

Document ID#: 2143439  
Subject: Shoulder Arthroscopy: Surgical, Surgically Assisted  
Effective Date: January 1, 2010

Clinical Documentation and Prior Authorization Required	√	Type of Review - Case Management	
Not Covered		Type of Review – Precertification Department	√
		Administrative Process (Internal Use Only)	LPN

**Note:** Background, product, and disclaimer information is located at the end of this document.

Effective January 1, 2010 Tufts Health Plan will be requiring prior authorization for certain elective arthroscopic and arthroscopically assisted shoulder procedures for members 18 and older.

In order to obtain prior authorization for these surgical shoulder arthroscopies, an InterQual® SmartSheet™ for Shoulder Arthroscopy; Surgical must be completed and faxed to the Tufts Health Plan Precertification Department at 617-972-9409.

InterQual® SmartSheets™ for this procedure are available by logging on to our web site and accessing the Prior Authorization InterQual® Criteria Link under the Clinical Resources section. If you are not a Tufts Health Plan Registered Provider, please click on the [Provider Log-in](#) and follow instructions.

**PROCEDURES REQUIRING PRIOR AUTHORIZATION:**

Tufts Health Plan will be using the InterQual® SmartSheet™ for the following diagnoses and associated CPT codes only:

Associated CPT Code <sup>1</sup>	Description/Diagnosis	Tufts Health Plan Organization Policy Note
23130, 23412, 23415, 23420, 23450, 23455, 23460, 23462, 23466, 29806, 29807, 29826, 29827	Repair of chronic rotator cuff repair	None
23130, 23412, 23415, 23420, 23450, 23455, 23460, 23462, 23466, 29806, 29807, 29826, 29827	Repair of acute rotator cuff repair	None
23130, 23412, 23415, 23420, 23450, 23455, 23460, 23462, 23466, 29806, 29807, 29826, 29827	Decompression of subacromial space/acromioplasty for chronic rotator cuff tendonitis	None
23130, 23412, 23415, 23420, 23450, 23455, 23460, 23462, 23466, 29806, 29807, 29826, 29827	Recurrent anterior dislocation	None
29806, 29807, 29819, 29822, 29823, 29824, 29826, 29827, 29828	Removal of intra-articular loose body	None
29806, 29807, 29819, 29822, 29823, 29824, 29826, 29827, 29828	Lavage of joint aspirate diagnostic for infection	None
29806, 29807, 29819, 29822, 29823, 29824, 29826, 29827, 29828	Chondroplasty	None
29806, 29807, 29819, 29822, 29823, 29824, 29826, 29827, 29828	Repair of chronic rotator cuff repair	None

29806, 29807, 29819, 29822, 29823, 29824, 29826, 29827, 29828	Repair of acute rotator cuff repair	None
29806, 29807, 29819, 29822, 29823, 29824, 29826, 29827, 29828	Decompression of subacromial space/acromioplasty for chronic rotator cuff tendonitis	None
29806, 29807, 29819, 29822, 29823, 29824, 29826, 29827, 29828	Resection of distal clavicle	None
29806, 29807, 29819, 29822, 29823, 29824, 29826, 29827, 29828	Joint exploration post penetrating joint injury	None
29806, 29807, 29819, 29822, 29823, 29824, 29826, 29827, 29828	Recurrent anterior dislocation	None

<sup>1</sup> A complete description of the associated CPT codes is included within this Medical Necessity Guideline

## Codes

The following CPT codes require prior authorization:

Code	Description
23130	Acromioplasty or acromionectomy, partial, with or without coracoacromial ligament release
23412	Repair of ruptured musculotendinous cuff (e.g., rotator cuff) open; chronic
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; Putti-Platt procedure or Magnuson type operation; with labral repair (e.g., Bankart procedure)
23460	Capsulorrhaphy, anterior, any type; with bone block
23462	Capsulorrhaphy, anterior, any type; with bone block; with coracoid process transfer
23466	Capsulorrhaphy, glenohumeral joint, any type multi-directional instability
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
29822	Arthroscopy, shoulder, surgical; debridement, limited
29823	Arthroscopy, shoulder, surgical; debridement, extensive
29824	Arthroscopy, shoulder, surgical; distal claviclectomy including distal articular surface (Mumford procedure)
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with or without coracoacromial release
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
29828	Arthroscopy, shoulder, surgical; biceps tenodesis

## Approval History

Reviewed by the Medical Affairs Medical Policy Committee on June 6, 2009 for January 1, 2010 effective date.

Subsequent Endorsement Date(s) and Changes Made

## Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for Tufts Health Plan benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. Tufts Health Plan makes coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe, but proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the Tufts Health Plan service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. Tufts Health Plan revises and updates Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

Medical Necessity Guidelines apply to all fully insured Tufts Health Plan products unless otherwise noted in this guideline or the Member's benefit document. This guideline does not apply to Tufts Health Plan Medicare Preferred or to certain delegated service arrangements. For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. Applicable state or federal mandates will take precedence. Providers in the New Hampshire service area are subject to CIGNA HealthCare's provider arrangement for the purpose of CareLink<sup>SM</sup>.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.