Musculoskeletal Program

Level of Care for Musculoskeletal Surgery

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AIM SpecialtyHealth.
8600 West Bryn Mawr Avenue
South Tower - Suite 800 Chicago, IL 60631
www.aimspecialtyhealth.com

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Description and Application of the Guidelines

The AIM Clinical Appropriateness Guidelines (hereinafter "AIM Clinical Appropriateness Guidelines" or the "Guidelines") are designed to assist providers in making the most appropriate treatment decision for a specific clinical condition for an individual. As used by AIM, the Guidelines establish objective and evidence-based, where possible, criteria for medical necessity determinations. In the process, multiple functions are accomplished:

- To establish criteria for when services are medically necessary
- To assist the practitioner as an educational tool
- To encourage standardization of medical practice patterns
- To curtail the performance of inappropriate and/or duplicate services
- To advocate for patient safety concerns
- To enhance the quality of healthcare
- To promote the most efficient and cost-effective use of services

AIM guideline development process complies with applicable accreditation standards, including the requirement that the Guidelines be developed with involvement from appropriate providers with current clinical expertise relevant to the Guidelines under review and be based on the most up to date clinical principles and best practices. Relevant citations are included in the "References" section attached to each Guideline. AIM reviews all of its Guidelines at least annually.

AIM makes its Guidelines publicly available on its website twenty-four hours a day, seven days a week. Copies of the AIM Clinical Appropriateness Guidelines are also available upon oral or written request. Although the Guidelines are publicly-available, AIM considers the Guidelines to be important, proprietary information of AIM, which cannot be sold, assigned, leased, licensed, reproduced or distributed without the written consent of AIM.

AIM applies objective and evidence-based criteria and takes individual circumstances and the local delivery system into account when determining the medical appropriateness of health care services. The AIM Guidelines are just guidelines for the provision of specialty health services. These criteria are designed to guide both providers and reviewers to the most appropriate services based on a patient's unique circumstances. In all cases, clinical judgment consistent with the standards of good medical practice should be used when applying the Guidelines. Guideline determinations are made based on the information provided at the time of the request. It is expected that medical necessity decisions may change as new information is provided or based on unique aspects of the patient's condition. The treating clinician has final authority and responsibility for treatment decisions regarding the care of the patient and for justifying and demonstrating the existence of medical necessity for the requested service. The Guidelines are not a substitute for the experience and judgment of a physician or other health care professionals. Any clinician seeking to apply or consult the Guidelines is expected to use independent medical judgment in the context of individual clinical circumstances to determine any patient's care or treatment.

The Guidelines do not address coverage, benefit or other plan specific issues. If requested by a health plan, AIM will review requests based on health plan medical policy/guidelines in lieu of the AIM Guidelines.

The Guidelines may also be used by the health plan or by AIM for purposes of provider education, or to review the medical necessity of services by any provider who has been notified of the need for medical necessity review, due to billing practices or claims that are not consistent with other providers in terms of frequency or some other manner.

Level of Care Guidelines for Musculoskeletal Surgery and Procedures

Evidence is growing that supports the safety and effectiveness of the outpatient surgery setting for many orthopedic and spine surgical procedures. Procedures that were formerly done inpatient are now being successfully performed in the outpatient surgery setting. Factors that have contributed to this movement include:

- Patient preference for outpatient surgery
- Equal or better outcomes compared to inpatient setting
- Lower costs and operational efficiency
- Minimal invasive techniques and improved surgical technologies
- Improved anesthesia techniques and better post-operative pain management

Appropriate patient selection for the outpatient setting is paramount to avoiding complications and readmissions. Patients with certain risk profiles should preferably have their procedures done inpatient to avoid complications and poor outcomes.

The intent of this guideline is to assist in determining the appropriate level of care needed to safely and effectively perform the intended surgical procedure. In addition to the guideline requirements, AIM will also consider the geographical proximity, availability, and capability of in-network facilities and the requesting provider's existing surgical privileges status. Provider should be prepared to submit the required supporting medical documentation to include but not limited to:

- Provider office notes detailing preoperative medical optimization
- List of managed or unmanaged comorbidities and/or other surgical risk factors
- If being requested, the specific reason for an inpatient preoperative day (see Preoperative Day Requirements).
- Copies of medical consultations or clearances.
- Patient consent to outpatient selection
- If available, ASA physical status (Appendix A), Charleston Comorbidity Score, or other validated surgical risk score.

