

AANA's Position Statement on Coding for Superior Capsular Reconstruction

Coding of arthroscopic superior capsular reconstruction (SCR) has been a recent topic of debate among surgeons and coding experts. According to a CPT® Advisor article published in April 2017, it was recommended that SCR be coded as an unlisted procedure using 29999.

We disagree with this conclusion. Further, given the high degree of surgical expertise required for this technique, we have great concern that this coding determination was not vetted by individuals with experience or an in-depth understanding of the pathology SCR treats.

In patients with chronic rotator cuff disease, loss of the glenohumeral force couple, generated by the rotator cuff, results in superior subluxation of the humeral "head" and attenuation of tendon and joint capsule. Tissue degeneration also results in a high risk of failure when using more traditional repair techniques. In this setting, it may be necessary to augment the rotator cuff repair (complete or partial) with reconstruction of the superior joint capsule. In summation, restoration of the superior capsule creates a static restraint to superior migration and serves an internal splint to augment a rotator cuff repair.

While the combination of these techniques for management of rotator cuff disease is a new concept, the individual surgical procedures have established diagnostic and procedural codes. When the surgeon performs both procedures, we recommend 29827 for coding of rotator cuff repair and 29806 for capsular reconstruction. These codes have been previously described and valued through the peer-reviewed RUC and CPT processes.

From a diagnosis standpoint, superior capsular procedure is used for management of superior subluxation of the humeral head (ICD 10: S43.081). For open surgical techniques, coding of surgical management of shoulder instability can be performed using the family of codes 23450-23466. Using anatomic and non-anatomic techniques, these codes describe a variety of open techniques that address multidirectional shoulder instability to repair or reconstruct deficient glenohumeral joint capsule.

According to CPT, code 29806 should be used when an arthroscopic technique is utilized. In a SCR, the surgeon may use autograft or allograft tissue to reconstruct or repair deficient capsular tissues. As such, they should report 29806 when the technique is performed arthroscopically. The surgeon should be sure to document restoration of the deficient superior capsular tissue and reduction of superior subluxation of the glenohumeral joint (ICD 10: S43.081). The following narrative would describe evaluation, preparation and fixation of a superior capsular graft:

"Using an arthroscopic technique, suture anchors were placed along the superior boarder of the glenoid and humeral head in preparation for repair of the superior capsule. Capsular tissue was mobilized and felt to be insufficient for repair. A dermal allograft was fashioned on the back table and cut to appropriate size for implantation. The graft was taken to the operative field, and suture limbs from the previously inserted anchors were retrieved through a lateral cannula. The suture limbs were passed through the appropriate locations in graft prior to insertion of the graft into the subacromial space. The graft was shuttled through the lateral cannula into the subacromial space. The graft was then spread out in the subacromial space. Sutures from the anchors in the glenoid and humeral head were then sequentially retrieved and tied to secure

the graft in position, resulting in restoration of the superior capsular tissue and reduction superior subluxation of the humeral head.”

If the surgeon also performs an arthroscopic repair, the residual rotator cuff tissue (complete or partial) 29827 should also be reported. The surgeon should be sure to document the details of their repair of the rotator cuff tissue. The following narrative would describe repair of residual infraspinatus tissue to the graft and posterior inferior humeral head:

“The tendon of the infraspinatus was mobilized in preparation for surgical repair. Using a suture passed through the capsular graft, a marginal convergence stitch was passed and tied to secure the superior edge of the rotator cuff tissue. Next, using a suture limb from the posterior anchor previously placed in the humeral head, a suture was passed through the lateral edge of the infraspinatus tendon and repaired back to its anatomic insertion on the humerus.”