

Surgery of the Hand or Wrist (for Ohio Only)

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[Instructions for Use](#)

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Related Policies
None

Application

This Medical Policy only applies to the state of Ohio. Any requests for services that are stated as unproven or services for which there is a coverage or quantity limit will be evaluated for medical necessity using Ohio Administrative Code 5160-1-01.

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.

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
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

CPT Code	Description
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

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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. See the following website for additional information:

<http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmnm.cfm>. (Accessed February 27, 2023)

References

Ohio Administrative Code/5160/Chapter 5160-1-01. Medicaid medical necessity: definitions and principles. Available at:

<https://codes.ohio.gov/ohio-administrative-code/rule-5160-1-01>. Accessed April 21, 2023.

Policy History/Revision Information

Date	Summary of Changes
11/01/2023	<p>Application</p> <ul style="list-style-type: none"> Added language to indicate any requests for services that are stated as unproven or services for which there is a coverage or quantity limit will be evaluated for medical necessity using Ohio Administrative Code, Rule 5160-1-01 <p>Coverage Rationale</p> <ul style="list-style-type: none"> Revised language pertaining to medical necessity clinical coverage criteria; added reference to the InterQual® CP: Procedures: <ul style="list-style-type: none"> Arthroplasty, Metacarpophalangeal (MCP) Joint, Digits Removal or Revision, Arthroplasty, Wrist <p>Applicable Codes</p> <ul style="list-style-type: none"> Removed CPT code 25332 and 25447 <p>Supporting Information</p> <ul style="list-style-type: none"> Added <i>References</i> section Archived previous policy version CS3430H.A – P

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state (Ohio Administrative Code [OAC]) or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state (OAC) or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state (OAC) or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state (OAC) 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 uses InterQual[®] for the primary medical/surgical criteria, and the American Society of Addiction Medicine (ASAM) for substance use, in administering health benefits. If InterQual[®] does not have applicable criteria, UnitedHealthcare may also use UnitedHealthcare Medical Policies, Coverage Determination Guidelines, and/or Utilization Review Guidelines that have been approved by the Ohio Department for Medicaid Services. The UnitedHealthcare Medical Policies, Coverage Determination Guidelines, and Utilization Review 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.