosteroid injection(s)
      b. At least one of the following are met:
         i. Chronic pain despite conservative medical therapy
         ii. Significant functional impairment of the shoulder for at least 1 year
         iii. Progression of significant functional impairment of the shoulder despite use of conservative medical therapy
   2. Procedure coincident with indicated repair of rotator cuff tear or fracture

B. Rotator cuff repair, with or without acromioplasty, is considered medically necessary for any of the following:
   1. MRI or other imaging evidence of full-thickness injury when repair is needed due to at least one of the following:
      a. Massive tear with retraction or avulsion
      b. Inability to externally rotate arm against resistance
      c. Inability to elevate arm on physical examination
      d. Disabling limitation of function in affected arm
      e. Symptoms have failed to improve with at least 3 months of conservative treatment including at least 2 of the following:
         i. NSAIDs and/or analgesics
         ii. Local modalities such as ice or heat
         iii. Physical therapy, or detailed professionally-directed home exercise program
         iv. Intra-articular corticosteroid injection(s)
   2. MRI or other imaging evidence of partial-thickness tear with pain and functional impairment that has failed to improve after at least 3 months of conservative therapy including NSAIDs and physical therapy, unless contraindicated; or
   3. Revision of failed previous rotator cuff repair

C. Open or arthroscopic Mumford procedure (distal claviculectomy), with or without rotator cuff repair or acromioplasty, is considered medically necessary when ALL of the following are met:
   1. Positive physical findings including tenderness to palpation of the AC joint, positive cross-body adduction text, positive active compression test, pain with maximal internal rotation, and/or pain and crepitation of the AC joint with full circumduction
   2. Positive radiographic findings, such as type I or II AC separation or significant AC joint degeneration
   3. Conservative treatment has been attempted and failed for at least 3 months
      a. Treatment should consist of at least 2 of the following, unless contraindicated;
         i. NSAIDs and/or analgesics
         ii. Local modalities such as ice or heat
         iii. Physical therapy, or detailed professionally-directed home exercise program
         iv. Intra-articular corticosteroid injection(s)

**II. Criteria for Exclusion**

A. Rotator cuff repair is not considered to be medically necessary when the above criteria has not been met, and for asymptomatic full-thickness tears.
B. Distal claviculectomy is considered not medically necessary for patients with chronic type III, IV, V, or VI AC separations.
C. For persons with significant co-morbidities or complications, the medical record must contain documentation of the risk/benefit of procedure.

**III. Device Considerations**

A. Only implants with FDA approval are considered to be medically appropriate

**IV. Surgical Considerations**

A. Pre-Operative Considerations:
   1. Preoperative evaluation, including:
      a. Routine preoperative evaluation.
   2. Diagnostic test scheduling, including:
      a. Imaging study (MRI, MR arthrography, ultrasound)
      b. Diagnostic arthroscopy
   3. Preoperative treatment, procedures, and stabilization, including:
      a. Physical therapy
   4. Preoperative discharge planning as appropriate
B. Intra-Operative Considerations:
   1. Antibacterial wipes
   2. Antibacterial nasal swab
C. Post-Operative & Inpatient Considerations:
   1. Monitoring patient's status for deterioration and comorbid conditions; key items include:
      a. Pain management
      b. Neurologic status in both arms
D. Discharge Planning & Considerations:
   1. Assessment of needs and planning for care, including:
      a. Develop treatment plan (involving multiple providers as needed)
      b. Evaluate and address preadmission functioning as needed
      c. Evaluate and address patient or caregiver preferences as indicated
      d. Identify skilled services needed at next level of care, with specific attention to:
         i. Neurologic status assessment
         ii. Pain management

iii. Wound or dressing management
e. Evaluate and address psychosocial status issues as indicated.

