UnitedHealthcare®

MEDICAL POLICY

SHOULDER REPLACEMENT SURGERY (ARTHROPLASTY)

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Related Policies:
None

INSTRUCTIONS FOR USE
This Medical Policy provides assistance in interpreting UnitedHealthcare benefit plans. When deciding coverage, the enrollee specific document must be referenced. The terms of an enrollee's document (e.g., Certificate of Coverage (COC) or Summary Plan Description (SPD)) may differ greatly. In the event of a conflict, the enrollee's specific benefit document supersedes this Medical Policy. All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements and the plan benefit coverage prior to use of this Medical Policy. Other Policies and Coverage Determination Guidelines may apply. UnitedHealthcare reserves the right, in its sole discretion, 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 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.

COVERAGE RATIONALE

For information regarding medical necessity review, when applicable, see MCG™ Care Guidelines, 18th edition, 2014, Shoulder Arthroplasty, S-634 (ISC).

For information regarding medical necessity review, when applicable, see MCG™ Care Guidelines, 18th edition, 2014, Shoulder Hemiarthroplasty, S-633 (ISC).

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 June 2014

- 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 is not regulated by the FDA. However, devices and instruments used during the surgery 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 June 2014.

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.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Medicare does not have a National Coverage Determination (NCD) for shoulder replacement surgery. Local Coverage Determinations (LCDs) do not exist at this time. (Accessed June 24, 2014

APPLICABLE CODES

The codes listed in this policy are for reference purposes only. Listing of a service or device code in this policy does not imply that the service described by this code is a covered or non-covered health service. Coverage is determined by the benefit document. This list of codes may not be all inclusive.

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

POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
09/01/2014	• Routine review; no content changes • Archived previous policy version 2014T0556F