CLINICAL GUIDELINES

Addendum to Musculoskeletal Management Guidelines

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bridgespan™

eviCore innovative solutions healthcare

Clinical guidelines for medical necessity review of speech therapy services.

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Addendum to Musculoskeletal Management Guidelines

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CMM-401: Discography

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CMM-401.1: Definitions

Discography is a diagnostic procedure in which a contrast material (dye) is injected into the nucleus pulposus of a disc. It has been used to justify the need for surgical intervention to treat back or neck pain. The general intent is to determine whether the disc is the source of pain (i.e., a diagnosis of discogenic pain) in patients with predominantly axial back or neck pain. Discography is presumed to yield two results:

- Pain provocation (provocative discography) - whether the patient's typical pain was reproduced by the injection of the contrast material (dye)
- Morphology - whether the contrast material (dye) images an abnormal pattern of the disc (e.g., annular tears, disc herniation) often based on a computed tomography (CT) scan.

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

Behavioral yellow flags are defined as an active or history of substance abuse, depression, dissatisfaction with work, job disability, or anxiety diagnosis.

Clinically meaningful improvement is a global assessment showing at least 50% improvement, or pain relief is defined as a two (2) point drop in VAS pain scale where 10 is the worst pain imaginable and 0 is no pain at all.

CMM-401.2: General Guidelines

Any of the following are considered to be red flags and the request for discography should go to medical review:

- Suspected unstable fractures of the spine which may be evidenced by a history of a recent fall or injury, and major motor weakness of a limb, or progressive neurological deficits, or bladder or bowel dysfunction.
- History of cancer with suspicion of metastatic spread which may be evidenced by major motor weakness of a limb, or pain which increases at night or at rest, or progressive neurological deficits, or bladder or bowel dysfunction, or unexplained weight loss of more than 10 pounds in 6 weeks.
- Infection with suspicion of an epidural abscess/discitis which may be evidenced by progressive neurological deficits, or fever of 100.4 for more than 48 hours, and C- reactive protein >10 mg/L, or recent (within 2 weeks) interventional spine procedures, or ESR >20 mm/hr, or immunocompromised (either immunodeficiency from any cause or IV drug abuse).
- Cauda equina syndrome which may be evidenced by bladder or bowel dysfunction, or saddle anesthesia, or progressive neurological deficits.

A post-discography CT scan is automatically approved as an add-on.

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CMM-401.3: Indications

A diagnostic discography is considered **medically necessary** when it is an authorized benefit coverage for a planned discography.

Discography as a provocative diagnostic test for axial pain is considered **medically necessary** when all of the following are met:

- Absence of red flag conditions
- Less than clinically meaningful improvement for at least 6 weeks which includes both of the following:
  - NSAIDS and/or muscle relaxants
  - Conservative self-care (muscle stretching, over the counter medications, regular exercise) or prescribed physical therapy core strengthening program
- Pain pattern and/or physical examination suggesting disc disease as evidenced by all of the following:
  - Subacute axial pain > 12 weeks
  - Axial pain worsening with upright posture
  - Absence of signs and symptoms of radicular pain
  - Absence of trigger points in affected area
  - Absence of signs and symptoms of sacroiliac joint dysfunction
- Facet joint disease has been evaluated and ruled out
- Imaging suggestive of disc damage as evidenced by any of the following:
  - Annular tears
  - Contained disc herniation
  - High intensity zones
- Absence of centralized pain syndromes, fibromyalgia, multicentric pain syndromes
- Evidence of both of the following for patients with chronic pain where there has been continuous opiate usage for 3 months or longer:
  - Co-management of behavioral health and medical conditions
  - A plan to address potential opiate overuse or abuse
- Coordination with a physician who may perform the succeeding covered therapeutic procedure

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CMM-401.4: Non-Indications

- The performance of a discography procedure in the presence of any red flag condition (see **CMM-401.2: General Guidelines**) is considered **not medically necessary**.
- The performance of functional anesthetic discography is considered **experimental investigational, or unproven**.
- Chemonucleolysis is considered inclusive with a discography procedure and is considered **not medically necessary** as a separate procedure.
- A diagnostic discography is considered **not medically necessary** for either of the following:
  - Not coincident with a surgical procedure that includes a discectomy
  - Not performed by both the surgeon and a supervising radiologist

CMM-401.5: 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 individual payor.

