American Academy of Orthopaedic Surgeons
Government Relations Department
9400 West Higgins Road
Rosemont, IL 60018

January 12, 2026

Dear CPT Staff:

On behalf of the Arthroscopy Association of North America (AANA) and the American Orthopaedic Society for Sports Medicine (AOSSM), we respectfully submit this request for approval of the existing CPT® code for arthroscopic subacromial decompression (SAD), with clarification that reflects current evidence and appropriate clinical use.

Our goal is not to modify the CPT code language itself, but to ensure that its application is aligned with the substantial body of literature demonstrating that SAD is an evidence-supported procedure for mechanical impingement and, in appropriately selected cases, a protective adjunct to rotator cuff repair (RCR). Updated guidance acknowledging these indications will help reduce administrative confusion, promote accurate reporting and support value-based patient care.

Although SAD is widely performed, the current code structure creates ambiguity, particularly around its application during RCR. This has led many to default to treating SAD as a "bundled" component of RCR, despite peer-reviewed data showing that acromial morphology and extrinsic impingement forces directly influence tendon loading, abrasion and repair survivorship. Numerous studies demonstrate that patients with lateral acromial overhang (elevated acromial index), increased critical shoulder angle or curved/hooked acromial morphology are at significantly higher risk of rotator cuff degeneration and repair failure (Moor et al., 2013). In these high-risk morphologic patterns, subacromial decompression reduces mechanical abrasion and optimizes the biologic environment for healing (Maguire et al., 2024).

There is comprehensive evidence supporting the use of acromioplasty in appropriately selected patients undergoing rotator cuff repair. A review of existing randomized trials comparing RCR with and without acromioplasty challenges the commonly cited 'no difference' conclusion, which is not supported by robust data (Clark et al., 2025). More importantly, when higher quality outcomes such as reoperation rates are examined, patients who did not undergo acromioplasty experienced substantially higher reoperation rates (15% vs. 4.1%), with the highest risk seen in those with type III (hooked) acromions (Maguire, et al. 2024). All in all, these findings demonstrate stronger evidence for acromioplasty, particularly in patients with high-risk acromial morphology.

Furthermore, we strongly dispute suggestions that SAD is indicated for conditions such as os acromiale, tumor or fracture, as more appropriate indications for acromioplasty exist. These conditions each have distinct diagnostic and operative pathways that are entirely separate from the role of SAD in treating mechanical impingement. Including such conditions may lead to confusion and diminish coding accuracy and the evidence-based application of this procedure.

Additionally, multiple investigations have reported lower reoperation rates and lower revision RCR rates when SAD is performed in patients with mechanical impingement or high-risk acromial morphology (Cheng et al., 2018). By decreasing the likelihood of recurrent tearing and the need for return to the

operating room, SAD lowers the overall cost of care and improves long-term outcomes. These benefits are most pronounced in patients with discrete, documented impingement or morphologic risk factors – precisely the situations for which this clarification is intended. Finally, a SAD does not appreciably add to the overall case cost when accounting for additional equipment or increased operative time.

For these reasons, we believe it is essential that reporting of a SAD be accurately distinguished when it is performed for mechanical impingement or as an adjunct to rotator cuff repair for the prevention of repair failure. Clarifying the intent and clinical appropriateness of SAD will support higher-quality data capture, preserve coding integrity and ensure that surgeons are able to reflect the true care delivered to patients.

AANA and AOSSM fully support this request and ask that both societies be listed as endorsing and sponsoring organizations in the official record.

Thank you for your time and consideration.

Sincerely,

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