SHOULDER REPLACEMENT SURGERY (ARTHROPLASTY)

Policy Number: 2020T0556N **Effective Date**: April 1, 2020

Instructions for Use

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COVERAGE RATIONALE

Shoulder replacement surgery is proven and medically necessary in certain circumstances.
For medical necessity clinical coverage criteria, see the following MCG™ Care Guidelines, 24th edition, 2020:
- Shoulder Arthroplasty, S-634 (ISC)
- Shoulder Hemiarthroplasty, S-633 (ISC)

Click here to view the MCG™ Care Guidelines.

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.

CPT Codes*	Required Clinical Information
Shoulder Arthroplasty, Arthroplasty Revision	

23472
23473
23474
	Medical notes documenting **all** of the following:
	• Specific diagnostic image(s) that show the abnormality for which surgery is being requested, which may include MRI, CT scan, X-ray, and/or bone scan; consultation with requesting surgeon may be of benefit to select the optimal images
	  ○ **Note**: Diagnostic images must be labeled with:
	  ▪ The date taken
	  ▪ Applicable case number obtained at time of notification, or member's name and ID number on the image(s)
	  ○ Submission of diagnostic imaging is required via the external portal at www.uhcprovider.com/paan or via email at CCR@uhc.com; faxes will not be accepted
	• Diagnostic image(s) report(s)
	• Condition requiring procedure
	• 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
	• Co-morbid medical condition(s)
	• Therapies tried and failed for the following including dates:
	  ○ Orthotics
	  ○ Medications/injections
	  ○ Physical therapy
	  ○ Surgical
	  ○ Other pain management procedures

CPT Codes*	Required Clinical Information
Shoulder Arthroplasty, Arthroplasty Revision	

	• If the location is being requested as an inpatient stay, provide medical 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
	• For **revision** surgery, include documentation of the complication and complete (staged) surgical plan

Shoulder Hemi-Arthroplasty	

23470	Medical notes documenting **all** of the following:
	• Specific diagnostic image(s) that show the abnormality for which surgery is being requested, which may include MRI, CT scan, X-ray, and/or bone scan; consultation with requesting surgeon may be of benefit to select the optimal images
	  ○ **Note**: Diagnostic images must be labeled with:
	  ▪ The date taken
	  ▪ Applicable case number obtained at time of notification, or member's name and ID number on the image(s)
	  ○ Submission of diagnostic imaging is required via the external portal at www.uhcprovider.com/paan or via email at CCR@uhc.com; faxes will not be accepted
	• Diagnostic image(s) report(s)
	• 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.

CPT Code	Description
23470	Arthroplasty, glenohumeral joint; hemiarthroplasty
23472	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (e.g., total shoulder)
23473	Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component
23474	Revision of total shoulder arthroplasty, including allograft when performed; humeral and glenoid component

U.S. FOOD AND DRUG ADMINISTRATION (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

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 January 10, 2020)

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 13, 2020)

POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
04/01/2020	**Coverage Rationale** • Replaced reference to "MCG™ Care Guidelines, *23rd* edition*, 2019*" with "MCG™ Care Guidelines, *24th* edition*, 2020*" **Documentation Requirements** • Updated required clinical information for shoulder replacement surgery (arthroplasty) **Supporting Information** • Removed *Professional Societies* section • Archived previous policy version 2019T0556M

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.