SHOULDER REPLACEMENT SURGERY (ARTHROPLASTY)

Policy Number: 2019T0556M

Effective Date: April 1, 2019

Shoulder replacement surgery is proven and medically necessary in certain circumstances. For medical necessity clinical coverage criteria, see the following MCG™ Care Guidelines, 23rd edition, 2019:

- Shoulder Arthroplasty, S-634 (ISC)
- Shoulder Hemiarthroplasty, S-633 (ISC)

**DOCUMENTATION REQUIREMENTS**

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The documentation requirements outlined below are used to assess whether the member meets the clinical criteria for coverage but do not guarantee coverage of the service requested.

<table>
<thead>
<tr>
<th>CPT Codes*</th>
<th>Required Clinical Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Shoulder Arthroplasty, Arthroplasty Revision</strong></td>
<td>Medical notes documenting all of the following:</td>
</tr>
<tr>
<td>23472</td>
<td>Complete report(s) of diagnostic imaging (MRI, CT scan, x-rays and bone scan)</td>
</tr>
<tr>
<td>23473</td>
<td>Condition requiring procedure</td>
</tr>
<tr>
<td>23474</td>
<td>Severity of pain and details of functional disability(ies) interfering with activities of daily living (preparing meals, dressing, driving, walking)</td>
</tr>
<tr>
<td></td>
<td>Physician’s treatment plan including pre-op discussion</td>
</tr>
<tr>
<td></td>
<td>Pertinent physical examination of the relevant joint</td>
</tr>
<tr>
<td></td>
<td>Co-morbid medical condition(s)</td>
</tr>
<tr>
<td></td>
<td>Therapies tried and failed for the following including dates:</td>
</tr>
<tr>
<td></td>
<td>o Orthotics</td>
</tr>
<tr>
<td></td>
<td>o Medications/injections</td>
</tr>
<tr>
<td></td>
<td>o Physical therapy</td>
</tr>
<tr>
<td></td>
<td>o Surgical</td>
</tr>
<tr>
<td></td>
<td>o Other pain management procedures</td>
</tr>
<tr>
<td></td>
<td>If the location is being requested as an inpatient stay, provide medical notes to support at least one of the following:</td>
</tr>
<tr>
<td></td>
<td>o Surgery is bilateral</td>
</tr>
<tr>
<td></td>
<td>o Member has significant co-morbidities; include the list of comorbidities and current treatment</td>
</tr>
<tr>
<td></td>
<td>o Member does not have appropriate resources to support post-operative care after an outpatient procedure; include the barriers to care as an outpatient</td>
</tr>
<tr>
<td></td>
<td>For revision surgery, include documentation of the complication and complete (staged) surgical plan</td>
</tr>
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## CPT Codes

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<td>23470</td>
<td>Arthroplasty, glenohumeral joint; hemiarthroplasty</td>
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<tr>
<td>23472</td>
<td>Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (e.g., total shoulder)</td>
</tr>
<tr>
<td>23473</td>
<td>Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component</td>
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### Required Clinical Information

**Shoulder Hemi-Arthroplasty**

Medical notes documenting all of the following:
- Complete report(s) of diagnostic imaging (MRI, CT scan, x-rays and bone scan)
- Condition requiring procedure
- Co-morbid medical condition(s)
- Severity of pain and details of functional disability(ies) interfering with activities of daily living (preparing meals, dressing, driving, walking)
- Physician’s treatment plan, including pre-op discussion
- Pertinent physical examination of the relevant joint
- Therapies tried and failed for the following including dates:
  - Orthotics
  - Medications/injections
  - Physical therapy
  - Surgery
  - Other pain management procedures
- Document the member has the ability to participate in post-surgical rehab
- If the location is being requested as an inpatient stay, provide office notes to support at least one of the following:
  - Surgery is bilateral
  - Member has significant co-morbidities; include the list of comorbidities and current treatment
  - Member does not have appropriate resources to support post-operative care after an outpatient procedure; include the barriers to care as an outpatient

### Additional Clinical Information

**Note:** Device information is not utilized in prior authorization determinations.

Provide the following details on the device you intend to use during the procedure:

- Specify which implant brand or manufacturer to be used:
  - Arthrex
  - BioMet
  - Conformis
  - Consensus
  - DePuy Synthes
  - DJO Surgical
  - MicroPort
  - Smith & Nephew
  - Stryker
  - Zimmer
  - Other (include name and reason for this selection)
- Provide the fixation type from the following:
  - Cemented
  - Cemented with antibiotic impregnated
  - Non-cemented
  - Other (if another fixation type, then explain)
  - Cannot identify fixation prior to procedure

*For code descriptions, see the [Applicable Codes](#) section.

### Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Coverage Determination Guidelines may apply.