CPT®	Code Description/Definition
62290	Injection Procedure for Discography Each Level; Lumbar
62291	Injection Procedure for Discography Each Level; Cervical or Thoracic
72285	Discography, cervical or thoracic, radiological supervision and interpretation
72295	Discography, lumbar, radiological supervision and interpretation

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.

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CMM-402: Greater Occipital Nerve Block

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CMM-402.1: Definitions

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

Behavioral yellow flags are defined as an active or history of substance abuse, depression, dissatisfaction with work, job disability, or anxiety diagnosis.

Clinically meaningful improvement is a global assessment showing at least 50% improvement, or pain relief is defined as a two (2) point drop in VAS pain scale where 10 is the worst pain imaginable and 0 is no pain at all.

CMM-402.2: General Guidelines

- A complete headache history must be performed which shows that other primary causes of severe headaches (including the presence of any red flags) have been considered.
- For the purposes of this guideline, red flags are diagnostic considerations with secondary causes of severe headache.
- Presence of any of the following are considered to be red flags and the request for greater occipital nerve block(s) should go to medical review:
  - Multiple sclerosis associated headache, trigeminal neuralgia in a young adults
  - Intracranial infection with fever, altered consciousness or personality change in IVD use or TB
  - Stroke with new onset muscle weakness, sensory changes, alteration in speech
  - Malignant hypertension

CMM-402.3: Indications

The performance of the first greater occipital nerve block for occipital neuralgia is considered **medically necessary** when all of the following are met:

- Absence of red flag conditions
- Diagnosis of occipital neuralgia as evidenced by both of the following:
  - Paroxysmal stabbing pain, with or without aching between attacks, in the distribution of the nerve
  - Tenderness over the affected nerve
- Evidence of a comprehensive headache evaluation with consideration of alternative causes such as any of the following:
  - Exertional headache
  - Migraine with or without aura
  - Medication overuse headache

The performance of the second and subsequent greater occipital nerve block(s) for recurrent occipital neuralgia are considered **medically necessary** when all of the following are met:

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- Absence of red flag conditions
- Significant improvement after first injection
- Self-care is attempted at headache onset and ineffective and includes both of the following:
  - Anti-inflammatory medications or muscle relaxants
  - Rest, massage, or heat
- Confirmed diagnosis of recurrent occipital neuralgia as evidenced by tenderness to palpation over the greater occipital nerve
- Evidence of both of the following for patients with chronic pain where there has been continuous opiate usage for 3 months or longer:
  - Co-management of behavioral health and medical conditions
  - A plan to address potential opiate overuse or abuse

CMM-402.4: Non-Indications

- Greater occipital nerve blocks are considered **not medically necessary** for any of the following:
  - When performed in conjunction with additional pain management procedures [cervical facet injections/medial branch blocks (CPT®64490, 64491, and 64492) or trigger point injections (CPT®20552)] planned on the same day unless there has been recent discontinuation of anticoagulant therapy for the purpose of interventional pain management with injections
  - More than 6 greater occipital nerve blocks in the same anatomic areas in the past 12 months
  - Less than 4 weeks since the last occipital nerve block, cervical trigger point injection, or cervical facet injection/medial branch block
- Occipital nerve ablation by any method is considered **experimental, investigational, or unproven**.

CMM-402.5: 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 individual payor.

CPT®	Code Description/Definition
64405	Injection, Anesthetic Agent; Greater Occipital Nerve

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.

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CMM-403: Neurolytic Agent Creation of Lesion

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CMM-403.1: Definitions

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

For the purpose of this guideline, any of the following are considered to be red flags:

- Suspected unstable fractures of the spine which may be evidenced by a history of a recent fall or injury, and major motor weakness of a limb, or progressive neurological deficits, or bladder or bowel dysfunction.
- History of cancer with suspicion of metastatic spread which may be evidenced by major motor weakness of a limb, or pain which increases at night or at rest, or progressive neurological deficits, or bladder or bowel dysfunction, or unexplained weight loss of more than 10 pounds in 6 weeks.
- Infection with suspicion of an epidural abscess/discitis which may be evidenced by progressive neurological deficits, or fever of 100.4 for more than 48 hours, and C- reactive protein >10 mg/L, or recent (within 2 weeks) interventional spine procedures, or ESR >20 mm/hr, or immunocompromised (either immunodeficiency from any cause or IV drug abuse).
- Cauda equina syndrome which may be evidenced by bladder or bowel dysfunction, or saddle anesthesia, or progressive neurological deficits.

