

Surgery of the Hand or Wrist

Policy Number: CS343.I
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[Instructions for Use](#)

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Commercial Policy
<ul style="list-style-type: none"> Surgery of the Hand or Wrist

Application

This Medical Policy does not apply to the states listed below; refer to the state-specific policy/guideline, if noted:

State	Policy/Guideline
Idaho	Surgery of the Hand or Wrist (for Idaho Only)
Indiana	None
Kansas	Surgery of the Hand or Wrist (for Kansas Only)
Kentucky	Surgery of the Hand or Wrist (for Kentucky Only)
Nebraska	None
New Jersey	None
New Mexico	Surgery of the Hand or Wrist (for New Mexico Only)
North Carolina	Surgery of the Hand or Wrist (for North Carolina Only)
Ohio	Surgery of the Hand or Wrist (for Ohio Only)
Pennsylvania	Surgery of the Hand or Wrist (for Pennsylvania Only)
Tennessee	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.](#)

Medical Records Documentation Used for Reviews

Benefit coverage for health services is determined by federal, state, or contractual requirements, and applicable laws that may require coverage for a specific service. Medical records documentation may be required to assess whether the member meets the clinical criteria for coverage but does not guarantee coverage of the service requested; refer to the guidelines titled [Medical Records Documentation Used for Reviews](#).

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
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

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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: <http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm>. (Accessed February 13, 2025)

Policy History/Revision Information

Date	Summary of Changes
04/01/2026	Template Update <ul style="list-style-type: none">Removed content/language pertaining to the state of Louisiana
10/01/2025	Application North Carolina <ul style="list-style-type: none">Added language to indicate this Medical Policy does not apply to the state of North Carolina; refer to the state-specific policy version

Date	Summary of Changes
07/01/2025	<p data-bbox="337 128 1044 161">Medical Records Documentation Used for Reviews</p> <ul data-bbox="337 161 1516 348" style="list-style-type: none"> <li data-bbox="337 161 716 195">● Added language to indicate: <ul data-bbox="386 195 1516 348" style="list-style-type: none"> <li data-bbox="386 195 1442 258">○ Benefit coverage for health services is determined by the federal, state, or contractual requirements, and applicable laws that may require coverage for a specific service <li data-bbox="386 258 1516 348">○ Medical records documentation may be required to assess whether the member meets the clinical criteria for coverage but does not guarantee coverage of the service requested; refer to the guidelines titled Medical Records Documentation Used for Reviews <p data-bbox="337 348 664 382">Supporting Information</p> <ul data-bbox="337 382 883 415" style="list-style-type: none"> <li data-bbox="337 382 883 415">● Archived previous policy version CS343.H

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, 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.