Shoulder Replacement Surgery (Arthroplasty)

Guideline Number: MMG117.L
Effective Date: November 1, 2020

Instructions for Use

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Related Policies
None

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.

Required Clinical Information
Shoulder Arthroplasty, Arthroplasty Revision
Medical notes documenting the following, as 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 that 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 images ○ Note: When requested, diagnostic image(s) 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)

Required Clinical Information
Shoulder Arthroplasty, Arthroplasty Revision

- Upon request, diagnostic imaging must be submitted via the external portal at www.uhcprovider.com/paan; faces 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
- 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

Medical notes documenting the following, as 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 that 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 images
  - Note: When requested, diagnostic image(s) 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)
  - Upon request, diagnostic imaging must be submitted via the external portal at www.uhcprovider.com/paan; faces 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
- The member has the ability to participate in post-surgical rehabilitation
- 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

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

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 guideline 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 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.

Guideline History/Revision Information

Date	Summary of Changes
01/01/2021	Template Update • Reformatted policy; transferred content to new template
11/01/2020	Documentation Requirements • Replaced language indicating “diagnostic image(s) *are* required” with “diagnostic image(s) *may be* required *upon request*” Supporting Information • Archived previous policy version MMG117.K

Instructions for Use

This Medical Management Guideline 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 guideline, 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 Management Guideline is provided for informational purposes. It does not constitute medical advice.

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

Member benefit coverage and limitations may vary based on the member’s benefit plan Health Plan coverage provided by or through UnitedHealthcare of California, UnitedHealthcare Benefits Plan of California, UnitedHealthcare of Oklahoma, Inc., UnitedHealthcare of Oregon, Inc., UnitedHealthcare Benefits of Texas, Inc., or UnitedHealthcare of Washington, Inc.