Surgery of the Shoulder (for Nebraska Only)

Policy Number: CS109NE.P
Effective Date: August 1, 2022

Instructions for Use

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Related Policies
None

Application

This Medical Policy only applies to the State of Nebraska.

Coverage Rationale

Surgery of the shoulder is proven and medically necessary in certain circumstances. For medical necessity clinical coverage criteria, refer to the:

- InterQual® CP: Procedures:
  - Arthroscopy or Arthroscopically Assisted Surgery, Shoulder
  - Arthroscopy or Arthroscopically Assisted Surgery, Shoulder (Adolescent)
  - Arthroscopy, Diagnostic, +/- Synovial Biopsy, Shoulder
  - Arthrotomy, Shoulder
  - Joint Replacement, Shoulder
  - Removal and Replacement, Total Joint Replacement (TJR), Shoulder
- InterQual® Client Defined, CP: Procedures, Arthroplasty, Removal or Revision, Shoulder (Custom) - UHG

Click here to view the InterQual® criteria.

Documentation Requirements

Medical notes documenting the following, when applicable:

- 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)
- Upon request, we may require the 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: When requested, diagnostic images 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)
    - Upon request, diagnostic imaging must be submitted 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)
- Reports of all recent imaging studies and applicable diagnostic tests, including when applicable:
    - Microbiological findings
    - Synovial fluid cytology
    - Erythrocyte sedimentation rate (ESR)
    - C-reactive protein (CRP)
- Condition requiring procedure, including relevant past history with dates
- Physician's treatment plan including pre-op discussion
- Feasibility of arthroscopic approach
- 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
- Member has the ability to participate in post-surgical rehabilitation
- For revision surgery, also include:
    - Details of complication
    - Complete (staged) surgical plan
- 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

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
29805	Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure)

CPT Code	Description
29806	Arthroscopy, shoulder, surgical; capsulorrhaphy
29807	Arthroscopy, shoulder, surgical; repair of slap lesion
29819	Arthroscopy, shoulder, surgical; with removal of loose body or foreign body
29820	Arthroscopy, shoulder, surgical; synovectomy, partial
29822	Arthroscopy, shoulder, surgical; debridement, limited, 1 or 2 discrete structures (e.g., humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies])
29823	Arthroscopy, shoulder, surgical; debridement, extensive, 3 or more discrete structures (e.g., humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies])
29824	Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure)
29825	Arthroscopy, shoulder, surgical; with lysis and resection of adhesions, with or without manipulation
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (i.e., arch) release, when performed (List separately in addition to code for primary procedure)
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
29828	Arthroscopy, shoulder, surgical; biceps tenodesis

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.

Surgeries of the shoulder are procedures and, therefore, not regulated by the FDA. However, devices and instruments used during the surgery may require FDA approval. Refer to the following website for additional information: http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm. (Accessed October 27, 2021)

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

08/01/2022	Coverage Rationale
	• Revised language pertaining to medical necessity clinical coverage criteria; added reference to the InterQual® CP: Procedures, Removal and Replacement, Total Joint Replacement (TJR), Shoulder
	• Revised documentation requirements:
	  ○ Added language to require:
	  ▪ Feasibility of arthroscopic approach
	  ▪ The member has the ability to participate in post-surgical rehabilitation
	  ▪ For revision surgery, also include details of complication and complete (staged) surgical plan

Date	Summary of Changes
	▪ 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 ○ Replaced language requiring: ▪ "Diagnostic image(s) *are* required" with "diagnostic image(s) *may be* required *upon request*" ▪ "Diagnostic image(s) report(s)" with "reports *of all recent* imaging *studies and applicable* diagnostic *tests*" ▪ "Condition requiring procedure" with "condition requiring procedure, *including relevant past history with dates*" **Applicable Codes** • Removed CPT code 23412 **Supporting Information** • Archived previous policy version CS109NE.O

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.