Reporting Shoulder Surgery
Stay Up-to-date with Coding Rules and Payer Policies

Arthroscopic shoulder surgery is a minimally invasive procedure used to treat common shoulder problems such as rotator cuff tears, bursitis, tendonitis, arthritis, impingement, labral tears, and shoulder instability.

Arthroscopic Shoulder Procedures – Key CPT Codes

The Centers for Medicare & Medicaid Services (CMS) and the American Academy of Orthopedic Surgeons (AAOS) have different views on shoulder anatomy. Understanding these differences is crucial to understand how shoulder arthroscopy and debridement are reported by payer. While CMS considers the shoulder to be a single anatomic region, AAOS regards the glenohumeral joint, the acromioclavicular (AC) joint, and the subacromial bursa as separate anatomic areas. Let's discuss the guidelines for reporting key shoulder surgery codes.

Codes 29821-29823

- 29821 Arthroscopy, shoulder, surgical; synovectomy, complete
- 29822 Arthroscopy, shoulder, surgical; debridement, limited
- 29823 Arthroscopy, shoulder, surgical; debridement, extensive
- 29821 synovectomy, complete: According to the American Medical Association (AMA) and the AAOS, to report 29821, the "entire intra-articular synovium" must be removed. The AAOS instructs that 29821 should only be used when the underlying diagnosis is pathologic synovium such as is found in rheumatoid arthritis or pigmented villonodular synovitis.
- 29822, limited debridement and 29823 extensive debridement: With regard to the distinction between "limited" and "extensive" debridement as described in CPT codes 29822 and 29823, most payers follow AAOS Bulletin (April 2006) guidelines which are as follows:
    - Code 29822 covers limited debridement of soft or hard tissue and should be used for limited labral debridement, cuff debridement, or the removal of degenerative cartilage and osteophytes.
    - Code 29823 should be used only for extensive debridement of soft or hard tissue. It includes a chondroplasty of the humeral head or glenoid and associated osteophytes, or multiple soft tissue structures that are debrided such as labrum, subscapularis and supraspinatus.

Thus, debridement in a single area or compartment would be considered as limited. Extensive debridement comprises debridement of multiple soft

structures, multiple hard structures, or a combination of both. A 2017 AAPC article give the following examples of extensive debridement:

- A chondroplasty and a debridement of the labrum (a combination of hard and soft structures)
- An abrasion arthroplasty (microfracturing/drilling down to bleeding bone) and a biceps tenotomy (a combination of hard and soft structures)
- Debridement of a biceps tendon and a partial thickness rotator cuff tear (multiple soft structures)
  Documentation should indicate the areas/compartments in which debridement takes place

Changes to 29823, extensive debridement: In 2017, CMS made a notable change to code 29823, extensive debridement (in Section E, Chapter 4 of the NCCI policy manual). This code can be billed separately if the extensive debridement portion of the procedure is performed in a separate area of the shoulder joint with one of the following arthroscopic shoulder procedures:

- 29824 – Arthroscopic claviculectomy including distal articular surface
- 29827 – Arthroscopic rotator cuff repair
- 29828 – Biceps tenodesis

These changes are valid only for the extensive debridement code. It should be noted that the limited debridement code (29822) includes other, more extensive arthroscopic procedure codes.

- 29819 Arthroscopy, shoulder, surgical; with removal of loose body or foreign body: The AAOS points out that to use code 29819, the loose body in the shoulder should be larger than 5 mm. In this situation, coding 29827 (arthroscopic rotator cuff repair) with 29819-59 is allowed. Also, code 29807 arthroscopic repair of a superior labral anterior posterior (SLAP) lesion may also be billed with the loose body code (29819-59).
- Coding for SLAP (Superior Labrum Anterior and Posterior) Lesions
- A clear understanding of the anatomy of the lesion is essential for coding SLAP lesions correctly. A SLAP injury involves the top part of the labrum, where the biceps tendon attaches to the labrum. A SLAP tear occurs both in front (anterior) and back (posterior) of this attachment point. This injury can also involve the biceps tendon. The four types of SLAP tears are:
  - Type I-labral fraying with firmly attached labrum and biceps origin
  - Type II-labrum and biceps origin are detached from the labrum
  - Type III-bucket-handle labral tear with firmly attached labrum and biceps origin

- Type IV-bucket-handle tear of superior labrum with extension into the biceps tendon with biceps displacement

Type I and Type III SLAP lesions with firmly attached labrum and biceps origin are coded as 29822 (arthroscopic debridement, limited). Types II and IV involve disruption of the labrum attachment and should be reported using code 29807 to indicate repair of the lesions. The operative report should have a detailed description of the anchor or suture repair. Code 29823 should only be used if more extensive debridement is performed during the operation.

Code 29806, Arthroscopy, shoulder, surgical; capsulorrhaphy covers both anterior and posterior capsulorrhaphy (29806, lower half and 29807, upper half). If a repair is done both anteriorly and posteriorly, it would be coded as 29806-22.

A 2017 AAPC article states:

- NCCI bundles codes 29806 and 29807, and only allows one per shoulder, per session
- Per the AAOS Bulletin, modifier 22 should be appended for top and bottom repairs of the labrum at the same session, to report the additional work performed
- Private payer and workers' compensation carrier rules should be checked to see if they permit reporting either 29806 or 29807 on the same shoulder
- NCCI instructs that procedures on different shoulders can be indicated using modifiers LT Left side and RT Right side

Importance of Proper Clinical Documentation and Expert Coding Guidance

Coding for arthroscopic shoulder surgery is complex and errors can cause compliance problems as well as leave money on the table. The above-mentioned shoulder surgery codes and billing information is not exhaustive. That's why it's important for providers to have expert coders and billers onboard to ensure accurate reporting and optimal reimbursement.

Coders and providers should be knowledgeable about documentation requirements for proper reporting of shoulder procedures. The operative report should clearly specify what was done during the surgery and indicate the medical necessity for the procedure.