Cohere Medical Policy - Interphalangeal Joint Arthroplasty

Clinical Policy for Medical Necessity Review

Version: 3
Cohere Health UMC Approval Date: July 10, 2025
Last Annual Review: July 10, 2025
Revision: Not Applicable
Next Annual Review: July 10, 2026

Important Notices

Notices & Disclaimers:

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Policy Information:

Specialty Area: Musculoskeletal Care
Policy Name: Cohere Medical Policy - Interphalangeal Joint Arthroplasty
Type: [**X**] Adult (18+ yo) | [**X**] Pediatric (0-17 yo)

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Medical Necessity Criteria

Service: Interphalangeal Joint Arthroplasty

Cohere Health takes an evidence-based approach to reviewing imaging and procedure requests, meaning that sufficient clinical information must be provided at the time of submission to determine medical necessity. Documentation must include a recent and detailed history, physical examination related to the onset or change in symptoms, relevant lab results, prior imaging, and details of previous treatments. Advanced imaging or procedures should be requested after a clinical evaluation by the treating provider, which may include referral to a specialist.

- When a specific clinical indication is not explicitly addressed in the Cohere Health medical policy, medical necessity will be determined based on established clinical best practices, as supported by evidence-based literature, peer-reviewed sources, professional society guidelines, and state or national recommendations, unless otherwise directed by the health plan.
- Requests submitted without clinical documentation, or those that do not align with the provided clinical information—such as mismatched procedure, laterality, body part, or CPT code—may be denied for lack of medical necessity due to insufficient or inconsistent clinical information.
- When there are multiple diagnostic or therapeutic procedures requested simultaneously or within the past three months, each will be reviewed independently. Clinical documentation must clearly justify all of the following:
    - The medical necessity of each individual request
    - Why prior imaging or procedures were inconclusive, or why additional/follow-up studies are needed
    - How the results will impact patient management or treatment decisions
- Requests involving adjacent or contiguous body parts may be considered not medically necessary if the documentation demonstrates that the

patient's primary symptoms can be adequately assessed with a single study or procedure.

Description

Interphalangeal joint (i.e., hand or foot small joint) arthroplasty is a well-established surgery that can provide pain relief, preserve motion, and improve function of the hand or foot.[1–3] During an interphalangeal joint arthroplasty, tendons may be split or removed to access and replace the damaged joint.[1] Surgeons may use silicone, metal, pyrocarbon, or ceramic implants in a lateral, dorsal, or volar (i.e., side, upper, or palm/sole, respectively) approach.[2] All surgical techniques have shown improved postoperative grip and pinch strength, which are important factors in evaluating functional status.[2] Recovery may include immobilization of the hand or foot, then exercises to regain and improve function, including physical therapy, may be recommended.[1]

Medical Necessity Criteria

Indications

Interphalangeal joint arthroplasty is considered appropriate if **ALL** of the following are **TRUE**:

- **ANY** of the following:
  - Current nicotine user with no product use for 6 weeks; and **ANY** of the following[4,5]:
    - Negative urine (cotinine) lab test within 30 days; **OR**
    - Surgery is urgently required due to documented reason; **OR**
  - No history of nicotine product use within the last 12 months; **OR**
  - No lifetime history of nicotine product use, **AND**
- The patient has finger or toe pain and loss of motion, which is interfering with hand function and age-appropriate daily self-care and functional activities[6]; **AND**
- Radiographic confirmation of advanced joint disease of the proximal interphalangeal (PIP) joint, including **ANY** of the following[3]:
  - Joint degeneration, such as PIP joint space narrowing or bone deformities[7]; **OR**
  - Osteophytes[7,8]; **OR**
  - Subchondral sclerosis or cysts[7,8]; **OR**
  - Fracture-dislocations or fracture-subluxations[9,10]; **OR**
  - Juvenile idiopathic arthitis[11]; **OR**

    - Congenital deformity[12,13]; **AND**
- **ANY** of the following:
    - Failure of conservative management for greater than 3 months, including **ALL** of the following[6,14–16]:
        - Anti-inflammatory medications, non-opioid analgesics, or prescription medications (e.g., oral steroids, neuropathic pain medications) if not contraindicated; **AND**
        - Physical therapy, including a physician-directed home exercise program; **AND**
        - Orthotics (e.g., shoe modification, splinting, or padding); **AND**
        - **ANY** of the following:
            - Corticosteroid injection if medically appropriate; **OR**
            - Documentation that corticosteroid injection is contraindicated; **OR**
    - The patient's severe disability or deformity is significantly affecting their ability to perform age-appropriate daily self-care and functional activities.[9,10,17]

