Surgery of the Wrist or Thumb

Policy Number: 2026T0623M
Effective Date: August 1, 2026

➲ Instructions for Use

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Related Commercial/Individual Exchange Policy
• Outpatient Surgical Procedures – Site of Service
Community Plan Policy
• Surgery of the Wrist or Thumb

Application

UnitedHealthcare Commercial

This Medical Policy applies to UnitedHealthcare Commercial benefit plans.

UnitedHealthcare Individual Exchange

This Medical Policy applies to Individual Exchange benefit plans.

Coverage Rationale

Surgery of the wrist or thumb 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
- Arthroscopy or Arthroscopically Assisted Surgery, Wrist
- Joint Replacement, Wrist

Click here to view the InterQual® criteria.

Medical Records Documentation Used for Reviews

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. 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 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
25441	Arthroplasty with prosthetic replacement; distal radius

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CPT Code	Description
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)
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 wrist or thumb 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, 2026)

Policy History/Revision Information

Date	Summary of Changes
09/01/2026	**Related Policies** • Updated reference link to reflect the current Community Plan Medical Policy title for *Surgery of the Wrist or Thumb*

08/01/2026	**Title Change**
	• Previously titled *Surgery of the Hand or Wrist*
	Related Policies
	• Added reference link to the Medical Policy titled *Outpatient Surgical Procedures – Site of Service*
	Coverage Rationale
	• Replaced language indicating "surgery of the *hand or* wrist is proven and medically necessary in certain circumstances" with "surgery of the wrist *or thumb* is proven and medically necessary in certain circumstances"
	• Revised language pertaining to medical necessity clinical coverage criteria; removed reference to the InterQual® CP: Procedures:
	  ○ Arthroplasty, Metacarpophalangeal (MCP) Joint, Digits
	  ○ Arthroplasty, Proximal Interphalangeal (PIP) Joint, Fingers
	  ○ Arthroscopy, Diagnostic, +/- Synovial Biopsy, Wrist
	  ○ Removal or Revision, Arthroplasty, Wrist
	Medical Records Documentation Used for Reviews
	• Updated list of Medical Records Documentation Used for Reviews; replaced "prior therapies/treatments tried, failed, or contraindicated; include the dates and reason for discontinuation" with "prior therapies/treatments tried, failed, or contraindicated; include the dates, *duration*, and reason for discontinuation"
	Applicable Codes
	• Removed CPT codes 25449, 26530, 26531, 26535, 26536, and 29840
	Supporting Information
	• Updated *FDA* section to reflect the most current information
	• Archived previous policy version 2026T0623L

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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 the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, 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.

This Medical Policy may also be applied to Medicare Advantage plans in certain instances. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).

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.

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