2. Early identification of anticipated discharge destination; options include:
   a. Home, considerations include:
      i. Access to follow-up care
      ii. Home safety assessment.
      iii. Self-care ability, if appropriate.
      iv. Caregiver need, ability, and availability
   b. Post-acute skilled care or custodial care, as indicated.
3. Transition of care plan complete, which may include:
   a. Patient and caregiver education complete.
   b. Medication reconciliation completion includes:
      i. Compare patient's discharge list of medications (prescribed and over-the-counter) against physician's admission or transfer orders
      ii. Assess each medication for correlation to disease state or medical condition
      iii. Report medication discrepancies to prescribing physician, attending physician, and primary care provider, and ensure accurate medication order is identified.
      iv. Provide reconciled medication list to all treating providers
      v. Confirm that patient, family, or caregiver can acquire medication
      vi. Educate patient, family, and caregiver
         - Provide complete medication list to patient, family, or caregiver
         - Confirm that patient, family, or caregiver understands importance of presenting personal medication list to all providers at each care transition, including all physician appointments
         - Confirm that patient, family, or caregiver understands reason, dosage, and timing of medication (eg, use "teach-back" techniques)
   c. Plan communicated to patient, caregiver, and all members of care team, including:
      i. Inpatient care and service providers
      ii. Primary care provider
      iii. All post-discharge care and service providers
   d. Post-discharge appointment plans made as needed, which may include:
      i. Primary care provider
      ii. Orthopedic surgeon
      iii. Rehabilitation therapy services
      iv. Specialists for management of comorbid conditions
   e. Post-discharge testing and procedure plans made
   f. Referrals made for assistance or support, which may include:
      i. Financial, for follow-up care, medication, and transportation
      ii. Self-help or support groups
      iii. Smoking cessation counseling or treatment
   g. Medical equipment and supplies coordinated (ie, delivered or delivery confirmed) which may include:
      i. Immobilizers
      ii. Wound care supplies
4. The use of elastomeric infusion pumps, including but not limited to the On-Q infusion pump, is not considered to be medically necessary for post-operative pain management.

## V. Length of Stay Considerations

A. Goal length of stay: Ambulatory
B. Facility type: Ambulatory

## VI. Coding

A. CPT

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|---|---|
| 23130 | Acromioplasty or acromionectomy, partial, with or without coracoacromial ligament release |
| 23410 | Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute |
| 23412 | Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; chronic |
| 23415 | Coracoacromial ligament release, with or without acromioplasty |
| 23420 | Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty |
| 29826 | Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure) |
| 29827 | Arthroscopy, shoulder, surgical; with rotator cuff repair |

B. HCPCS

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|---|---|
| C1763 | Connective tissue, non-human (includes synthetic) |

C. ICD-10 Procedure
*No ICD-10 Procedure codes*

D. ICD-10 Diagnosis
*All associated ICD-10 Diagnosis codes*

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## Regulatory Data

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| **Policy Number/Name:** | **PA.CP.MP.OR.1018 Acromioplasty and Rotator Cuff Repair** |
| **Initial Approval and Effective Date:** | 02/05/2015 |
| **Reviewed Dates:** | 02/05/2015; 02/05/2016; 8/2/2016; 2/17/2017; 1/9/2018; 4/13/2018; 6/20/2018; 1/31/2019; 10/21/2019 |
| **All Approval Dates:** | 02/05/2015; 02/05/2016; 2/17/2017; 1/12/2018; 4/13/2018; 6/20/2018; 2/1/2019; 10/21/2019 |
| **Approval Authority:** | Utilization Management Committee |
| **Business Owner:** | Utilization Management |
| **Applicable lines of business:** | All |
| **Board approval, if appropriate:** | N/A |
| **Approval Signature:** | On file |

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|---|---|
| **URAC Standards:** | |
| | |
| **State Requirements:** | |
| **CMS/Federal Requirements:** | |
| **Corresponding policies:** | |

| Reviews, Revisions, and Approvals | Date | Approval Date |
|---|---|---|
| • New Policy created.<br>• Policy administered by Turning Point Healthcare Solutions | 03/20 | 7/2/20202 |

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by PA Health & Wellness, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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**Note: For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

**Note: For Medicare members,** to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.