Revisions to Arthroscopic Shoulder Debridement Codes

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Current Procedural Terminology (CPT®) codes (29822, 29823) for arthroscopic shoulder debridement have been the source of much confusion within the coding community. Over the years, countless questions have been submitted to the CPT® Network on this topic and these codes are associated with many of the frequently asked questions in various editions of *CPT® Assistant. To help prevent continued confusion and provide better clarification, new guidelines have been added and codes 29822 and 29823 have been revised for the CPT® 2021 code set. This article provides an overview of these revisions.*

Endoscopy/Arthroscopy

Arthroscopic removal of loose body(ies) or foreign body(ies) (ie, 29819, 29834, 29861, 29874, 29894, 29904) may be reported only when the loose body(ies) or foreign body(ies) is equal to or larger than the diameter of the arthroscopic cannula(s) used for the specific procedure, and can only be removed through a cannula larger than that used for the specific procedure or through a separate incision or through a portal that has been enlarged to allow removal of the loose or foreign body(ies).

29806 Arthroscopy, shoulder, surgical; capsulorrhaphy

▲**29822** debridement, limited, 1 or 2 discrete structures (eg, humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies])

(For open procedure, see specific open shoulder procedure performed)

▲**29823** debridement, extensive, 3 or more discrete structures (eg, humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies])

(For open procedure, see specific open shoulder procedure performed)

Codes 29822 and 29823 were identified as potentially misvalued by the AMA/Specialty Society Relative Value Scale (RVS) Update Committee (RUC) through several screens, including the high utilization screen, and was never surveyed for physician work. Therefore, these codes were referred to the CPT Editorial Panel for revision and to address coding confusion created by the lack of clarity in the existing code descriptors.

The new guidelines added to the Endoscopy/ Arthroscopy subsection clarify that arthroscopic removal of loose body(ies) or foreign body(ies) may be reported only when the loose body(ies) or foreign body(ies) is **equal to or larger than the diameter of the arthroscopic cannula(s)** used for the specific procedure, and can only be removed through **a cannula larger than that used for the specific procedure or through a separate incision or through a portal that has been enlarged** to allow removal of the loose or foreign body(ies).

For the CPT 2021 code set, the code descriptors of codes 29822 and 29823 have been revised based on the number of discreet structures debrided and

with examples of structures that constitute different sites of debridement. It is important to note that the examples listed are merely examples and are not meant to be taken as being exclusive of other structures. In addition, the terms limited and extensive have been retained in the revised code descriptors.

Code 29822 has been revised to specify that limited debridement includes one or two discrete structures, while code 29823 has been revised to describe extensive debridement that includes three or more discrete structures. Examples of structures that may be debrided for both codes include the humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, and foreign body(ies).

It is hoped that by specifying both the number and names of anatomical structures involved in shoulder debridement, users will be able to more accurately select the appropriate code based on the medical documentation in the operative report. As with all other arthroscopic debridement codes, it is important to note that the structures debrided as part of another procedure reported for the same session cannot be counted to meet the criteria of the debridement code. For example, a bursal-sided supraspinatus tear cannot be counted as a debrided structure if the supraspinatus is repaired in the same session.

The following clinical examples and new procedural descriptions reflect typical clinical scenarios for which these revised codes would be appropriately reported.

Clinical Example (29822)

A 50-year-old male presents with shoulder pain. He has failed treatment with physical therapy, anti-inflammatory medications, and a steroid injection. Magnetic resonance imaging (MRI) shows a tear of the biceps attachment at the superior labrum. A diagnosis of a symptomatic superior labrum anterior

posterior (SLAP) tear is made. An arthroscopic limited debridement of the proximal biceps and its attachment is performed.

Description of Procedure (29822)