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PROFESSIONAL SOCIETIES

American Academy of Orthopaedic Surgeons (AAOS)
• Total shoulder arthroplasty and hemiarthroplasty are options when treating patients with glenohumeral joint osteoarthritis. Strength of Recommendation: Weak
• We suggest total shoulder arthroplasty over hemiarthroplasty when treating patients with glenohumeral joint osteoarthritis. Strength of Recommendation: Moderate
• An option for reducing immediate postoperative complication rates is for patients to avoid shoulder arthroplasty by surgeons who perform less than two shoulder arthroplasties per year. Strength of Recommendation: Weak
• In the absence of reliable evidence, it is the opinion of this work group that physicians use peri-operative mechanical and/or chemical VTE (venous thromboembolism) prophylaxis for shoulder arthroplasty patients. Strength of Recommendation: Consensus
• The use of either keeled or pegged all polyethylene cemented glenoid components are options when performing total shoulder arthroplasty. Strength of Recommendation: Weak
• In the absence of reliable evidence, it is the opinion of this work group that total shoulder arthroplasty not be performed in patients with glenohumeral osteoarthritis who have an irreparable rotator cuff tear. Strength of Recommendation: Consensus
• We are unable to recommend for or against biceps tenotomy or tenodesis when performing shoulder arthroplasty in patients who have glenohumeral joint osteoarthritis. Strength of Recommendation: Inconclusive
• We are unable to recommend for or against a subscapularis transtendonous approach or a lesser tuberosity osteotomy when performing shoulder arthroplasty in patients who have glenohumeral joint osteoarthritis. Strength of Recommendation: Inconclusive
• We are unable to recommend for or against physical therapy following shoulder arthroplasty. Strength of Recommendation: Inconclusive

U.S. FOOD AND DRUG ADMINISTRATION (FDA)
Shoulder replacement surgery is a procedure and, therefore, not regulated by the FDA. However, devices and instruments used during the surgery may require FDA approval. See the following website for additional information (product codes KWS, HSD, KWT): http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm. (Accessed December 14, 2018)

FDA-approved total or partial shoulder replacement surgery devices are generally approved for the same indications, including any or all of the following:
• Non-inflammatory degenerative joint disease such as osteoarthritis or avascular necrosis (osteonecrosis) of the humeral head
• Rheumatoid arthritis
• Post-traumatic arthritis
• Complex fracture(s) of the proximal (upper) humerus
• Revision of failed shoulder replacement surgery
• Correction of functional deformity

FDA-approved reverse shoulder replacement surgery devices are generally approved for gross rotator cuff deficiency. The patient's joint must be anatomically and structurally suited to receive the selected implant(s), and a functional deltoid muscle is necessary to use the device.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)
Medicare does not have a National Coverage Determination (NCD) for shoulder replacement surgery (arthroplasty). Local Coverage Determinations (LCDs) do not exist at this time. (Accessed January 4, 2019)

POLICY HISTORY/REVISION INFORMATION

<table>
<thead>
<tr>
<th>Date</th>
<th>Action/Description</th>
</tr>
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<tbody>
<tr>
<td>09/23/2019</td>
<td><strong>Documentation Requirements</strong></td>
</tr>
<tr>
<td></td>
<td>• Updated and reformatted documentation requirements</td>
</tr>
<tr>
<td>Date</td>
<td>Action/Description</td>
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<tr>
<td>07/01/2019</td>
<td><strong>Template Update</strong></td>
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<tr>
<td></td>
<td>• Added <em>Documentation Requirements</em> section</td>
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<tr>
<td>04/01/2019</td>
<td><strong>Template Update</strong></td>
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<tr>
<td></td>
<td>• Reorganized policy template:</td>
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<tr>
<td></td>
<td>o Simplified and relocated <em>Instructions for Use</em></td>
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<td></td>
<td>o Removed <em>Benefit Considerations</em> section</td>
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<td></td>
<td>• Revised coverage rationale:</td>
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<tr>
<td></td>
<td>o Replaced reference to &quot;MCG™ Care Guidelines, 22nd edition, 2018&quot; with</td>
</tr>
<tr>
<td></td>
<td>&quot;MCG™ Care Guidelines, 23rd edition, 2019&quot;; refer to 23rd edition for</td>
</tr>
<tr>
<td></td>
<td>complete details on applicable updates to the MCG™ Care Guidelines</td>
</tr>
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<td></td>
<td>o Archived previous policy version 2018T0556L</td>
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</tbody>
</table>

**INSTRUCTIONS FOR USE**

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

This Medical Policy may also be applied to Medicare Advantage plans in certain instances. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence ([Medicare IOM Pub. No. 100-16, Ch. 4, §90.5](#)).

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.