Shoulder Joint Replacements

Policy Number:	**M20210611027**
Effective Date:	**9/1/2021**
Sponsoring Department:	**Health Care Services**
Impacted Department(s):	**Health Care Services**

Type of Policy: ☐ Internal ☒ External

Data Classification: ☐Confidential ☐Restricted ☒Public

Applies to (Line of Business):

☐ Corporate (All)
☒ State Products, if yes which plan(s): ☒MediSource; ☒MediSource Connect; ☒Child Health Plus; ☒Essential Plan
☒ Medicare, if yes, which plan(s): ☒MAPD; ☐PDP; ☒ISNP; ☒CSNP
☒ Commercial, if yes, which type: ☒Large Group; ☒Small Group; ☒Individual
☒ Self-Funded Services *(Refer to specific Summary Plan Descriptions (SPDs) to determine any pre-authorization or pre-certification requirements and coverage limitations. In the event of any conflict between this policy and the SPD of a Self-Funded Plan, the SPD shall supersede the policy.)*

Excluded Products within the Selected Lines of Business (LOB)

N/A

Applicable to Vendors? Yes ☐ No☒

Purpose and Applicability:

To set forth Independent Health's medical necessity criteria for **shoulder joint replacement** (arthroplasty).

Policy:

Background:
When medical therapy fails to control dysfunction or pain in the shoulder, reconstructive surgery should be considered. The main indications for surgery are intractable joint pain (with activity or at rest) and the presence of an unacceptable functional decline. Pain or functional declines are ascribed to joint

destruction. This must be accompanied by failure of all nonsurgical approaches to the management of arthritis including a change in disease-modifying, immunosuppressive, or biologic drug regimens, the use of more potent analgesics, and rehabilitation therapies.

An evaluation of the peer-reviewed scientific literature, including but not limited to subscription materials, has provided Independent Health the basis for its medical necessity coverage outlined below.

Commercial, Medicare Advantage, MediSource, MediSource Connect, Child Health Plus, and Essential Plan: cover shoulder joint replacement, including reverse shoulder arthroplasty utilizing the criteria below**.**

Adherence to a tobacco-cessation program resulting in abstinence from tobacco for at least 6 weeks prior to surgery is recommended. Or in smokers, medical documentation must state the provider reviewed the benefits of smoking cessation prior to elective surgery as it appears to improve a number of outcomes such as wound healing and postoperative pulmonary recovery.

Clinical Indications

Shoulder joint replacements are considered medically necessary when **All** of the following criteria are met:

- **1 or more** of the following procedures:
  - Hemiarthroplasty and **1 or more** of the following:
    - Malignancy involving the glenohumeral joint or surrounding soft tissue
    - Proximal humerus fracture not amenable to internal fixation
    - Advanced joint disease of the shoulder when **ALL** of the following requirements are met:
      - **1 or more** of the following conditions:
        - Osteoarthritis
        - Rheumatoid arthritis
        - Avascular necrosis
        - Post-traumatic arthritis
        - Osteonecrosis of the humeral head without glenoid involvement
        - Advanced joint disease due to rotator cuff tear arthropathy
        - Glenoid bone stock inadequate to support a glenoid prosthesis
      - Limited range of motion or crepitus of the glenohumeral joint on physical examination
      - Pain and loss of function of at least 6 months' duration that interferes with daily activities
      - Radiographic evidence of destructive degenerative joint disease, as evidenced by **2 or more** of the following:
        - Irregular joint surfaces
        - Glenoid sclerosis
        - Osteophyte changes
        - Flattened glenoid
        - Cystic changes in the humeral head
        - Joint space narrowing
  - Total shoulder arthroplasty and **1 or more** of the following:
    - Malignancy involving the glenohumeral joint or surrounding soft tissue

- Advanced joint disease of the shoulder when **ALL** of the following requirements are met:
  - **1 or more** of the following conditions:
    - Osteoarthritis
    - Rheumatoid arthritis
    - Avascular necrosis
    - Post-traumatic arthritis
  - Limited range of motion or crepitus of the glenohumeral joint on physical examination
  - Pain and loss of function of at least 6 months' duration that interferes with daily activities
  - Radiographic evidence of destructive degenerative joint disease, as evidenced by **2 or more** of the following:
    - Irregular joint surfaces
    - Glenoid sclerosis
    - Osteophyte changes
    - Flattened glenoid
    - Cystic changes in the humeral head
    - Joint space narrowing

- Reverse shoulder arthroplasty and **1 or more** of the following:
  - Reconstruction after a tumor resection
  - Glenohumeral osteoarthritis with irreparable rotator cuff tear
  - Failed hemiarthroplasty
  - Failed total shoulder arthroplasty with non-repairable rotator cuff
  - Shoulder fracture that is not repairable or cannot be reconstructed with other techniques
  - Advanced joint disease of the shoulder when **ALL** of the following requirements are met:
    - Deficient rotator cuff and limited ability to actively flex the upper extremity to 90 degrees against gravity
    - **1 or more** of the following conditions:
      - Osteoarthritis
      - Rheumatoid arthritis
      - Avascular necrosis
      - Post-traumatic arthritis
    - Limited range of motion or crepitus of the glenohumeral joint on physical examination
    - Pain and loss of function of at least 6 months' duration that interferes with daily activities
    - Radiographic evidence of destructive degenerative joint disease, as evidenced by **2 or more** of the following:
      - Irregular joint surfaces
      - Glenoid sclerosis
      - Osteophyte changes
      - Flattened glenoid
      - Cystic changes in the humeral head
      - Joint space narrowing

