Clinical Policy: Wrist Arthrodesis (Wrist Fusion)

Common Name: Wrist Fusion

Definition: Wrist fusion is a surgical procedure that immobilizes the wrist by fusing the forearm bone with the small bones of the wrist to relieve pain and stabilize the joint.

I. Criteria for Inclusion
Wrist arthrodesis is considered medically necessary when all of the following are met:

A. Treatment is indicated for one of the following:
   1. Pain and/or functional disability that interferes with daily activities and all of the following are met:
      a. Documentation of at least 3 months of failed conservative treatment, including both medications (e.g. NSAIDs, analgesics) and immobilization (e.g. brace, splint) unless severity of disease requires earlier intervention
      b. Radiographic evidence of one of the following:
         i. Advanced arthritis due to posttraumatic, inflammatory, septic, or degenerative process
         ii. Nonunion or malunion of distal radius fracture
         iii. Scaphoid nonunion
         iv. Pseudarthrosis of previous arthrodesis
         v. Preiser osteonecrosis or end-stage Kienbock disease
   2. Contracted or flail wrist associated with cerebral palsy, brachial plexus injury, or traumatic brain injury where fusion is needed to improve function, hygiene, and cosmetic appearance
   3. Primary or secondary tumor involving the wrist
   4. Failed proximal row carpectomy, scapholunate reconstruction, partial wrist arthrodesis, or total wrist arthroplasty

B. Age between 15 (with documented closure of growth plates) and 55, or age > 55 with active or high-demand occupation or lifestyle

II. Criteria for Exclusion
A. In persons with any of the following contraindications, wrist fusion is considered not medically necessary:
   1. Neurologic disease or injury resulting in significant sensory deprivation distal to fusion
   2. Recent surgery on a lower limb or regular use of the affected extremity for support during ambulation or transferring
   3. Recent infection of the wrist joint

See Important Reminder at the end of this policy for important regulatory and legal information.
4. Known hypersensitivity to implant materials
B. For persons with significant co-morbidities or complications, the medical record must contain documentation of the risk/benefit of wrist arthrodesis.

III. Surgical Considerations
A. Pre-Operative Considerations:
   1. Preoperative care planning needs may include:
      a. Routine preoperative evaluation
      b. Preoperative treatment, procedures, and stabilization, including:
         i. Physical and occupational therapy consultation to establish postoperative rehabilitation goals
         ii. Rheumatology consultation
         iii. Nutrition evaluation
      c. Preoperative discharge planning as appropriate
B. Intra-Operative Considerations:
   1. Antibacterial wipes
   2. Antibacterial nasal swab
C. Post-Operative & Inpatient Considerations:
   1. Hospital evaluation and care needs may include:
      a. Monitoring patient's status for deterioration and comorbid conditions
D. Discharge Planning & Considerations:
   1. Discharge planning includes:
      a. Assessment of needs and planning for care, including:
         i. Develop treatment plan (involving multiple providers as needed).
         ii. Evaluate and address preadmission functioning as needed
         iii. Evaluate and address patient or caregiver preferences as indicated.
         iv. Identify skilled services needed at next level of care, with specific attention to:
            • Cast or immobilizer care
            • Neurologic status assessment
            • Rehabilitation therapy or equipment coordination
         v. Evaluate and address psychosocial status issues as
      b. Early identification of anticipated discharge destination; options include:
         i. Home, considerations include:
            • Access to follow-up care
            • Home safety assessment
            • Self-care ability, if appropriate
            • Caregiver need, ability, and availability
         ii. Post-acute skilled care or custodial care, as indicated
      c. Transition of care plan complete, which may include:
         i. Patient and caregiver education
         ii. Medication reconciliation completion includes:
• Compare patient's discharge list of medications (prescribed and over-the-counter) against physician's admission or transfer orders.
• Assess each medication for correlation to disease state or medical condition.
• Report medication discrepancies to prescribing physician, attending physician, and primary care provider, and ensure accurate medication order is identified.
• Provide reconciled medication list to all treating providers.
• Confirm that patient, family, or caregiver can acquire medication.
• Educate patient, family, and caregiver.
• Provide complete medication list to patient, family, or caregiver.
• Confirm that patient, family, or caregiver understands importance of presenting personal medication list to all providers at each care transition, including all physician appointments.
• Confirm that patient, family, or caregiver understands reason, dosage, and timing of medication (eg, use "teach-back" techniques).

iii. Plan communicated to patient, caregiver, and all members of care team, including:
• Inpatient care and service providers
• Primary care provider
• All post-discharge care and service providers

iv. Post-discharge appointment plans made as needed, which may include:
• Primary care provider
• Orthopedic surgeon
• Rehabilitation therapy services
• Rheumatologist
• Specialists for management of comorbid conditions

v. Post-discharge testing and procedure plans made, which may include:

vi. Referrals made for assistance or support, which may include:
• Financial, for follow-up care, medication, and transportation
• Smoking cessation counseling or treatment

vii. Medical equipment and supplies coordinated (ie, delivered or delivery confirmed) which may include:
• Wound care supplies

IV. Length of Stay Considerations
A. Goal length of stay: Ambulatory
B. Facility type criteria: Ambulatory

V. Coding
A. CPT Codes

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<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>25800</td>
<td>Arthrodesis, wrist; complete, without bone graft (includes radiocarpal and/or intercarpal and/or carpometacarpal joints)</td>
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**Clinical Policy**

**Wrist Arthrodesis (Wrist Fusion)**

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<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>25805</td>
<td>Arthrodesis, wrist; with sliding graft</td>
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<td>25810</td>
<td>Arthrodesis, wrist; with iliac or other autograft (includes obtaining graft)</td>
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<td>25820</td>
<td>Arthrodesis, wrist; limited, without bone graft (eg, intercarpal or radiocarpal)</td>
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<tr>
<td>25825</td>
<td>Arthrodesis, wrist; with autograft (includes obtaining graft)</td>
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B. HCPCS

*No HCPCS Codes*

C. ICD-10 Procedure

*No ICD-10 Procedure codes*

D. ICD-10 Diagnosis

*All associated ICD-10 Diagnosis codes*

References


**Regulatory Data**

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<thead>
<tr>
<th>Policy Number/Name:</th>
<th>PA.CP.MP.OR.1032 Wrist Fusion</th>
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<tbody>
<tr>
<td>Initial Approval and Effective Date:</td>
<td>1/30/2018</td>
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<tr>
<td>Reviewed Dates:</td>
<td>1/19/2018; 2/11/2019</td>
</tr>
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<td>All Approval Dates:</td>
<td>1/30/2018; 2/15/2019</td>
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<tr>
<td>Approval Authority:</td>
<td>Utilization Management Committee</td>
</tr>
<tr>
<td>Business Owner:</td>
<td>Utilization Management</td>
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<tr>
<td>Applicable lines of business:</td>
<td>All</td>
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<td>Board approval, if appropriate:</td>
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<td>Approval Signature:</td>
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**URAC Standards:**

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**State Requirements:**

- 

**CMS/Federal Requirements:**

- 

**Corresponding policies:**

- 

**Reviews, Revisions, and Approvals**

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<tr>
<td>03/20</td>
<td>7/2/2020</td>
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• New Policy created.
• Policy administered by Turning Point Healthcare Solutions

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by PA Health & Wellness, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a
contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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