Surgery of the Hand or Wrist

Guideline Number: MMG189.E
Effective Date: September 1, 2023

Instructions for Use

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Related Policies
None

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, Metacarpophalangeal (MCP) Joint, Digits
- Arthroplasty, Proximal Interphalangeal (PIP) Joint, Fingers
- Arthroscopy or Arthroscopically Assisted Surgery, Wrist
- Arthroscopy, Diagnostic, +/- Synovial Biopsy, Wrist
- Joint Replacement, Wrist
- Removal or Revision, Arthroplasty, Wrist

Click here to view the InterQual® criteria.

Documentation Requirements

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 documentation requirements outlined below are used to assess whether the member meets the clinical criteria for coverage but do not guarantee coverage of the service requested.

Required Clinical Information
Surgery of the Hand or Wrist

Medical notes documenting the following, when applicable:
• Upon request we may require the specific diagnostic image(s) that show the abnormality for which surgery is being requested, which may include MRI, CT scan, X-ray, and/or bone scan; consultation with requesting surgeon may be of benefit to select the optimal images
  ○ **Note**: When requested, diagnostic image(s) must be labeled with:
  ▪ The date taken
  ▪ Applicable case number obtained at time of notification, or member's name and ID number on the image(s)
  ○ Upon request diagnostic image(s) must be submitted via the external portal at www.uhcprovider.com/paan; faxes will not be accepted
• Reports of recent imaging studies and applicable diagnostic tests, including:

Required Clinical Information
Surgery of the Hand or Wrist
○ Microbiological findings ○ Synovial exam ○ Erythrocyte sedimentation rate (ESR) ○ C-reactive protein (CRP) • Condition requiring procedure • Severity of pain and details of functional impairment, including activities of daily living ADL) • Pertinent physical examination of the relevant joint • Co-morbid medical condition(s) • Prior therapies/ treatments tried, failed, or contraindicated; include the dates and reason for discontinuation • History of previous surgery(ies) to the same joint, if applicable • Physician's treatment plan including pre-op discussion • For revision surgery, also include: ○ Details of complication ○ Complete (staged) surgical plan • If the location is being requested as an inpatient stay, provide documentation to support site of care

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 guideline 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.

CPT Code	Description
25280	Lengthening or shortening of flexor or extensor tendon, forearm and/or wrist, single, each tendon
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)
25449	Revision of arthroplasty, including removal of implant, wrist joint
26530	Arthroplasty, metacarpophalangeal joint; each joint
26531	Arthroplasty, metacarpophalangeal joint; with prosthetic implant, each joint
26535	Arthroplasty, interphalangeal joint; each joint
26536	Arthroplasty, interphalangeal joint; with prosthetic implant, each joint
29840	Arthroscopy, wrist, diagnostic, with or without synovial biopsy (separate procedure)
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

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 February 27, 2023)

Guideline History/Revision Information

Date	Summary of Changes
09/01/2023	**Applicable Codes** • Removed CPT codes 25332 and 25447 **Supporting Information** • Archived previous policy version MMG189.D

Instructions for Use

This Medical Management Guideline 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 the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this guideline, 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 Management Guideline 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 West Medical Management Guidelines 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.

Member benefit coverage and limitations may vary based on the member's benefit plan Health Plan coverage provided by or through UnitedHealthcare of California, UnitedHealthcare Benefits Plan of California, UnitedHealthcare of Oklahoma, Inc., UnitedHealthcare of Oregon, Inc., UnitedHealthcare Benefits of Texas, Inc., or UnitedHealthcare of Washington, Inc.