2011 Procedures Adult Criteria

Arthroscopy, Surgical, Wrist(1*RIN)

CLIENT:	Name	D.O.B.	ID#	GROUP#
CPT/ICD9:	Code	Facility	Service Date	
PROVIDER:	Name		ID#	Phone#
	Signature		Date	

ICD-9-CM: 80.23, 80.73, 81.93

INDICATIONS (choose one and see below)

- ☐ 100 Removal of intra-articular loose body (O)
- ☐ 200 Lavage of joint with joint aspirate diagnostic for infection (I) ♦
- ☐ 300 Repair/debridement of acute ligamentous/TFCC injury (O)
- ☐ 400 Repair of chronic ligamentous/TFCC injury (O)
- ☐ 500 Synovectomy (major) (O)
- ☐ 600 Joint exploration post penetrating joint injury (O) ♦
- ☐ Indication Not Listed (Provide clinical justification below)

☐ 100 Removal of intra-articular loose body (O) **[All]**(2)
- ☐ 110 Symptoms at wrist **[One]**
  - ☐ 111 Joint pain
  - ☐ 112 Locking
- ☐ 120 Findings at wrist **[One]**
  - ☐ 121 Pain with passive ROM
  - ☐ 122 Limited ROM
- ☐ 130 Loose body by imaging(3)

☐ 200 Lavage of joint with joint aspirate diagnostic for infection (I) ♦(4, 5)

☐ 300 Repair/debridement of acute ligamentous/TFCC injury (O) **[All]**(6, 7, 8)
- ☐ 310 Wrist injury by Hx
- ☐ 320 Pain/instability at wrist
- ☐ 330 Findings at wrist **[One]**
  - ☐ 331 Tenderness
  - ☐ 332 Pain with provocative wrist maneuvers/palpation(9)
- ☐ 340 Ligamentous/TFCC injury **[One]**
  - ☐ 341 Abnormal bone alignment by PE/imaging(10)

- ☐ 342 Ligamentous/TFCC tear by imaging
- ☐ 350 No/mild arthritic changes by x-ray[11]

☐ 400 Repair of chronic ligamentous/TFCC injury (O) **[All]**[6, 7]
- ☐ 410 Pain/instability at wrist interferes with ADLs[12]
- ☐ 420 Findings at wrist **[One]**
  - ☐ 421 Tenderness
  - ☐ 422 Subluxation with motion
  - ☐ 423 Pain with provocative wrist maneuvers/palpation[9]
- ☐ 430 Ligamentous/TFCC injury **[One]**
  - ☐ 431 Abnormal bone alignment by PE/imaging[10]
  - ☐ 432 Ligamentous/TFCC tear by imaging
- ☐ 440 No/mild arthritic changes by x-ray[11]
- ☐ 450 Continued Sx/findings **after** NSAID **[One]**[13, 14]
  - ☐ 451 Rx ≥ 4 wks
  - ☐ 452 Contraindicated/not tolerated[15]

☐ 500 Synovectomy (major) (O) **[All]**[16]
- ☐ 510 Wrist pain
- ☐ 520 Joint swelling
- ☐ 530 Limited ROM[17]
- ☐ 540 No/minimal degenerative changes in bone/cartilage by x-ray[18]
- ☐ 550 Systemic rheumatic disorder by Hx[19]
- ☐ 560 Sx/findings unimproved after disease-specific Rx ≥ 12 wks[20, 21]

☐ 600 Joint exploration post penetrating joint injury (O) ♦

Notes

(1)-RIN:
For arthroscopic wrist ganglion cyst excision, see the "Ganglion Cyst Excision" criteria subset in the *Hand, Plastic & Reconstructive* category.

(2)
Loose bodies in synovial joints are formed by several mechanisms, including trauma with fracture, joint disintegration from degeneration, and synovial proliferation. Examples of loose bodies include osteochondritis dissecans fragments, chondral fragments, and calcified loose bodies. Loose bodies that are stable or attached to a synovial membrane, recess, or bursa tend to be asymptomatic and can be treated conservatively. Loose bodies that move within the joint cavity can become trapped between the articular surfaces causing pain, limited motion, locking, and effusion (Dubberley et al., J Bone Joint Surg Br 2005; 87(5): 684-686).

(3)
Imaging may include x-ray, MRI, MR arthrogram, or arthrogram.

(4)
The initial diagnosis of joint infection is made by the clinical findings of pain, fever, effusion, joint tenderness, and perhaps erythema or warmth of the skin over the joint. Infection is confirmed by arthrocentesis and analysis of the joint fluid.

