Medical Policy Guidelines

Shoulder Injury – Prior Authorization Requirements

This medical policy outlines the requirements for prior authorization of diagnostic imaging and treatments related to shoulder injuries. It is designed to ensure evidence-based, medically necessary care and appropriate utilization of health plan resources for members presenting with shoulder pain, instability, or loss of function.

1. Coverage Criteria

Prior authorization is required for advanced diagnostic procedures and surgical interventions related to shoulder injuries. Authorization will be approved when all of the following criteria are met:

• Shoulder pain persisting beyond 6 weeks despite conservative management (e.g., rest, ice, NSAIDs, physical therapy).

• Physical exam findings and/or imaging consistent with conditions such as rotator cuff tear, labral tear, bursitis, or shoulder impingement.

• Non-surgical treatments (e.g., steroid injections, PT) have been documented and failed to relieve symptoms.

• Specialist referral includes supporting diagnostic test results or clinical justification for advanced imaging or surgery.

2. Diagnostic Procedures Requiring Prior Authorization

Procedure	CPT Code	Authorization Required
MRI of Shoulder (without contrast)	73221	Yes
MRI of Shoulder (with contrast)	73222	Yes
CT Scan of Upper Extremity	73200	Yes
Ultrasound of Shoulder Joint	76881	No
X-ray of Shoulder (2 or more views)	73030	No

3. Non-Covered Services

The following services are considered experimental, investigational, or not medically necessary for shoulder injury management and will not be covered:

• Platelet-rich plasma (PRP) or stem cell injections for rotator cuff tears or tendon injuries.

• Arthroscopic subacromial decompression for isolated shoulder impingement without full-thickness rotator cuff tear.

• Acupuncture for shoulder pain management.

• Custom shoulder braces without documentation of failed standard immobilization devices.

4. Documentation Requirements

Providers must submit the following documentation to support prior authorization requests:

• Detailed clinical notes describing onset, duration, mechanism, and severity of symptoms.

• Evidence of conservative management and outcomes.

• Relevant imaging or test results supporting the diagnosis.

• Treatment plan outlining rationale for advanced imaging or surgical procedure.

5. Surgical Procedures Requiring Prior Authorization

Procedure	CPT Code	Authorization Required
Arthroscopic Shoulder Surgery	29806	Yes
Rotator Cuff Repair	29827	Yes
Labral Repair (SLAP or Bankart)	29807	Yes
Total Shoulder Arthroplasty	23472	Yes
Reverse Shoulder Replacement	23474	Yes

6. Medical Review Guidelines

All prior authorization requests will undergo clinical review by a licensed physician or appropriate medical professional. Requests not meeting the criteria outlined may be denied, with opportunities for peer-to-peer discussion or submission of additional documentation.

Note: This policy is reviewed annually and updated based on current clinical guidelines and payer utilization data.

Disclaimer

This policy serves as guidance for prior authorization and benefit coverage decisions. It does not replace clinical judgment or the terms of the member's benefit plan. Final coverage determinations are based on member eligibility, plan provisions, and applicable laws or regulations.