Surgery of the Hand or Wrist

Policy Number: CS343.E
Effective Date: June 1, 2022

Instructions for Use

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Application

This Medical Policy only applies to Arizona, District of Columbia, Maryland, Michigan, Minnesota, Mississippi, Missouri, North Carolina, Ohio, Rhode Island, and Texas.

Refer to the guidelines listed below for the following states:

State	Policy/Guideline
Kentucky	Surgery of the Hand or Wrist (for Kentucky Only)
Pennsylvania	Surgery of the Hand or Wrist (for Pennsylvania Only)

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® 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 federal, state, or contractual requirements 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.

CPT Code	Description
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
Joint Replacement, Wrist	
25332	Arthroplasty, wrist, with or without interposition, with or without external or internal fixation
25441	Arthroplasty with prosthetic replacement; distal radius
25442	Arthroplasty with prosthetic replacement; distal ulna
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

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: http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm. (Accessed June 2, 2021)

Policy History/Revision Information

Date	Summary of Changes
06/01/2022	Coverage Rationale • Removed reference to specific InterQual® release date; refer to the most current InterQual® criteria Application *Mississippi and North Carolina* • Added language to indicate this Medical Policy applies to the states of Mississippi and North Carolina (retired state-specific policy versions)

Date	Summary of Changes
	Supporting Information • Archived previous policy version CS343.D

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state or contractual requirements for benefit plan coverage. 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. The 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.