This guideline does not address the clinical appropriateness of the procedure. The AIM prior authorization process for clinical appropriateness of the surgical procedure is completed separately and precedes the level of care determination.

An outpatient surgical procedure is defined as one where a patient arrives at an ambulatory surgery center (ASC) or hospital-based outpatient department (HOPD) on the same day as the procedure is being performed and is discharged the same day or within a 23-hour observation period.

The inpatient surgical setting, rather than the outpatient setting, is required only if the patient's medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting. The selection of surgical setting is not justified when it is solely for the convenience of the patient, the patient's family, or the provider.

Spine

Outpatient Level of Care: Spine Surgery

Outpatient (hospital or ASC) level of care is considered medically necessary for elective spine surgery when all of the following are present and when the patient meets the criteria for at least one surgical indication in the AIM Musculoskeletal Joint Surgery guidelines.

- Appropriate procedure
    - Cervical
        - One- or two-level anterior cervical discectomy and fusion (ACDF) between C3 and C7
        - One- or two-level cervical disc arthroplasty between C3-C7
        - One- or two-level foraminotomy
    - Lumbar
        - One- or two-level discectomy and/or decompression (laminectomy, laminotomy, or foraminotomy)
        - Vertebroplasty
        - Kyphoplasty
- Appropriate patient
    - Age less than 65
    - Low medical comorbidity risk
        - Charlson comorbidity index (CCI) 2 or less
        - American Society of Anesthesiologists (ASA) class 2 or less
    - Patient has received education on the procedure, anesthetic- related issues, aims of surgery, postoperative symptoms, and expectations
- Appropriate outpatient facility
    - Capability for 23-hour observation or is a hospital outpatient center on the main hospital campus.
- Appropriate post-surgical disposition
    - Responsible adult (caregiver) living with, or staying with the patient who is available to care for them for at least 24 hours after surgery
    - Patient resides within a reasonable distance (30-minute drive) of an emergency medical facility

Inpatient Level of Care: Spine Surgery

Inpatient level of care is considered medically necessary for spine surgery when at least one of the following patient or surgical specific risk factors is present and when the patient meets the criteria for at least one surgical indication in the AIM Musculoskeletal Spine Surgery guidelines.

Patient

- Demographic/constitutional
    - Age greater than 65 or less than 19
    - BMI > 40 kg/m^2
    - Pregnancy
- Medical risk factors
    - Medical comorbidity likely to require more than 6 hours of postoperative observation
        - Charlson comorbidity index (CCI) greater than 2
        - ASA class greater than 2
        - Recent venous thromboembolic event (VTE)
        - Severe or uncontrolled diabetes
        - Severe anemia requiring preoperative transfusion
        - Coagulopathy
        - Recent unexplained weight loss
        - Malnutrition
        - Chronic pulmonary disease
            - COPD, severe and/or oxygen dependent
            - Respiratory distress
        - Obstructive sleep apnea
        - Liver disease – cirrhosis
        - Vascular
            - Cardiovascular disease
                - myocardial infarction (MI) within six (6) months of intended surgery
                - angina pectoris with severe functional limitation
                - cardiac arrhythmia
                - implantable cardiac device (defibrillator, pacemaker)

        - Cerebrovascular disease
            - recent stroke or transient ischemic attack (TIA)
    - Uncontrolled preoperative pain
    - Prior complication of anesthesia
    - Prior postoperative complication
        - Ileus
        - Urinary retention

- Psychiatric/cognitive
    - Ongoing substance abuse
    - Cognitive impairment
- Social
    - Patient resides outside of a reasonable distance (30-minute drive) of an emergency medical facility
    - No responsible/reliable adult (caregiver) living with, or staying with the patient who is available to care for them for at least 23 hours after surgery.
    - Patient does not agree to surgery outside the inpatient hospital setting or is expected to be noncompliant with perioperative care (example: severe anxiety about receiving surgery in a nonhospital setting)
- Functional status
    - Patient unable to care for individual needs
    - Functional impairment likely to necessitate inpatient rehabilitation after surgery (example: moderate to severe myelopathy)
    - Patient is at high risk for falls

Note: The presence of medical and/or psychiatric comorbidities alone may not always justify an inpatient level of care, but rather consideration should be given if poorly controlled, unstable, untreated, or anticipated to require treatment postoperatively.