CMM-403.2: General Guidelines

The presence of a red flag condition does not preclude the certification for creation of lesion by neurolytic agent. Medical necessity must be met despite the presence of any red flag condition.

CMM-403.3: Indications

Creation of the initial lesion is considered **medically necessary** when all of the following are met:

- History, signs, and symptoms include both of the following:
  - Recurrent, severe, unilateral, shock-like pain in the forehead, and/or face, and/or jaw
  - There is a diagnosis of trigeminal neuralgia with evidence of consideration of alternative diagnoses
- Imaging which includes either of the following:
  - MRI demonstrates absence of an intra-cranial mass or multiple sclerosis
  - If multiple sclerosis, intracranial mass or other potentially causative condition is present, treatment in addition to percutaneous therapy has been planned or initiated
- Prior therapy which includes any of the following:
  - Neuropathic pain pharmacologic therapy with adequate dosing has been tried without adequate response

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- There is a recurrence of signs and symptoms after a period of response to Rx therapy
- There are contraindications to available pharmacologic therapies

- Planned treatment includes both of the following:
  - Imaging guidance with fluoroscopy or CT
  - Neurolytic method is thermal radiofrequency, glycerol, or alcohol

Creation of the second or subsequent lesion is considered **medically necessary** when all of the following are met:

- History, signs, and symptoms include all of the following:
  - Recurrent, severe, unilateral, shock-like pain in the forehead, and/or face, and/or jaw
  - There is a diagnosis of trigeminal neuralgia with evidence of consideration of alternative diagnoses
  - Previous neurolysis produced significant and durable pain relief
  - MRI at time of initial treatment demonstrated absence of an intra-cranial mass or multiple sclerosis
  - If multiple sclerosis, intracranial mass or other potentially causative condition is present, treatment in addition to percutaneous therapy has been prescribed
- Prior therapy includes both of the following:
  - There is a response of at least 6 months pain improvement after previous neurolysis
  - Neuropathic pain pharmacologic therapy with adequate dosing has been tried since recurrence of symptoms without adequate response or there are contraindications to available pharmacologic therapies
- Planned treatment includes both of the following:
  - Imaging guidance with fluoroscopy or CT
  - Neurolytic method is thermal radiofrequency, glycerol, or alcohol

CMM-403.4: Non-Indications

Creation of lesion by neurolytic agent is considered **not medically necessary** when performed without fluoroscopic or CT imaging guidance.

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CMM-403.5: 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 individual payor.

CPT®	Code Description/Definition
61790	Creation of Lesion by Stereotactic* Method, Percutaneous, by Neurolytic Agent (e.g., Alcohol, Thermal, Electrical, Radiofrequency); Gasserian Ganglion
61791	Creation of Lesion by Stereotactic* Method, Percutaneous, by Neurolytic Agent (e.g., Alcohol, Thermal, Electrical, Radiofrequency); Trigeminal Medullary Tract

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.

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CMM-404: Epidurography

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CMM-404.1: Definitions

Epidurography is radiography of the spine after a radiopaque medium has been injected into the epidural space. It is used as a diagnostic study to potentially find the source of pain in the spine that may not be evident on imaging studies (i.e., MRI/CT) and is designed to assist in making decisions for treatment of the patient. A separate report from another spinal procedure, such as an epidural steroid injection, is necessary. The report should include a formal radiologic report with all of the following:

- A diagnostic evaluation following the injection of contrast
- Permanent images in multiple planes of a specific anatomic region
- The degree of fluid flow (or lack thereof) in the epidural space with notation of scarring or nerve impingement or enlargement

Please note: An injection of contrast during an image guided epidural steroid injection is not an epidurogram.

CMM-404.2: General Guidelines

Epidurography (CPT®72275) includes fluoroscopic guidance, epidurogram, documentation of images, and a formal written report. These should not be submitted separately.

