Medical Treatment Guidelines

Washington State Department of Labor and Industries

Criteria for shoulder surgery

A request may be appropriate for ↓	If the patient has ↓	AND the diagnosis is supported by ↓ ↓ ↓			AND this has been done (if recommended) ↓
Surgical procedure	**Diagnosis**	**Clinical findings**			**Conservative care**
		Subjective	**Objective**	**Imaging**	
Rotator cuff repair (CPT 23410, 23412, 23420).	**Full thickness rotator cuff tear** **AND** Cervical pathology and frozen shoulder syndrome have been ruled out.	Shoulder pain and inability to elevate the arm; Tenderness over the greater tuberosity is common in acute cases.	Patient may have weakness with abduction testing; May also demonstrate atrophy of shoulder musculature; Usually has full passive range of motion.	Conventional x-rays, AP, and true lateral or axillary view **AND** Gadolinium MRI, Ultrasound, or Arthrogram shows positive evidence of deficit in rotator cuff.	Not required.
Rotator cuff repair CPT 23410, 23412, or 23420) **OR** **Anterior acromioplasty** [1] (CPT 23130, 23415, 29826).	**Partial thickness rotator cuff repair** **OR** **Acromial Impingement Syndrome** (80% of these patients will get better without surgery) [1].	Pain with active arc motion 90-130 ° **AND** Pain at night; Tenderness over the greater tuberosity is common in acute cases.	Weak or absent abduction. May also demonstrate atrophy **AND** Tenderness over rotator cuff or anterior acromial area **AND** Positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test).	Conventional x-rays, AP, and true lateral or axillary view **AND** Gadolinium MRI, Ultrasound, or Arthrogram shows positive evidence of deficit in rotator cuff.	Recommend 3-6 months: Three months is adequate if treatment has been continuous, six months if treatment has been intermittent. Treatment must be directed toward gaining full ROM, which requires both stretching and strengthening to balance the musculature.
Treatment of acromioclavicular dislocation, **acute or chronic** (CPT 23550).	**Shoulder AC joint Separation.**	Pain with marked functional difficulty.	Marked deformity.	Conventional x-rays Show Grade III+ separation.	Recommend at least 3 months. Most patients with grade III AC dislocations are best treated non-operatively.
Partial claviculectomy (includes Mumford procedure) (CPT 23120, 29824).	**Post traumatic arthritis of AC joint.**	Pain at AC joint; aggravation of pain with shoulder motion or carrying weight **OR** Previous Grade I or II AC separation.	Tenderness over the AC joint; Most symptomatic patients with partial AC join separation have a positive bone scan **AND/OR** Pain relief obtained with an injection of anesthetic for diagnostic therapeutic trial.	Conventional films show either: (a) Post traumatic changes of AC joint, OR (b) Severe DJD of AC joint, OR (c) Complete or incomplete separation of AC joint. **AND** Bone scan is positive for AC joint separation.	At least 6 weeks of care directed toward symptom relief prior to surgery. Surgery is not indicated before 6 weeks.

[1] Neer, C. S. Anterior acromioplasty for the chronic impingement syndrome in the shoulder: a preliminary report. Journal of Bone & Joint Surgery, American Volume. 54(1):41-50, 1972 (Jan.).

Reference: Provider Bulletin 02-01; Date Introduced: March 2002.

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Criteria for Shoulder Surgery -- Continued

A request may be appropriate for ↓	If the patient has ↓	AND the diagnosis is supported by ↓ ↓ ↓			AND this has been done (if recommended) ↓
Surgical procedure	**Diagnosis**	**Clinical findings**			**Conservative care**
		Subjective	**Objective**	**Imaging**	
Capsulorrhaphy or Bankart procedure (CPT 23450, 23455, 29806).	**Recurrent glenohumeral dislocations.**	History of multiple dislocations that inhibit activities of daily living.	At least one of the following: Positive apprehension findings; OR Injury to the humeral head; OR Documented dislocation under anesthesia.	Conventional x-rays, AP and true lateral or axillary view.	None required.
Tenodesis of long head of biceps (CPT 23430). Consideration of tenodesis should include the following: Patient should be a young adult; Not recommended as an independent stand alone procedure. There must be evidence of an incomplete tear.	**Incomplete tear or raying of the proximal biceps tendon.** The diagnosis of fraying is usually identified at the time of acromioplasty or rotator cuff repair so may require retrospective review.	Complaint of more than "normal" amount of pain that does not resolve with attempt to use arm. Pain and function fails to follow normal course of recovery.	Partial thickness tears do not have the classical appearance of ruptured muscle.	Same as that required to rule out full thickness rotator cuff tear: Conventional x-rays, AP, and true lateral or axillary view **AND** Gadolinium MRI, Ultrasound, or Arthrogram shows positive evidence of deficit in rotator cuff.	None required
Tenodesis of long head of biceps (CPT 23430).	**Complete tear of the proximal biceps tendon.**	Pain, weakness, and deformity.	Classical appearance of ruptured muscle.	Not required.	Surgery almost never considered in full thickness ruptures.
Reinsertion of ruptured biceps tendon (CPT 24342).	**Distal rupture of the biceps tendon.**	All should be repaired within 2-3 weeks of injury or diagnosis. A diagnosis is made when the physician cannot palpate the insertion of the tendon at the patient's antecubital fossa. Surgery is not indicated if 3 or more months have elapsed.			
Diagnostic arthroscopy (CPT 29805).	**Shoulder arthroscopy for diagnostic purposes.**	Most orthopedic surgeons can generally determine the diagnosis through examination and imaging studies alone. Diagnostic arthroscopy should be limited to cases where imaging is inconclusive and acute pain or functional limitation continues despite conservative care. Shoulder arthroscopy should be performed in the outpatient setting. Requests for authorization of this procedure in the inpatient setting will be reviewed by a peer physician. If a rotator cuff tear is shown to be present following a diagnostic arthroscopy, follow the guidelines for either a full or partial thickness rotator cuff tear.			