

SHOULDER REPLACEMENT SURGERY (ARTHROPLASTY)

Policy Number: SURGERY 101.13 T2

Effective Date: October 1, 2018

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Related Policy
None

INSTRUCTIONS FOR USE

This Clinical Policy provides assistance in interpreting Oxford benefit plans. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members. Oxford reserves the right, in its sole discretion, to modify its policies as necessary. This Clinical Policy is provided for informational purposes. It does not constitute medical advice. The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies.

When deciding coverage, the member specific benefit plan document must be referenced. The terms of the member specific benefit plan document [e.g., Certificate of Coverage (COC), Schedule of Benefits (SOB), and/or Summary Plan Description (SPD)] may differ greatly from the standard benefit plan upon which this Clinical Policy is based. In the event of a conflict, the member specific benefit plan document supersedes this Clinical Policy. All reviewers must first identify member eligibility, any federal or state regulatory requirements, and the member specific benefit plan coverage prior to use of this Clinical Policy. Other Policies may apply.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines 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.

CONDITIONS OF COVERAGE

Applicable Lines of Business/ Products	This policy applies to Oxford Commercial plan membership.
Benefit Type	General benefits package
Referral Required (Does not apply to non-gatekeeper products)	No
Authorization Required (Precertification always required for inpatient admission)	Yes
Precertification with Medical Director Review Required	No
Applicable Site(s) of Service (If site of service is not listed, Medical Director review is required)	Inpatient, Outpatient

BENEFIT CONSIDERATIONS

Before using this policy, please check the member specific benefit plan document and any federal or state mandates, if applicable.

Essential Health Benefits for Individual and Small Group

For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits ("EHBs"). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage for benefits which are deemed EHBs, the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute EHBs is made on a state by state basis. As such, when using this policy, it is important to refer to the member specific benefit plan document to determine benefit coverage.

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, 22nd edition, 2018:

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

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 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

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PROFESSIONAL SOCIETIES

American Academy of Orthopaedic Surgeons (AAOS)

Treatment of Glenohumeral Joint Osteoarthritis. Guidance and Evidence Report. December 4, 2009. Available at: <http://www.aaos.org/research/guidelines/gloquideline.pdf>. (Accessed December 15, 2017)

- 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 a specific type of humeral prosthetic design or method of fixation when performing shoulder arthroplasty in patients with 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 15, 2017)

FDA-approved total or partial shoulder replacement surgery devices are generally approved for the same indications, including any or all of the following:

- Complex fracture(s) of the proximal (upper) humerus
- Correction of functional deformity
- Non-inflammatory degenerative joint disease such as osteoarthritis or avascular necrosis (osteonecrosis) of the humeral head
- Post-traumatic arthritis
- Revision of failed shoulder replacement surgery
- Rheumatoid arthritis

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

The foregoing Oxford policy has been adapted from an existing UnitedHealthcare national policy that was researched, developed and approved by UnitedHealthcare Medical Technology Assessment Committee. [2017T0556J]

POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
10/01/2018	<ul style="list-style-type: none"> • Updated coverage rationale; modified language to clarify: <ul style="list-style-type: none"> ○ The listed service is proven and medically necessary in certain circumstances ○ See the referenced MCG™ Care Guidelines for <i>medical necessity</i> clinical coverage criteria • Archived previous policy version SURGERY 101.12 T2