Shoulder Replacement Surgery (Arthroplasty) (for Louisiana Only)

Policy Number: CS109LA.L
Effective Date: July 1, 2021

Instructions for Use

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Application

This Medical Policy only applies to the state of Louisiana.

Coverage Rationale

Shoulder replacement surgery is proven and medically necessary in certain circumstances. For medical necessity clinical coverage criteria, refer to the InterQual® 2021, Apr. 2021 Release, CP: Procedures:

- Joint Replacement, Shoulder
- Removal and Replacement, Total Joint Replacement (TJR), Shoulder

Click here to view the InterQual® criteria.

Documentation Requirements

Provide medical notes documenting the following:

- Pertinent physical examination of the relevant joint
- Severity of pain as documented on a validated pain scale
- Functional disability(ies) as documented on a validated functional disability scale or described as interfering with activities of daily living (preparing meals, dressing, driving, walking)
- Specific diagnostic image(s) that documents the severity of joint disease using a validated scale (e.g., Walch classification of primary glenohumeral osteoarthritis) and shows 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 image(s)
  - Note: Diagnostic images:
    - May include MRI, CT scan, X-ray, and/or bone scan, and
    - Must be labeled with the:
      - Date taken
      - Applicable case number obtained at time of notification, or the 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; faxes will not be accepted
- Advanced joint disease using a validated scale (e.g., Walch classification of primary glenohumeral osteoarthritis)
- Diagnostic image(s) report(s)
- Condition requiring procedure
- Physician's treatment plan including pre-op discussion
- Co-morbid medical condition(s)
- Therapies tried (including dates) and failed as documented by a lack of clinically significant improvement between at least two measurements concurrent to the therapy, on validated pain or functional disability scale(s) or quantifiable symptoms; these therapies could include:
  - Nonoperative Therapy (i.e., orthotics, medications/injections, physical therapy, other pain management procedures, etc.)
  - Surgery

Definitions

Nonoperative Therapy: Consists of an appropriate combination of medication (i.e., nonsteroidal anti-inflammatory drugs [NSAIDs], analgesics, etc.) in addition to physical therapy or other interventions based on the individual's specific presentation, physical findings and imaging results. (Ansok and Muh, 2018)

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 federal, state, or contractual requirements 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 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 May 7, 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.

References

Ansok CB, Muh SJ. Optimal management of glenohumeral osteoarthritis. Orthop Res Rev. 2018;10:9-18.

Vo KV, Hackett DJ, Gee AO, Hsu JE. Classifications in Brief: Walch classification of primary glenohumeral osteoarthritis. Clin Orthop Relat Res. 2017;475(9):2335-2340.

Policy History/Revision Information

Date	Summary of Changes
07/01/2021	Coverage Rationale • Replaced reference to "InterQual® 2020" with "InterQual® 2021" Supporting Information • Archived previous policy version CS109LA.K

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state or contractual requirements for benefit plan coverage. 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.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The 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.