Surgical

- Procedures listed in Addendum E: HCPCS Codes That Would Be Paid Only as Inpatient Procedures for CY 2018 of the Centers for Medicare and Medicaid Services Hospital Outpatient Prospective Payment CMS-1678-FC. Available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1678-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending

- Indications that are emergent and/or systemic
    - Acute trauma with fracture
    - Spinal neoplasm
    - Septic arthritis
    - Complication of inflammatory arthritis / seronegative spondyloarthropathy (SpA)
- Prolonged operative or anesthesia time (anticipated > 3 hours)
- Revision surgery
- Procedure specific
    - Cervical
        - More than two-level anterior cervical discectomy and fusion
        - Procedures involving the craniocervical junction (C1-C2)
        - Posterior cervical fixation
        - Corpectomy
    - Thoracic
        - Any procedure or level
    - Lumbar
        - More than two-level discectomy or decompression
        - Any level fusion
- Surgical facility does not have capability for 23-hour observation or arrangements in place for overnight hospital admission
- Discharge on the day of surgery is not likely

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Figure 1. CPT codes in scope for spine surgery

Anterior Cervical Discectomy Fusion (ACDF) or Artificial Cervical Disc Arthroplasty

22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2
22552	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for separate procedure)
22554	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2
22585	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)
22856	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); single interspace, cervical
22858	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); second level, cervical (List separately in addition to code for primary procedure)
22845	Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure)
22853	Insertion of interbody biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace (List separately in addition to code for primary procedure)

Cervical Laminotomy/Laminectomy

63020	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical
63035	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)
63040	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; cervical
63043	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional cervical interspace (List separately in addition to code for primary procedure)
63075	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace
63076	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, each additional interspace (List separately in addition to code for primary procedure)

Lumbar Discectomy/Laminectomy

63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar

63042 Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar

63044 Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional lumbar interspace (List separately in addition to code for primary procedure)

63056 Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; lumbar (including transfacet, or lateral extraforaminal approach) (eg, far lateral herniated intervertebral disc)

63057 Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; each additional segment, thoracic or lumbar (List separately in addition to code for primary procedure)

63005 Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; lumbar, except for spondylolisthesis

63012 Laminectomy with removal of abnormal facets and/or pars inter-articularis with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar (Gill type procedure)

63017 Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), more than 2 vertebral segments; lumbar

63047 Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar

63048 Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar

Vertebroplasty/Kyphoplasty

22510 Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic

22511 Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral

22512 Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; each additional cervicothoracic or lumbosacral vertebral body (List separately in addition to code for primary procedure)

22513 Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance

22514 Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance

22515 Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance

Joint

Outpatient Level of Care: Joint Surgery

Historically, orthopedic hip, knee, and shoulder arthroscopic and sports medicine procedures (Figure 2) have been done on an outpatient basis. The performance of orthopedic arthroscopic and sports medicine procedures in the inpatient setting is generally considered **not medically necessary**. Requests to perform these procedures inpatient should be considered rare and will be reviewed on a case-by-case basis.

Inpatient Level of Care: Joint Surgery

Inpatient level of care is considered medically necessary for joint surgery when at least one of the following patient or surgical specific risk factors is present and when the patient meets the criteria for at least one surgical indication in the AIM Musculoskeletal Joint Surgery guidelines.

Patient

- Demographic/constitutional
    - Age greater than 65 or less than 19
    - BMI > 40 kg/m^2
    - Pregnancy
- Medical risk factors
    - Medical comorbidity likely to require more than six (6) hours of postoperative observation
        - Charlson comorbidity index (CCI) greater than 2
        - ASA class greater than 2
        - Recent venous thromboembolic event (VTE)
        - Severe or uncontrolled diabetes
        - Severe anemia requiring preoperative transfusion
        - Coagulopathy
        - Recent unexplained weight loss
        - Malnutrition
        - Chronic pulmonary disease
            - COPD, severe and/or oxygen dependent
            - Respiratory distress
        - Obstructive sleep apnea
        - Liver disease – cirrhosis
        - Vascular

