Surgery of the Ankle

Policy Number: SURGERY 121.1 T2
Effective Date: November 1, 2021

Instructions for Use

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Related Policies
None

Coverage Rationale

Surgery of the ankle is proven and medically necessary in certain circumstances. For medical necessity clinical coverage criteria, refer to the:

- InterQual® 2021, Apr. 2021 Release, CP: Procedures:
  - Arthrodesis, Ankle (Talotibial Joint)
  - Arthroscopy, Surgical, Ankle
  - Arthrotomy, Ankle
  - Total Joint Replacement (TJR), Ankle
- InterQual® Client Defined 2021, CP: Procedures:
  - Arthroplasty, Ankle (Without Implant) (Custom) - UHG
  - Arthroplasty, Removal or Revision, Ankle (Custom) - UHG

Click here to view the InterQual® criteria.

Documentation Requirements

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 documentation requirements outlined below are used to assess whether the member meets the clinical criteria for coverage but do not guarantee coverage of the service requested.

Required Clinical Information
Surgery of the Ankle

Medical notes documenting the following, when applicable:
• Upon request we may require the specific diagnostic image(s) that show the abnormality for which surgery is being requested, which may include MRI, CT scan, X-ray, and/or bone scan; consultation with requesting surgeon may be of benefit to select the optimal images
Note: When requested, diagnostic image(s) must be labeled with:
  • The date taken
  • Applicable case number obtained at time of notification, or member's name and ID number on the image(s)

Required Clinical Information
Surgery of the Ankle

Upon request diagnostic image(s) must be submitted via the external portal at www.uhcprovider.com/paan; faxes will not be accepted
• Reports of all recent imaging studies and applicable diagnostic tests, including:
  • Microbiological findings
  • Synovial exam
  • Erythrocyte sedimentation rate (ESR)
  • C-reactive protein (CRP)
• Condition requiring procedure
• Severity of pain and details of functional disability(ies) interfering with activities of daily living (preparing meals, dressing, driving, walking)
• Pertinent physical examination of the relevant joint
• Co-morbid medical condition(s)
• Prior therapies/ treatments tried, failed, or contraindicated; include the dates and reason for discontinuation
• Date of previous failed surgery to the same joint, if applicable
• Physician's treatment plan including pre-op discussion
• For revision surgery, also include:
  • Details of complication
  • Complete (staged) surgical plan
• If the location is being requested as an inpatient stay, provide medical notes to support the following, when applicable:
  • Surgery is bilateral
  • Member has significant co-morbidities; include the list of comorbidities and current treatment
• Member does not have appropriate resources to support postoperative care after an outpatient procedure; include the barriers to care as an outpatient

Prior Authorization Requirements

Prior authorization is required in all sites of service.

Notes:
- Participating providers in the office setting: Prior authorization is required for services performed in the office of a participating provider.
- Non-participating/out-of-network providers in the office setting: Prior authorization is not required but is encouraged for out-of-network services. If prior authorization is not obtained, Oxford will review for out-of-network benefits and medical necessity after the service is rendered.

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 may apply.

CPT Code	Description
Arthrotomy, Ankle	
27685	Lengthening or shortening of tendon, leg or ankle; single tendon
Total Joint Replacement (TJR), Ankle	
27700	Arthroplasty, ankle
27702	Arthroplasty, ankle; with implant (total ankle)
27703	Arthroplasty, ankle; revision, total ankle

CPT Code	Description
Total Joint Replacement (TJR), Ankle	
27704	Removal of ankle implant
Arthroscopy, Surgical, Ankle	
29891	Arthroscopy, ankle, surgical; excision of osteochondral defect of talus and/or tibia, including drilling of the defect
29892	Arthroscopically aided repair of large osteochondritis dissecans lesion, talar dome fracture, or tibial plafond fracture, with or without internal fixation (includes arthroscopy)
29894	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; with removal of loose body or foreign body
29895	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; synovectomy, partial
29897	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; debridement, limited
29898	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; debridement, extensive
29899	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; with ankle arthrodesis
Arthrodesis, Ankle (Talotibilial Joint)	
29899	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; with ankle arthrodesis

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 ankle are procedures and, therefore, not regulated by the FDA. However, devices and instruments used during the surgery may require FDA approval. See the following website for additional information: http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm. (Accessed July 27, 2020)

Policy History/Revision Information

Date	Summary of Changes
11/01/2021	• New Clinical Policy

Instructions for Use

This Clinical Policy provides assistance in interpreting UnitedHealthcare Oxford 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, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare Oxford reserves the right to modify its Policies as necessary. This Clinical Policy is provided for informational purposes. It does not constitute medical advice.

The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. UnitedHealthcare Oxford Clinical 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.