Sentara Health Plans

Medicaid

Shoulder-Elbow Joint Resurfacing Arthroplasty with Allograft Tissue, Surgical 111

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Effective Date	9/1994
Next Review Date	1/2026
Coverage Policy	Surgical 111
Version	5

All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*.

Description & Definitions:

Resurfacing is leaving the patient's native surface intact and you are replacing a superficial layer.

A revision of the joint involves total joint replacement where you are replacing one or both ends of the joint.

Shoulder or elbow resurfacing arthroplasty is a surgical procedure used as an alternative to total replacement. With this procedure, you are leaving the patient's native surface intact and replacing a superficial layer of it.

Allograft refers to tissue from a donor of the same species.

Criteria:

Shoulder/Elbow Joint Resurfacing Arthroplasty with Allograft Tissue is considered **not medically necessary** for any indication, as the current role remains uncertain, based on review of existing evidence.

Document History:

Revised Dates:

- 2025: January – added CPT codes 23473, 23474. No changes to criteria.
- 2024: January
- 2020: January
- 2016: May
- 2015: January

- 2012: January
- 2011: January
- 2010: January, February
- 2009: January, March
- 2008: January
- 2006: August
- 2004: May (taken out of archive)
- 1999: November (archived)

Reviewed Dates:

- 2023: January
- 2022: January
- 2021: January
- 2020: January
- 2018: June, November
- 2017: December
- 2014: February
- 2013: February
- 2012: February
- 2005: February, December
- 2003: June, July, October
- 1998: November
- 1996: September

Effective Date:

- September 1994

Coding:

Medically necessary with criteria:

Coding	Description
	None

Considered Not Medically Necessary:

Coding	Description
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
23929	Unlisted procedure, shoulder
24370	Revision of total elbow arthroplasty, including allograft when performed; humeral or ulnar component
24371	Revision of total elbow arthroplasty, including allograft when performed; humeral and ulnar component

24999	Unlisted procedure, humerus or elbow

U.S. Food and Drug Administration (FDA) - approved only products only.

The preceding codes are included above for informational purposes only and may not be all inclusive. Additionally, inclusion or exclusion of a treatment, procedure, or device-code(s) does not constitute or imply member coverage or provider reimbursement.

Special Notes: *

- Coverage: See the appropriate benefit document for specific coverage determination. Member specific benefits take precedence over medical policy.
- Application to products: Policy is applicable to Sentra Health Plan Medicaid products.
- Authorization requirements: Pre-certification by the Plan is required.
- Special Notes:
    - Medicaid
        - This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.
        - Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.
        - The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.
        - Service authorization requests must be accompanied by sufficient clinical records to support the request. Clinical records must be signed and dated by the requesting provider withing 60 days of the date of service requested.

References:

Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

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Keywords:

Shoulder/Elbow Joint Resurfacing Arthroplasty with Allograft Tissue, SHP Surgical 111, replacement, superficial layer, joint reconstruction, joint replacement, donor tissue, resurfacing, revision, elbow, shoulder, New arthroscopic biologic shoulder resurfacing