        - Cardiovascular disease
            - myocardial infarction (MI) within six (6) months of intended surgery
            - angina pectoris with severe functional limitation
            - cardiac arrhythmia
            - implantable cardiac device (defibrillator, pacemaker)
        - Cerebrovascular disease
            - recent stroke or transient ischemic attack (TIA)
    - Uncontrolled preoperative pain
    - Prior complication of anesthesia
    - Prior postoperative complication
        - Ileus
        - Urinary retention

- Psychiatric/cognitive
    - Ongoing substance abuse
    - Cognitive impairment
- Social
    - Patient resides outside of a reasonable distance (30-minute drive) of an emergency medical facility
    - No responsible/reliable adult (caregiver) living with, or staying with the patient who is available to care for them for at least 23 hours after surgery.
    - Patient does not agree to surgery outside the inpatient hospital setting or is expected to be noncompliant with perioperative care (example: severe anxiety about receiving surgery in a nonhospital setting)
- Functional status
    - Patient unable to care for individual needs
    - Functional impairment likely to necessitate inpatient rehabilitation after surgery (example: moderate to severe myelopathy)
    - Patient is at high risk for falls

Note: The presence of medical and/or psychiatric comorbidities alone may not always justify an inpatient level of care but rather consideration should be given if poorly controlled, unstable, untreated, or anticipated to require treatment post operatively.

Surgical

- Procedures listed in Addendum E: HCPCS Codes That Would Be Paid Only as Inpatient Procedures for CY 2018 of the Centers for Medicare and Medicaid Services Hospital Outpatient Prospective Payment CMS-1678-FC. Available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1678-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending
- Indications that are emergent and/or systemic
    - Acute trauma with fracture
    - Spinal neoplasm
    - Septic arthritis
    - Complication of inflammatory arthritis / seronegative spondyloarthropathy (SpA)
- Prolonged operative or anesthesia time (> 3 hours)
- Revision surgery
- Surgical facility does not have capability for 23-hour observation or arrangements in place for overnight hospital admission
- Discharge on the day of surgery is not likely

Selected References

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Figure 2. Outpatient CPT codes in scope for joint surgery

Knee Arthroscopy and open procedures

27331	Arthrotomy, knee; including joint exploration, biopsy, or removal of loose or foreign bodies
27332	Arthrotomy, with excision of semilunar cartilage (meniscectomy) knee; medial OR lateral
27333	Arthrotomy, with excision of semilunar cartilage (meniscectomy) knee; medial AND lateral
27334	Arthrotomy, with synovectomy, knee; anterior OR posterior
27335	Arthrotomy, with synovectomy, knee; anterior AND posterior including popliteal area
27403	Arthrotomy with meniscus repair, knee
27405	Repair, primary, torn ligament and/or capsule, knee; collateral
27407	Repair, primary, torn ligament and/or capsule, knee; cruciate
27409	Repair, primary, torn ligament and/or capsule, knee; collateral and cruciate ligaments
27412	Autologous chondrocyte implantation, knee
27415	Osteochondral allograft, knee, open
27416	Osteochondral autograft(s), knee, open (eg, mosaicplasty) (includes harvesting of autograft[s])
27427	Ligamentous reconstruction (augmentation), knee; extra-articular
27428	Ligamentous reconstruction (augmentation), knee; intra-articular (open)
27429	Ligamentous reconstruction (augmentation), knee; intra-articular (open) and extra-articular
29866	Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the autograft[s])
29867	Arthroscopy, knee, surgical; osteochondral allograft (eg, mosaicplasty)
29868	Arthroscopy, knee, surgical; meniscal transplantation (includes arthrotomy for meniscal insertion), medial or lateral
29870	Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)
29873	Arthroscopy, knee, surgical; with lateral release
29874	Arthroscopy, knee, surgical; for removal of loose body or foreign body (eg, osteochondritis dissecans fragmentation, chondral fragmentation)
29875	Arthroscopy, knee, surgical; synovectomy, limited (eg, plica or shelf resection) (separate procedure)
29876	Arthroscopy, knee, surgical; synovectomy, major, 2 or more compartments (eg, medial or lateral)
29877	Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty)
29879	Arthroscopy, knee, surgical; abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture
29880	Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed
29881	Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed
29882	Arthroscopy, knee, surgical; with meniscus repair (medial OR lateral)
29883	Arthroscopy, knee, surgical; with meniscus repair (medial AND lateral)

