# CMM-407: Arthroscopy: Subtalar Joint

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Definitions

Red flags indicate comorbidities that require urgent/emergent diagnostic imaging and/or referral for definitive therapy.

Clinically meaningful improvement is defined as at least 50% improvement noted on global assessment.

General Guidelines

- Either of the following are considered red flag conditions for subtalar joint arthroscopy:
  - Post-reduction evaluation and management of the subtalar dislocation
  - Septic arthritis in the subtalar joint

- Although imaging may be normal, prior to subtalar joint arthroscopy, radiographic imaging should be performed and include both of the following:
  - Plain X-rays with one or more views (anteroposterior, lateral, axial, and/or Broden’s) to confirm and differentiate any of the following:
    - Degenerative joint changes
    - Loose bodies
    - Osteochondral lesions
    - Impingement
    - Calcaneal or talar fractures
    - Os trigonum

  - Advanced imaging with MRI or CT scan to confirm one or more of the following:
    - Abnormal effusion
    - Os trigonum syndrome
    - Sinus tarsi syndrome
    - Degenerative joint disease
    - Loose bodies
    - Osteochondral lesions
    - Chondromalacia
    - Arthrofibrosis
    - Impingement
    - Calcaneal or talar fractures
**Indications**

Subtalar joint arthroscopy is considered **medically necessary** when all of the following are met:

- Performed for any of the following:
  - Subtalar joint pain of indeterminate etiology of at least 3 months
  - Presence of a loose or foreign body in the subtalar joint
  - Synovitis of the subtalar joint
  - Arthritis of the subtalar joint (arthrodesis)

- Subjective symptoms including any of the following:
  - Painful ankle joint
  - Joint swelling
  - Soft-tissue swelling
  - Painful or altered gait
  - Stiffness
  - Catching, locking, giving way
  - Instability of the ankle/subtalar

- Objective findings including any of the following:
  - Pain or fullness within the sinus tarsi
  - Pain reproduced with manipulation of the subtalar joint
  - Subtalar instability
  - Positive for locking, popping, catching within the subtalar
  - Limited motion of the subtalar joint
  - Positive posterior impingement signs

- Imaging results are inconclusive (refer to CMM-407: General Guidelines for imaging needs)

- Less than clinically meaningful improvement with conservative treatment including any of the following:
  - Any of the following for at least 6 weeks:
    - NSAIDs
    - Self-care consisting of rest, ice, and/or heat
    - Activity modifications
  - Bracing
  - Walker boot
  - Subtalar corticosteroid injection unless contraindicated (e.g., patient refuses corticosteroid injection, patient is diabetic, etc.)
Non-Indications

Subtalar joint arthroscopy is considered not medically necessary when any of the following contraindications are present:

- Infection in the intraarticular or surrounding soft tissue
- The patient is functionally unable to benefit from surgery and associated rehabilitation
- Medical comorbidities that make surgery or anesthesia unsafe
- Loss of complete joint space (exception arthrodesis)
- Peripheral vascular disease
- The patient is unable to comply with weight-bearing restrictions

Procedure (CPT®) Codes

This guideline relates to the CPT® code set below. Codes are displayed for informational purposes only. Any given code’s inclusion on this list does not necessarily indicate prior authorization is required. Pre-authorization requirements vary by payor.

<table>
<thead>
<tr>
<th>CPT®</th>
<th>Code Description/Definition</th>
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<tbody>
<tr>
<td>29904</td>
<td>Arthroscopy, subtalar joint, surgical; with removal of loose body or foreign body</td>
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<tr>
<td>29905</td>
<td>Arthroscopy, subtalar joint, surgical; with synovectomy</td>
</tr>
<tr>
<td>29906</td>
<td>Arthroscopy, subtalar joint, surgical; with debridement</td>
</tr>
<tr>
<td>29907</td>
<td>Arthroscopy, subtalar joint, surgical; with subtalar arthrodesis</td>
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This list may not be all inclusive and is not intended to be used for coding/billing purposes. The final determination of reimbursement for services is the decision of the individual payor (health insurance company, etc.) and is based on the member/patient/client/beneficiary’s policy or benefit entitlement structure as well as any third party payor guidelines and/or claims processing rules. Providers are strongly urged to contact each payor for individual requirements if they have not already done so.
References