SHOULDER REPLACEMENT SURGERY (ARTHROPLASTY)

Guideline Number: MMG117.I **Effective Date**: April 1, 2019

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, 23rd edition, 2019:

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

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

Joint Replacement – Shoulder Arthroplasty, Arthroplasty Revision

Medical notes documenting **all** of the following:

- Complete report(s) of diagnostic imaging (MRI, CT Scan, X-rays and Bone Scan)
- Specify which implant brand or manufacturer to be used (e.g., Arthrex, DePuy, Synthes, Zimmer BioMet, DJO Surgical, Stryker, Wright Medical, or Other and include name and reason for this selection)
- Specify which manufacturer model to be used (e.g., Asphere, Biolox Delta, Compress, Duracon, Kinective, Pinnacle)
- Provide the fixation type from the following:
  - Cemented
  - Cemented with antibiotic impregnated
  - Non-cemented
  - Other - If another fixation type then explain
- Current medical notes indicating:
  - 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

Required Clinical Information
Joint Replacement – 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

Joint Replacement – Shoulder Hemi-Arthroplasty

Medical notes documenting **all** of the following:
• Complete report(s) of diagnostic imaging (MRI, CT Scan, X-rays and Bone Scan)
  ○ Location and number of fractures
• Specify which implant brand or manufacturer to be used (e.g., Arthrex, DePuy Synthes, Zimmer BioMet, DJO Surgical, Stryker, Wright Medical, or Other and include name and reason for this selection)
• Specify which manufacturer model to be used (e.g., Asphere, Biolox Delta, Compress, Duracon, Kinective, Pinnacle)
• Provide the fixation type from the following:
  ○ Cemented
  ○ Cemented with antibiotic impregnated
  ○ Non-cemented
  ○ Other - If another fixation type then explain
• Current physician's office notes including if applicable:
  ○ 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

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

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/gloguideline.pdf (Accessed December 14, 2018)

- 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 14, 2018)

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.

GUIDELINE HISTORY/REVISION INFORMATION

Date	Action/Description
07/01/2019	**Template Update** • Added *Documentation Requirements* section

04/01/2019	• Reorganized policy template:
	  ○ Simplified and relocated *Instructions for Use*
	  ○ Removed *Benefit Considerations* section
	• Revised coverage rationale:
	  ○ Replaced reference to "MCG™ Care Guidelines, *22nd* edition, *2018*" with "MCG™ Care Guidelines, *23rd* edition, *2019*"; refer to 23rd edition for complete details on applicable updates to the MCG™ Care Guidelines

Date	Action/Description
	• Archived previous policy version MMG117.H

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 benefit 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.