CMM-404.3: Indications

Epidurography for initial mapping of the epidural space is considered **medically necessary** when both of the following are met:

- Medical/surgical history suggests significantly abnormal anatomy of the epidural space
- Diagnostic mapping of anatomy of the epidural space beyond available CT or MRI imaging is required to plan a therapeutic procedure

Epidurography for subsequent mapping of the epidural space is considered **medically necessary** when all of the following are met:

- Medical/surgical history suggests significantly abnormal anatomy of the epidural space
- Diagnostic mapping of anatomy of the epidural space beyond available CT or MRI imaging is required to plan a therapeutic procedure
- Clinically significant change in anatomy since the initial procedure

CMM-404.4: Non-Indications

Epidurography for mapping of the epidural space is considered **not medically necessary** when used for determining needle placement during a procedure (e.g., epidural steroid injection).

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CMM-404.5: 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 individual payor.

CPT®	Code Description/Definition
72275	Epidurography, radiological supervision and interpretation

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.

CMM-404.6: Reference

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3. Saunders Comprehensive Veterinary Dictionary, 3 ed. © 2007 Elsevier, Inc.

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CMM-405: Spinal Fluoroscopy

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CMM-405.1: Definitions

Fluoroscopy is an imaging procedure using continuous X-ray image shown on a monitor for the purpose of locating anatomic structures.

CMM-405.2: General Guidelines

- A concomitant procedure needing the assistance of X-ray guidance must be documented as the primary procedure.
- The patient must have no contraindications for use of X-ray.
- Please note: this guideline only applies to fluoroscopically guided spinal procedures.

CMM-405.3: Indications

Fluoroscopic imaging guidance is considered **medically necessary** when all of the following are met:

- Performed with a spinal or paraspinal (adjacent to the spinal column) diagnostic or therapeutic injection procedure
- Placement of needle or catheter at the neural structure cannot be adequately performed without image guidance
- Imaging guidance is not included in the planned procedure(s)

CMM-405.4: Non-Indications

Separate submission of fluoroscopic imaging guidance when it is included in a planned procedure is considered **not medically necessary**.

CMM-405.5: 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 individual payor.

CPT®	Code Description/Definition
77003	Fluoroscopic Guidance and Localization of Needle or Catheter Tip for Spine or Paraspinous Diagnostic or Therapeutic Injection Procedures (Epidural or Subarachnoid) (List separately in addition to code for primary procedure)

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.

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CMM-406: Arthroscopy: Ankle

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CMM-406.1: 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.

CMM-406.2: General Guidelines

- Any of the following are considered red flag conditions for arthroscopically aided repair of the ankle (CPT®29892):
  - Septic arthritis of the ankle joint
  - Acute osteochondral injuries
  - Talus or tibia fracture with loose cartilage or bony fragment in the joint
  - Locked joint
- There are no red flag conditions for endoscopic plantar fasciotomy.
- Any of the following are considered red flag conditions for ankle arthroscopy:
  - Septic arthritis of the ankle joint
  - Acute osteochondral injuries (OCD) of the ankle joint
  - Talus, fibula, or tibia fracture with suspected loose cartilage or bony fragment in the ankle joint
  - Ankle joint dislocation
  - Locked joint
- Although imaging may often be normal, prior to ankle arthroscopy, radiographic imaging should be done to determine and rule out deformity, moderate arthritis, and/or severe arthritis. It should also be done to evaluate and confirm mild arthritis, OCD, talus fracture, ankle fracture, pilon fracture, and/or impingement, Os trigonum, or loose bodies. This radiographic imaging may include any or all of the following:
  - Ankle three view standing plain X-rays
    - Anteroposterior, lateral, and mortise
    - Stress views optional
  - MRI (almost always necessary to evaluate synovitis, OCD, fracture, instability/ligamentous injury, loose body, avascular necrosis)
  - Bone scan (used to determine inflammation)
  - CT scan (used to asses fractures, loose bodies, OCD)

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CMM-406.3: Indications

Arthroscopically aided repair of the ankle (CPT®29892) for osteochondritis dissecans lesion, talar dome fracture, or tibial plafond fracture is considered **medically necessary** when all of the following are met:

