Joint replacement (shoulder)

We provide coverage for this procedure for adult members who meet medical necessity criteria. Submit authorization requests through the e-referral system.

The submitter will receive a prompt to complete a questionnaire to determine the appropriateness of the requested service. The questions are listed below.

If all questions are answered, e-referral will either approve or pend the case. If the case pends and we cannot authorize it, we will contact the provider for additional clinical information. Authorization is not a guarantee of payment.

Payment is based on established claim edits. We will retrospectively monitor compliance with this authorization requirement.

Applicable procedure codes: *23470, *23472

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See below for the questions you’ll encounter in the e-referral system.

<table>
<thead>
<tr>
<th>Question</th>
<th>Possible answers: □ Yes □ No □ No imaging performed □ N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the patient have AVASCULAR NECROSIS identified by imaging AND symptoms such as pain, loss of range of motion of the shoulder, weakness or stiffness?</td>
<td></td>
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<tr>
<td>Possible answers: □ Yes □ No □ No imaging performed □ N/A</td>
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<tr>
<td>Does the patient have an INTRA-ARTICULAR FRACTURE of the shoulder WITH the humeral head being fractured into MORE THAN three parts AND is the repair of the humeral head NOT able to be achieved by an open reduction and fixation (ORIF)?</td>
<td></td>
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</tbody>
</table>
Joint replacement (shoulder)

For Medicare Plus BlueSM PPO, BCN HMOSM (commercial) and BCN AdvantageSM members

Effective Dec. 8, 2019

Preview questionnaire

Q Does the patient have a BONE TUMOR of the shoulder that was identified by imaging?

A Possible answers: □ Yes □ No □ No imaging performed □ N/A

Q Does the patient have ALL of the following (A-F)? A. Imaging confirms a nonunion or malunion fracture of either the glenoid or the humeral head. B. Shoulder pain that interferes with activities of daily living (for example, eating, bathing, dressing, toileting, walking). C. Shoulder pain with either active or passive range of motion of the shoulder. D. Limited range of motion (active or passive) of the shoulder. E. Crepitus with rotation of the shoulder joint. F. Pain increases with initiation of activity.

A Possible answers: □ Yes □ No □ N/A

Q Does the patient have OSTEOARTHRITIS or POST TRAUMATIC ARTHRITUS and AT LEAST TWO of the following (A-C)? A. Shoulder pain that interferes with activities of daily living (for example, eating, bathing, dressing, toileting, walking). B. Shoulder pain that increases with initiation of activity. C. Shoulder pain with either active or passive range of motion of the shoulder.

A Possible answers: □ Yes □ No □ N/A

Q Does the patient have OSTEOARTHRITIS, RHEUMATOID ARTHRITIS or POST TRAUMATIC ARTHRITUS and EITHER limited range of motion (active or passive) of the shoulder OR crepitus with rotation of the shoulder joint?

A Possible answers: □ Yes □ No □ N/A

Q Does the patient have OSTEOARTHRITIS or POST TRAUMATIC ARTHRITUS and bone-on-bone contact identified by imaging?

A Possible answers: □ Yes □ No □ No imaging performed □ N/A
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Does the patient have OSTEOARTHRITIS, RHEUMATOID ARTHRITIS or POST TRAUMATIC ARTHRITIS and AT LEAST TWO of the following imaging findings (A-F)? A. Subchondral cysts. B. Subchondral sclerosis. C. Bone spurs. D. Joint subluxation. E. Joint space narrowing. F. Bony glenoid deformity.

Possible answers: □ Yes □ No □ No imaging performed □ N/A

Does the patient have RHEUMATOID ARTHRITIS and AT LEAST TWO of the following (A-D)? A. Shoulder pain that interferes with activities of daily living (for example, eating, bathing, dressing, toileting, walking). B. Shoulder pain that increases with initiation of activity. C. Shoulder pain with range of motion (active or passive). D. Pain at night.

Possible answers: □ Yes □ No □ N/A

Does the patient have a shoulder condition NOT related to RHEUMATOID ARTHRITIS AND ALL of the following treatment within the last year (A-C)? A. NSAID (non-steroidal anti-inflammatory drugs) FOR AT LEAST 3 weeks (unless contraindicated/not tolerated). B. Physician directed home exercise OR occupational therapy or physical therapy FOR AT LEAST 6 weeks. C. Activity modification FOR AT LEAST 6 weeks.

Possible answers: □ Yes □ No □ N/A

Does the patient have RHEUMATOID ARTHRITIS affecting the shoulder AND continued symptoms or findings after treatment FOR AT LEAST 12 weeks within the last year with ALL of the following (A-D)? A. Medications for rheumatoid arthritis such as disease modifying antirheumatic drugs, methotrexate, or oral steroids. B. NSAID (non-steroidal anti-inflammatory drugs) (unless contraindicated/not tolerated). C. Physician directed home exercise OR occupational therapy or physical therapy. D. Activity modification.

Possible answers: □ Yes □ No □ N/A

Does the patient have an active infection in any location in the body excluding bacteriuria?

Possible answers: □ Yes □ No