- Revision or replacement of a shoulder prosthesis and **1 or more** of the following:
  - Aseptic loosening of one or more prosthetic components confirmed by imaging

        - Fracture of one or more components of the prosthesis confirmed by imaging
        - Periprosthetic infection confirmed by gram stain and culture
        - Instability of the glenoid or humeral components
        - Migration of the humeral head
- Documentation in the medical record of **ALL** of the following:
    - Submission of clinical documentation including **All** of the following:
        - That the anticipated level of function should place limited demands on the shoulder joint
        - That the deltoid muscle is intact
        - That the shoulder joint is anatomically and structurally suited to receive selected implants (i.e., adequate bone stock to allow for firm fixation of implant)
        - Symptom duration and severity
        - Specific functional limitations related to symptoms
        - Type and duration of all therapeutic measures provided or if conservative management is not appropriate, the reason must be clearly documented
        - Documented compliance with a plan of therapy that includes elements from these areas or if conservative management is not appropriate, the reason must be clearly documented
    - Documented clinical assessment of the member by the requesting provider within 3 months of the request
    - Documentation reflected in the member's medical records required of non-surgical medical management measures by the requesting provider, ordered by them or other health professionals during the patient's course of treatment for a period of 3 months for the condition(s) and **ALL** of the following:
        - Documentation establishes a history of a reasonable attempt at conservative therapy as appropriate for the member in their current episode of care
        - Documentation includes the start and concluding date of each therapy with the results of therapy included
        - Documentation includes a combination of strategies to reduce inflammation, alleviate pain, and improve function, including **2 or more** of the following:
            - Activity modification; the description of activity modification as ordered by the provider and outcomes of modification(s) are required to be documented in the medical record
            - Physical therapy; complete therapy progress note documentation submission by the therapy provider required
            - Physician or physical therapist-supervised therapeutic home exercise program which includes flexibility and muscle strengthening exercises; complete therapy progress note submission by the therapy provider required
            - Prescription or non-prescription strength anti-inflammatory medications and analgesics; outcomes of medication therapy, including medication name, dosage and frequency documented in the medical record by the ordering provider including the start and end dates of medication therapies
            - Intraarticular corticosteroid injection(s); procedure report submission required, and outcomes of therapy documented in the medical record
    - **1 or more** of the following:
        - The member has no medical comorbidities

- For members with significant conditions or co-morbidities, such as coronary artery disease or obstructive pulmonary disease, the risk/benefit of the procedure was appropriately addressed in the medical record
- For members with diabetes every effort was made to ensure it is well controlled. For members with poor control as evidenced by an elevated HbA1c levels (> 8.5%), every effort was made to optimize glycemic levels prior to elective surgery. Or if optimization was not possible, there is documentation that the surgeon has reviewed the increased risks associated with joint replacement procedures with the member prior to the procedure

Shoulder joint replacement, including reverse shoulder arthroplasty is **NOT COVERED** for **Any** of the following:

- Active infection of the joint
- Active systemic bacteremia
- Active skin infection (exception: recurrent cutaneous staph infections) or open wound within the planned surgical site of the shoulder
- Rapidly progressive neurologic disease
- Total shoulder arthroplasty or hemiarthroplasty under conditions which would result in excessive stress on the implant, including but not limited to Charcot joint and paralytic conditions of the shoulder

Pre-Authorization Required? Yes ☒ No ☐

Preauthorization is required for this service.

Definitions

Hemiarthroplasty is a surgical procedure where the head of the humerus is replaced with a metal ball and stem, similar to the component used in a total shoulder replacement.

Reverse shoulder arthroplasty is a surgical procedure where a metal ball is attached to the shoulder bone and a plastic socket is attached to the upper arm bone. This allows the patient to use the deltoid muscle instead of the torn rotator cuff to lift the arm.

Shoulder joint replacement (arthroplasty) is a surgical procedure where the arthritic joint surfaces are replaced with a highly polished metal ball attached to a stem, and a plastic socket.

References

Related Policies, Processes and Other Documents
N/A

Non-Regulatory references
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Yong PH, Weinberg L, Torkamani N, et al. The Presence of Diabetes and Higher HbA1c Are Independently Associated With Adverse Outcomes After Surgery. Diabetes Care. 2018 Jun;41(6):1172-1179.

Regulatory References

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This policy contains medical necessity criteria that apply for this service. Please note that payment for covered services is subject to eligibility criteria, contract exclusions and the limitations noted in the member's contract at the time the services are rendered.

Version Control

Signature / Approval on File? Yes ☒ No☐

Revision Date	Owner	Notes
6/1/2026	Health Care Services	Revised
3/1/2026	Health Care Services	Revised
8/1/2025	Health Care Services	Revised- Formatting only
5/1/2025	Health Care Services	Reviewed
5/1/2024	Health Care Services	Revised
1/1/2024	Health Care Services	Revised

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8/1/2022	Health Care Services	Revised
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