Under anesthesia, make a posterior portal to gain access to the glenohumeral joint. Create an anterior portal in the rotator interval and insert a cannula. Maneuver the camera and alter the humeral head rotation and position in order to view all structures of the glenohumeral joint. Assess the articular side of the subscapularis visually by internally and externally rotating the humeral head and palpate with a probe assessing for partial tears. Assess the anterior capsule, anterior glenohumeral ligaments, and rotator interval visually and palpate for tears or abrasions. Assess the subscapularis fossa visually and use a probe to assess for loose bodies. Visualize the articular side of the supraspinatus and infraspinatus and palpate by taking the humeral head through forward flexion, internal, and external rotation to assess for undersurface tears. Visualize the articular cartilage of the humeral head and glenoid and palpate for chondral damage. Visualize and palpate the labrum circumferentially to assess for tears. Visualize the long head of the biceps tendon and palpate at its insertion on the supraglenoid tubercle. Ramp the tendon into the joint to assess the extra-articular 3 to 5 cm for tears and to assess for medial subluxation. Take arthroscopic images and videos for documentation. A partial tear of the attachment of the long head of the biceps to the superior labrum is noted, which is indicative of a type I SLAP lesion. Through the anterior portal, use manual resecting instruments and a shaver to debride torn or non-adherent tissue from the biceps tendon and superior labrum. Then place the arthroscope in the glenohumeral joint through the anterior portal. Assess the same structures from a different vantage point to ensure that no pathology was missed. Debride the biceps and labrum further, placing instruments through the posterior portal. Place the arthroscope in the subacromial space through the posterior portal. Create a lateral portal in the subacromial space. Assess the bursal side of the rotator cuff by taking the humeral head through range of motion. Use a probe to palpate the bursal side of the rotator cuff. Move the arthroscope to the lateral portal to ensure full visualization. Remove the arthroscope and close the portals with sutures. Inject the portals with bupivacaine hydrochloride and epinephrine.

Clinical Example (29823)

A 50-year-old male presents with one year of shoulder pain. He has failed treatment with physical therapy, anti-inflammatory medications, and a steroid injection. Magnetic resonance imaging (MRI) shows chondral degeneration of the humeral head and the glenoid and a partial bursal surface tear of the supraspinatus tendon. A diagnosis of articular cartilage degeneration and a partial rotator cuff tear is made. An arthroscopic extensive debridement of these three structures is performed.

Description of Procedure (29823)

Under anesthesia, make a posterior portal to gain access to the glenohumeral joint. Create an anterior portal in the rotator interval and insert a cannula. Maneuver the camera and alter the humeral head rotation and position to view all structures of the glenohumeral joint. Assess the articular side of the subscapularis visually by internally and externally rotating the humeral head and palpate with a probe assessing for partial tears. Assess the anterior capsule, anterior glenohumeral ligaments, and rotator interval visually and palpate for tears or abrasions. Assess the subscapularis fossa visually and use a probe to assess for loose bodies. Visualize the articular side of the supraspinatus and infraspinatus and palpate by taking the humeral head through forward flexion, internal, and external rotation to assess for undersurface tears. Visualize the articular cartilage of the humeral head and glenoid and palpate for chondral damage. Visualize and palpate the labrum circumferentially to assess for tears. Visualize the long head of the biceps tendon and palpate at its insertion on the supraglenoid tubercle. Ramp the tendon into the joint to assess the extra-articular 3 to 5 cm for tears and to assess for medial subluxation. Take arthroscopic images and videos for documentation. Identify chondral degeneration of the humeral head and glenoid. Place a probe through the anterior portal to measure and manipulate the chondral damage of the glenoid. Use manual resecting instruments and a shaver to debride delaminating tissue from the glenoid to create smooth borders. Note the size, location, depth, and pattern of the lesion before and after debridement. Take arthroscopic images or videos for documentation. Note chondral degeneration of the humeral head and address with debridement using a shaver from the anterior portal. Take the humeral head through a range of motion to allow the shaver access to the lesion. Debride delaminating

chondral margins to a stable transition. Note the size, location, depth, and pattern of the lesion before and after debridement. Take arthroscopic images or videos for documentation. Then place the arthroscope in the glenohumeral joint through the anterior portal. Assess the same structures from a different vantage point to ensure that no pathology was missed. Debride the glenoid and humeral head articular cartilage further by placing instruments through the posterior portal. Obtain final image documentation. Place the arthroscope in the subacromial space through the posterior portal. Create a lateral portal in the subacromial space. Assess the bursal side of the rotator cuff by taking the humeral head through range of motion.

Use a probe to palpate the bursal side of the rotator cuff. A partial tear of the bursal side of the rotator cuff is identified. The tear is less than 50% thickness of the rotator cuff tendon. Move the arthroscope to the lateral portal to ensure full visualization with additional assessment of the lesion. Place a shaver and use to debride the partial tear to a smooth transition. Note the size, location, depth, and pattern of the lesion before and after debridement. Take arthroscopic images or videos for documentation. Remove the arthroscope and close the portals with sutures. Inject the portals with bupivacaine hydrochloride and epinephrine.