Non-Indications

Interphalangeal joint arthroplasty is not considered appropriate if **ANY** of the following is **TRUE**:

- Persistent infection at the surgical site[18]; **OR**
- Non-reconstructable or irreparable extensor or flexor tendon mechanism; **OR**
- Skin defect or loss[19]; **OR**
- The procedure is a distal interphalangeal (DIP) joint arthroplasty with implant[8]; **OR**
- The procedure is an interphalangeal joint replacement of the thumb.[20]

Level of Care Criteria

Outpatient

Procedure Codes (CPT/HCPCS)

CPT/HCPCS Code	Code Description
26535	Arthroplasty, interphalangeal joint; each joint
26536	Arthroplasty, interphalangeal joint; with prosthetic implant, each joint

Medical Evidence

Musso-Daury et al. (2024) performed a systematic review and meta-analysis of randomized controlled trials that identified several conservative, non-pharmacological interventions for the management of chronic pain in patients with juvenile idiopathic arthritis (JIA). The authors strongly recommend integrating physical exercise programs into the care of JIA-related chronic pain for a minimum of 3 months to enhance emotional and physical well-being in children and adolescents with JIA.[16] Although the majority of the studies in this review were for large joints, a recent case series also points to the effectiveness of conservative care for small joints, specifically with corticosteroid and other medication therapies.[15]

Terpstra et al. (2022) provide insight into prominent hand osteoarthritis therapy guidelines and examine how closely clinical practices align with these guidelines. Significant variations exist in the application of treatment options. An optimal balance between non-pharmacological and pharmacological approaches could be enhanced by increasing referrals to physical or occupational therapists. It is advised to consider guidelines from organizations such as the European Alliance of Associations for Rheumatology (EULAR), OsteoArthritis Research Society International (OARSI), and American College of Rheumatology (ACR) for referral, alongside embracing a multidisciplinary treatment strategy. EULAR recommends reserving surgical interventions for patients with severe disability or deformity or when conservative care modalities have not been successful.[6]

Chan et al. (2021) reviewed distal interphalangeal joint (DIPJ) arthroplasty. The authors examine surgical techniques, implant varieties, clinical outcomes, and associated complications. A comprehensive search across five databases from inception to April 18, 2020 yielded insights suggesting that silicone implants for DIPJ arthroplasty may present a viable alternative to arthrodesis (i.e., joint fusion). Arthroplasty can facilitate the preservation of joint mobility, alleviate pain, and enhance patient satisfaction. However, the available evidence remains insufficient to designate any specific implant design or surgical approach as definitively superior.[8]

Demino et al. (2021) conducted a systematic literature review to present postoperative results of different treatment approaches for proximal interphalangeal (PIP) joint fracture-dislocations. Outcomes assessed included range of motion (ROM) at the PIP joint, grip strength (as a percentage of the contralateral hand), and Quick Disabilities of the Arm, Shoulder, and Hand (QuickDASH) scores. Articles were categorized by the surgical method used (e.g., open reduction, percutaneous fixation, dynamic external fixation, extension-block pinning, and hemi-hamate arthroplasty). A total of 48 articles including data from 746 hands (735 patients) were reviewed. Results showed that percutaneous fixation led to the highest postoperative ROM at final follow-up, while extension-block pinning resulted in the greatest grip strength. Dorsal fracture-dislocations generally exhibited higher average ROM and lower QuickDASH scores, whereas pilon fractures showed higher grip strength. However, no surgical approach or fracture type consistently produced superior outcomes. The authors concluded that surgical treatment requires careful decision-making based on considerations such as fracture type, joint space area, and fracture size.[9]

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Clinical Policy Revision History/Information

Original Date: April 5, 2024		
Review History		
Version 2	09/20/2024	Updated language regarding conservative treatment.
Version 3	07/10/2025	Annual review. No changes to procedure codes. Updated standard language for nicotine and conservative care indications. Added references to support conservative care as the primary treatment in pediatric/adolescent populations. Changed mentions of "activities of daily living" to "age-appropriate daily self-care and functional activities" to better encompass pediatric/adolescent populations, as some aspects of ADLs (work absenteeism, managing household tasks, etc.) do not apply to all ages. Broadened "PIP joint space narrowing" to "Joint degeneration, such as PIP joint space narrowing or bone deformities." Added indications for "fracture-dislocations or fracture-subluxations," "juvenile idiopathic arthritis," and "congenital deformity" to the radiographic confirmation section. Added indication for cases in which patients cannot undergo 3 months of conservative care: "the patient's severe disability or deformity is significantly affecting their ability to perform age-appropriate daily self-care and functional activities."

		Literature review - Description and Medical Evidence sections updated (including references).