Surgery of the Hand or Wrist

Policy Number: IEXT0558.02
Effective Date: July 1, 2021

Related Policies
None

Table of Contents

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicable States</td>
<td>1</td>
</tr>
<tr>
<td>Coverage Rationale</td>
<td>1</td>
</tr>
<tr>
<td>Applicable Codes</td>
<td>1</td>
</tr>
<tr>
<td>U.S. Food and Drug Administration</td>
<td>2</td>
</tr>
<tr>
<td>Policy History/Revision Information</td>
<td>2</td>
</tr>
<tr>
<td>Instructions for Use</td>
<td>2</td>
</tr>
</tbody>
</table>

Applicable States

This Medical Policy only applies to the states of Arizona, Maryland, North Carolina, Oklahoma, Tennessee, Virginia, and Washington.

Coverage Rationale

Surgery of the hand or wrist is proven and medically necessary in certain circumstances. For medical necessity clinical coverage criteria, refer to the InterQual® 2021, Apr. 2021 Release, CP: Procedures:
- Arthroplasty, Carpometacarpal (CMC) Joint, Thumb
- Arthroplasty, Proximal Interphalangeal (PIP) Joint, Fingers
- Arthroscopy or Arthroscopically Assisted Surgery, Wrist
- Arthroscopy, Diagnostic, +/- Synovial Biopsy, Wrist
- Joint Replacement, Wrist

Click here to view the InterQual® criteria.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>25332</td>
<td>Arthroplasty, wrist, with or without interposition, with or without external or internal fixation</td>
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<tr>
<td>25441</td>
<td>Arthroplasty with prosthetic replacement; distal radius</td>
</tr>
<tr>
<td>25442</td>
<td>Arthroplasty with prosthetic replacement; distal ulna</td>
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</tbody>
</table>
### CPT Code | Description
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**Joint Replacement, Wrist**
25443 | Arthroplasty with prosthetic replacement; scaphoid carpal (navicular)
25444 | Arthroplasty with prosthetic replacement; lunate
25445 | Arthroplasty with prosthetic replacement; trapezium
25446 | Arthroplasty with prosthetic replacement; distal radius and partial or entire carpus (total wrist)
25447 | Arthroplasty, interposition, intercarpal or carpometacarpal joints
25449 | Revision of arthroplasty, including removal of implant, wrist joint

**Arthroplasty, Carpometacarpal (CMC) Joint, Thumb**
25447 | Arthroplasty, interposition, intercarpal or carpometacarpal joints
26530 | Arthroplasty, metacarpophalangeal joint; each joint
26531 | Arthroplasty, metacarpophalangeal joint; with prosthetic implant, each joint

**Arthroscopy, Diagnostic, +/- Synovial Biopsy, Wrist**
29840 | Arthroscopy, wrist, diagnostic, with or without synovial biopsy (separate procedure)

**Arthroscopy or Arthroscopically Assisted Surgery, Wrist**
25280 | Lengthening or shortening of flexor or extensor tendon, forearm and/or wrist, single, each tendon
29843 | Arthroscopy, wrist, surgical; for infection, lavage and drainage
29844 | Arthroscopy, wrist, surgical; synovectomy, partial
29845 | Arthroscopy, wrist, surgical; synovectomy, complete
29846 | Arthroscopy, wrist, surgical; excision and/or repair of triangular fibrocartilage and/or joint debridement
29847 | Arthroscopy, wrist, surgical; internal fixation for fracture or instability

**Arthroplasty, Proximal Interphalangeal (PIP) Joint, Fingers**
26535 | Arthroplasty, interphalangeal joint; each joint
26536 | Arthroplasty, interphalangeal joint; with prosthetic implant, each joint

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**U.S. Food and Drug Administration (FDA)**

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

Surgeries of the hand or wrist are procedures and, therefore, not regulated by the FDA. However, devices and instruments used during the surgery may require FDA approval. Refer to the following website for additional information:


**Policy History/Revision Information**

<table>
<thead>
<tr>
<th>Date</th>
<th>Summary of Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>07/01/2021</td>
<td><strong>Coverage Rationale</strong>&lt;br&gt;• Replaced reference to “InterQual® 2020” with “InterQual® 2021”&lt;br&gt;<strong>Supporting Information</strong>&lt;br&gt;• Archived previous policy version IEXT0558.01</td>
</tr>
</tbody>
</table>

**Instructions for Use**

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from

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Surgery of the Hand or Wrist  
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the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right 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 InterQual® criteria, to assist us in administering health benefits. UnitedHealthcare Medical Policies 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.