KAISER PERMANENTE®

Kaiser Foundation Health Plan of Washington

Clinical Review Criteria
Shoulder Arthroplasty

Criteria

For Medicare Members

Source	Policy
CMS Coverage Manuals	None
National Coverage Determinations (NCD)	None
Local Coverage Determinations (LCD)	None
Local Coverage Article (LCA)	None
Kaiser Permanente Medical Policy	Due to the absence of an active NCD, LCD, or other coverage guidance, Kaiser Permanente has chosen to use their own Clinical Review Criteria, ***"Shoulder Arthroplasty"*** and "***Shoulder Hemiarthroplasty***" for medical necessity determinations. Refer to the Non-Medicare criteria below.

For Non-Medicare Members

Source	Policy
Shoulder Arthroplasty	**Effective until November 1st, 2024** Review for Elective Surgical Procedure Level of Care, No Medical Necessity criteria **Effective November 1st, 2024** Review for Elective Surgical Procedure Level of Care **and** Kaiser Permanente has elected to use Shoulder Arthroplasty, MCG* KP-S-634 11012024 Care Guideline for medical necessity determinations. For access to the MCG Clinical Guidelines criteria, please see the MCG Guideline Index through the provider portal under Quick Access
Shoulder Hemiarthroplasty	**Effective until November 1st, 2024** Review for Elective Surgical Procedure Level of Care, No Medical Necessity criteria. **Effective November 1st, 2024** Review for Elective Surgical Procedure Level of Care and Kaiser Permanente has elected to use Shoulder Hemiarthroplasty,

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	MCG* KP-S-633 11012024 Care Guideline for medical necessity determinations. For access to the MCG Clinical Guidelines criteria, please see the MCG Guideline Index through the provider portal under Quick Access

If requesting this service (*or these services*), please send the following documentation to support medical necessity:

- Last 6 months of clinical notes from requesting provider &/or specialist

The following information was used in the development of this document and is provided as background only. It is provided for historical purposes and does not necessarily reflect the most current published literature. When significant new articles are published that impact treatment option, Kaiser Permanente will review as needed. This information is not to be used as coverage criteria. Please only refer to the criteria listed above for coverage determinations.

Background

A shoulder arthroplasty involves replacement of the ball and socket of the shoulder joint and may be performed as either a traditional anatomic total shoulder arthroplasty (replacement of the head of the humerus "ball" and the cup of the scapula "socket" with mechanical components) or as a reverse total shoulder arthroplasty, wherein the mechanical "socket" is placed into the head of the humerus and the "ball" is attached to the glenoid cup in the shoulder blade. This guideline should be used for total shoulder arthroplasty, reverse total shoulder arthroplasty, and revision shoulder arthroplasty.(1)

Surgery may safely be performed in various settings. Some of the common settings used are an inpatient hospital or medical center, an off-campus outpatient hospital or medical center, or an on campus outpatient hospital. Costs for surgical procedures may vary among these different settings. To encourage the use of the most safe and appropriate, cost-effective sites of service for certain medically necessary outpatient surgical procedures, prior authorization is required for the site of service for the surgical procedures listed below.

References

1. Throckmorton TW. Shoulder and elbow arthroplasty. In: Azar FM, Beaty JH, editors. Campbell's Operative Orthopaedics. 14th ed. Philadelphia, PA: Elsevier; 2021:600-655.e8.

Applicable Codes

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT® or HCPCS Codes	Description	Medicare *IP Only List*
23335	Removal of prosthesis, includes debridement and synovectomy when performed; humeral and glenoid components (eg, total shoulder)	
23470	Arthroplasty, glenohumeral joint; hemiarthroplasty	
23472	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, 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	X

***Note:** Codes may not be all-inclusive. Deleted codes and codes not in effect at the time of service may not be covered.

****To verify authorization requirements for a specific code by plan type, please use the **Pre-authorization Code Check**.

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Date Created	Date Reviewed	Date Last Revised
06/04/2024	06/04/2024[MPC],	06/04/2024

[MPC] Medical Policy Committee

Revision History	Description
06/04/2024	MPC approved to adopt the proposed hybrid MCG criteria, KP-S-634 for Shoulder Arthroplasty and KP-S-633 for Shoulder Hemiarthroplasty procedures for Medicare and Non-Medicare Members. Requires 60-day notice, effective date 11/01/2024.

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