- Subjective symptoms including any of the following:
  - Painful ankle joint
  - Joint swelling
  - Soft-tissue swelling
  - Stiffness
  - Catching, locking
- Objective findings on physical examination including any of the following:
  - Tenderness
  - Limited ROM of ankle
  - Joint effusion or soft-tissue swelling
- Imaging results showing either of the following:
  - X-ray reveals osteochondral lesion/fracture of talar dome or tibial plafond fracture
  - CT or MRI demonstrates osteochondral lesion of talar dome or tibial plafond fracture
- Less than clinically meaningful improvement with conservative treatment including any of the following for at least 6 weeks:
  - Self-care consisting of rest, ice, and/or heat
  - Activity modifications (e.g., restriction of athletic pursuits and avoidance of symptomatic motion)
  - NSAIDS
  - Brace/cast usage

Endoscopic plantar fasciotomy for recalcitrant plantar fasciitis is considered **medically necessary** when all of the following are met:

- Subjective symptoms including any of the following:
  - Chronic heel pain made worse with continued weight bearing
  - Heel pain increased with the first few steps in the morning
  - Non-radiating heel pain
- Objective findings including tenderness in the area of the medial tubercle of calcaneous
- Imaging results showing either of the following:
  - MRI demonstrates fascial thickening and increased signal intensity in the substance of the plantar fascia
  - Ultrasound demonstrates thickened hypoechoic fascia
- Less than clinically meaningful improvement with conservative treatment including any of the following for at least 6 weeks:
  - Self-care consisting of rest, ice, and/or heat

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- Activity modifications (e.g., restriction of athletic pursuits and avoidance of symptomatic motion)
- Physical therapy and/or exercises
- NSAIDs
- Use of heel padding or custom orthosis
- Plantar fascia corticosteroid injection unless contraindicated (e.g., patient refuses corticosteroid injection, patient is diabetic, etc.)

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

- Subjective symptoms including any of the following:
  - History of mechanical symptoms (e.g., locking, catching, giving way)
  - Pain in the ankle joint
  - Pain in the ankle joint that worsens with walking
  - Limited range of motion or stiffness
  - Swelling in the ankle joint
  - Swelling in the soft tissues surrounding the ankle joint
- Objective findings including any of the following:
  - Positive joint line tenderness
  - Limited range of motion compared to the contralateral ankle joint
  - Positive ankle instability during the exam with the tilt test or the anterior drawer test
  - Deformity of the ankle joint
  - Callosity or ulceration of the foot
  - Positive anterior or posterior impingement signs during the exam as evidenced by pain or limited range of motion with dorsiflexion or plantar flexion
  - Visible and palpable effusion
- Imaging results are inconclusive (refer to **CMM-406.2: 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:
    - Activity modification
    - Rest, ice, and/or heat
    - NSAIDs, as allowed by allowed by medical comorbidities
  - Bracing, over the counter or custom for a minimum of 3 months
  - Walker boot for a minimum of 1-2 months

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CMM-406.4: Non-Indications

- Arthroscopically aided repair of the ankle is considered **not medically necessary** when any of the following contraindications to endoscopic plantar fasciotomy is 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
  - Peripheral vascular disease
  - The patient is unable to comply with weight-bearing restrictions
- Endoscopic plantar fasciotomy is considered **not medically necessary** when the contraindication of infection is present.
- Elective ankle arthroscopy is considered **not medically necessary** when any of the following contraindications are present:
  - Peripheral vascular disease
  - Poor soft tissues
  - Uncontrolled medical co-morbidities
  - The patient is unable to comply with weight-bearing restrictions

CMM-406.5: 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 individual payor.

CPT®	Code Description/Definition
29892	Arthroscopically aided repair of large osteochondritis dissecans lesion, talar dome fracture, or tibial plafond fracture, with or without internal fixation (includes arthroscopy)
29893	Endoscopic plantar fasciotomy
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
29891	Arthroscopy, ankle, surgical microfracture
29899	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; with ankle arthrodesis

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.

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CMM-407: Arthroscopy: Subtalar Joint

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CMM-407.1: 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.

CMM-407.2: 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

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CMM-407.3: 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-407.2: 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.)

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CMM-407.4: 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

CMM-407.5: 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

CPT®	Code Description/Definition
29904	Arthroscopy, subtalar joint, surgical; with removal of loose body or foreign body
29905	Arthroscopy, subtalar joint, surgical; with synovectomy
29906	Arthroscopy, subtalar joint, surgical; with debridement
29907	Arthroscopy, subtalar joint, surgical; with subtalar arthrodesis

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.

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