29884 Arthroscopy, knee, surgical; with lysis of adhesions, with or without manipulation (separate procedure)

29885 Arthroscopy, knee, surgical; drilling for osteochondritis dissecans with bone grafting, with or without internal fixation (including debridement of base of lesion)

29886 Arthroscopy, knee, surgical; drilling for intact osteochondritis dissecans lesion

29887 Arthroscopy, knee, surgical; drilling for intact osteochondritis dissecans lesion with internal fixation

29888 Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction

29889 Arthroscopically aided posterior cruciate ligament repair/augmentation or reconstruction

Hip Arthroscopy

29860 Arthroscopy, hip, diagnostic with or without synovial biopsy (separate procedure)

29861 Arthroscopy, hip, surgical; with removal of loose body or foreign body

29862 Arthroscopy, hip, surgical; with debridement/shaving of articular cartilage (chondroplasty), abrasion arthroplasty, and/or resection of labrum

29863 Arthroscopy, hip, surgical; with synovectomy

29914 Arthroscopy, hip, surgical; with femoroplasty (ie, treatment of cam lesion)

29915 Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion)

29916 Arthroscopy, hip, surgical; with labral repair

Shoulder Arthroscopy and open procedures

23105 Arthrotomy; glenohumeral joint, with synovectomy, with or without biopsy

23107 Arthrotomy, glenohumeral joint, with joint exploration, with or without removal of loose or foreign body

23120 Claviculectomy; partial

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)

23430 Tenodesis of long tendon of biceps

23440 Resection or transplantation of long tendon of biceps

23450 Capsulorrhaphy, anterior; Putti-Platt procedure or Magnuson type operation

23455 Capsulorrhaphy, anterior; with labral repair (eg, Bankart procedure)

23460 Capsulorrhaphy, anterior, any type; with bone block

23462 Capsulorrhaphy, anterior, any type; with coracoid process transfer

23465 Capsulorrhaphy, glenohumeral joint, posterior, with or without bone block

23466 Capsulorrhaphy, glenohumeral joint, any type multi-directional instability

29805 Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure)

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
29822	Arthroscopy, shoulder, surgical; debridement, limited
29823	Arthroscopy, shoulder, surgical; debridement, extensive
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 (ie, arch) release, when performed (List separately in addition to code for primary procedure)
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
29828	Arthroscopy, shoulder, surgical; biceps tenodesis

Appendix A. ASA Physical Status Classification System

ASA PS Classification	Definition	Examples, including, but not limited to:
ASA I	A normal healthy patient	Healthy, non-smoking, no or minimal alcohol use
ASA II	A patient with mild systemic disease	Mild diseases only without substantive functional limitations. Examples include (but not limited to): current smoker, social alcohol drinker, pregnancy, obesity (30 < BMI < 40), well-controlled DM/HTN, mild lung disease
ASA III	A patient with severe systemic disease	Substantive functional limitations; One or more moderate to severe diseases. Examples include (but not limited to): poorly controlled DM or HTN, COPD, morbid obesity (BMI ≥40), active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of ejection fraction, ESRD undergoing regularly scheduled dialysis, premature infant PCA < 60 weeks, history (>3 months) of MI, CVA, TIA, or CAD/stents.
ASA IV	A patient with severe systemic disease that is a constant threat to life	Examples include (but not limited to): recent (<3 months) MI, CVA, TIA, or CAD/stents, ongoing cardiac ischemia or severe valve dysfunction, severe reduction of ejection fraction, sepsis, DIC, ARD or ESRD not undergoing regularly scheduled dialysis
ASA V	A moribund patient who is not expected to survive without the operation	Examples include (but not limited to): ruptured abdominal/thoracic aneurysm, massive trauma, intracranial bleed with mass effect, ischemic bowel in the face of significant cardiac pathology or multiple organ/system dysfunction
ASA VI	A declared brain-dead patient whose organs are being removed for donor purposes	

*The addition of "E" denotes Emergency surgery: (An emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part)
Source: 2014 ASA Physical Status Classification System available at the American Society of Anesthesiologists website; Accessed November 21, 2017.

History

Status	Date	Action
Reviewed	12/12/2017	Independent Multispecialty Physician Panel review.
Created	03/01/2018	-