(5)
If the joint fluid has an elevated WBC but a negative Gram stain or culture and the clinical suspicion for joint infection is high, operative drainage is indicated.

(6)
Wrist stability is provided by a number of ligamentous and fibrocartilage structures that are susceptible to injury. These include the scapholunate and lunotriquetral interosseous ligaments, volar radiocarpal and ulnocarpal ligaments, and the triangular fibrocartilage complex (TFCC). Depending upon the location and grade of the injury as well as the integrity of the tissue, arthroscopic debridement or repair may be appropriate.

(7)
The location of the injury or the integrity of the tissue may preclude arthroscopic treatment of the injury. In these cases definitive treatment would require an open procedure. The decision to convert to an open procedure is a matter of clinical judgment.

(8)
There is no precise definition of "acute injury" in the literature. McKesson consultants feel that ≤ 6 wks can be considered an acute injury from the perspective of tissue changes.

(9)
Systematic palpation of all joints of the wrist is done to localize tenderness and pathology (Young et al., Orthop Clin North Am 2007; 38(2): 149-165, v; Eathorne, Prim Care 2005; 32(1): 17-33). A variety of provocative maneuvers (e.g., scaphoid shift test, ballottement tests) are used to assess wrist stability or kinematics (i.e., mechanics of motion) (Young et al., Orthop Clin North Am 2007; 38(2): 149-165, v; Eathorne, Prim Care 2005; 32(1): 17-33). The examination should include the carpus (i.e., carpal bones and articulations) as well as the distal radioulnar joint.

(10)
The most common imaging studies used to make this diagnosis are x-ray or fluoroscopy.

(11)
The pain of severe arthritis of the wrist can mimic that of a ligamentous injury. Although not an absolute contraindication to arthroscopy, arthritis should be excluded as the sole cause of the patient's pain before surgery is performed.

(12)
Activities of daily living (ADLs) are frequently divided into those simple activities relating to basic self-care and those that involve more complex interactions with others and the environment (called instrumental activities of daily living or IADLs). This criterion includes both types of activity. Whether a condition is of sufficient severity to interfere with ADLs or IADLs is somewhat subjective. There should be an indication that symptoms impede the patient's ability to effectively work, shop, manage at home, care for family members, or tend to personal hygiene.

(13)
In addition to NSAIDs, corticosteroid injection may also be helpful.

(14)-POL:
NSAIDs are preferred for the treatment of this condition because of their anti-inflammatory effect. It is a matter of local medical policy whether to accept acetaminophen or other analgesics as alternatives for NSAIDs.

(15)
Contraindications to NSAIDs may be absolute (e.g., pregnancy, history of allergic reaction) or relative (e.g., anticoagulant use, history of PUD).

(16)
Synovectomy is performed for generalized synovial disease. Rarely, it is performed for pigmented villonodular synovitis (PVNS). PVNS affects a single joint only and is usually diagnosed by synovial biopsy at diagnostic arthroscopy. If PVNS is severe enough to warrant synovectomy, the diagnostic arthroscopy converts to a surgical arthroscopy or arthrotomy.

(17)
It is not possible to define the precise ROM parameters that should be used to determine appropriateness of surgery. ROM varies from patient to patient and does not necessarily correlate with symptoms or the need for surgical intervention.

(18)

Better pain reduction and joint mobility are obtained for synovectomy performed in joints without significant cartilage damage or arthritic changes (Kim and Jung, Clin Med Res 2007; 5(4): 244-250; Carl et al., Arthroscopy 2005; 21(10): 1209-1218; Adolfsson, Hand Clin 2005; 21(4): 527-530).

(19)

Rheumatoid arthritis and SLE are examples of systemic rheumatic disorders.

(20)

What is included in disease-specific therapy varies depending on the disease process.

(21)

The front line pharmacological choices in treating rheumatoid arthritis are disease modifying antirheumatic drugs (DMARDs) (e.g., sulphasalazine, hydroxychloroquine, leflunomide, cyclosporin). These are used in combination with methotrexate and glucocorticoids as first-line treatment. Treatment should be initiated as soon as possible, ideally within 3 months of symptom onset. Management of rheumatoid arthritis may also include the use of biological agents (e.g., infliximab, etanercept, adalimumab, rituximab, abatacept) for progressive disease. NSAIDs, including COX II inhibitors, may be used concomitantly (Funovits et al., Ann Rheum Dis 2010, 69: 1589-95; National Collaborating Centre for Chronic Conditions, Rheumatoid arthritis: national clinical guideline for management and treatment in adults. 2009 [cited Mar, 2010]; Saag et al., Arthritis Rheum 2008; 59(6): 762-784).