Priority Health	BILLING POLICY No. 018
MUSCULOSKELETAL (MSK) SHOULDER	
Date of origin: Sept. 2024	**Review dates: 2/2025, 02/2026**

APPLIES TO
All plans

DEFINITION
Surgical treatment of the shoulder may be needed when all nonsurgical treatment has been exhausted, and the patient will need surgical intervention.

MEDICAL POLICY
Priority Health has contracted with TurningPoint Healthcare Solutions LLC (TurningPoint) for management of some shoulder services. Medical necessity for these procedures will be governed by the applicable TurningPoint clinical guidelines. To access these guidelines, log into your **prism** account. Under the Authorizations menu, click **Authorization Criteria Lookup** then the **TurningPoint link**.

POLICY SPECIFIC INFORMATION
Billing details
The shoulder should be recognized as four anatomic areas: glenohumeral, acromioclavicular, sternoclavicular and the bursal space. Approaches to each of these spaces is unique and different excisions are required to access each space.

Acromioplasty and rotator cuff repair
Acromioplasty is performed when there is an impingement in the shoulder. This can be done with a rotator cuff repair. Rotator cuff repair is done when there is a tear, weakness, or when there is limited functioning of the affected arm.

- Limited debridement (29822) is considered part of the arthroscopic repair even if done in a separate compartment.
- Extensive debridement (29823) is allowed if the debridement is done in a separate compartment of the shoulder.

Diagnostic arthroscopy
Priority Health follows Medicare guidelines.

If a diagnostic arthroscopy leads to a surgical arthroscopy at the same patient's encounter, only the surgical arthroscopy may be reported.

If an arthroscopic procedure is converted to an open procedure, only the open procedure may be reported. Neither a surgical arthroscopy nor a diagnostic arthroscopy code shall be reported with the open procedure code when a surgical arthroscopic procedure is converted to an open procedure.

If an arthroscopy is performed as a procedure to assess the surgical field or extent of disease, it's not separately reportable. If the findings of a diagnostic arthroscopy lead to the decision to perform an open procedure, the diagnostic arthroscopy may be separately reportable. Modifier 58 may be reported to indicate that the diagnostic arthroscopy and non-arthroscopic therapeutic procedures were staged or planned procedures. The medical record must indicate the medical necessity for the diagnostic arthroscopy. See CMS NCCI policy manual chapter 4 for additional details.

Sometimes an arthroscopic procedure starts out that way, but if the surgeon makes an incision and finishes it as an open procedure, it becomes a “mini-open procedure.” In this instance, only the open procedure requires coding and billing to be completed. See more information.

Labral tear repair
Arthroscopic Bankart repair is reported using CPT code 29806 (Arthroscopy, shoulder, surgical; capsulorrhaphy).

Per CPT guidelines, arthroscopic Bankart and SLAP repair are defined by codes 29806 (Arthroscopy, shoulder, surgical; capsulorrhaphy) and 29807 (Arthroscopy, shoulder, surgical; repair of SLAP lesion). If these procedures are done on the same shoulder during the same operative session, only one code is reported.

Synvoectomy
CPT 29826 (arthroscopy, shoulder surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament release, when performed) can only be billed along with one (or more) of the following CPT codes:

- 29806, 29807, 29819, 29820, 29821, 29822, 29823, 29824, 29825, 29827, and 29828.

For example, if a provider performs an arthroscopic subacromial decompression or acromioplasty but doesn’t perform any other procedure in the same operative setting, bill CPT code 29822 or 29823, depending upon the extent of the work involved. However, if the provider performs the decompression or acromioplasty together with an arthroscopic rotator cuff repair, bill CPT code 29827 and add on the CPT 29826. See more information.

Documentation requirements
Priority Health follows standard CMS DME documentation requirements. This list isn’t all inclusive. See CMS guidance for a complete list of requirements.

- Patient identification:
  - The beneficiary's name, date of service,
  - The provider's name should be on each page of the documentation.
- The operative note should include information on the following:
  - The use of modifiers by documenting separate procedures.
  - Start and stop time of the procedure

Modifiers
To indicate procedures on different shoulders, you may use modifiers for LT (left side) and RT (right side). See more under NCCI guidelines, chapter 4.

Per AAOS, for top and bottom repairs of the labrum at the same session, append modifier 22 to the code to acknowledge the additional work performed.

DISCLAIMER
Priority Health’s billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member’s benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member’s benefit plan or authorization isn’t being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn’t a guarantee of payment when proper billing and coding requirements or adherence to our policies aren’t followed. Proper billing and submission guidelines must be followed. We require

industry standard, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Feb. 5, 2025	Added "Disclaimer" section
February 17,2026	Reviewed, no changes