

# Surgery of the Ankle (for Kentucky Only)

**Policy Number:** CS340KY.10  
**Effective Date:** March 1, 2026

[Instructions for Use](#)

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| Related Policy  |
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## Application

This Medical Policy only applies to the state of Kentucky.

## Coverage Rationale

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

- Arthrodesis, Ankle (Talotibial Joint)
- Arthroscopy, Surgical, Ankle
- Arthrotomy, Ankle
- Total Joint Replacement (TJR), Ankle

[Click here to view the InterQual® criteria.](#)

## Medical Records Documentation Used for Reviews

Benefit coverage for health services is determined by the federal, state, or contractual requirements, and applicable laws that may require coverage for a specific service. Medical records documentation may be required to assess whether the member meets the clinical criteria for coverage but does not guarantee coverage of the services requested.

The patient's medical record must contain documentation that fully supports the medical necessity for the requested services. This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures. Documentation supporting the medical necessity should be legible, maintained in the patient's medical record, and must be made available upon request.

## 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 federal, state, or contractual requirements 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 and Guidelines may apply.

| CPT Code                                     | Description  |
|--|--|
| <b>Arthrotomy, Ankle</b>                     |  |
| 27685  | Lengthening or shortening of tendon, leg or ankle; single tendon (separate procedure)  |
| 28446  | Open osteochondral autograft, talus (includes obtaining graft[s])  |
| <b>Total Joint Replacement (TJR), Ankle</b>  |  |
| 27702  | Arthroplasty, ankle; with implant (total ankle)  |
| <b>Arthroscopy, Surgical, Ankle</b>          |  |
| 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   |
| <b>Arthrodesis, Ankle (Talotibial Joint)</b> |  |
| 29899  | Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; with ankle arthrodesis   |

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## 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. Refer to the following website for additional information: <http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm>. (Accessed February 19, 2025)

## Policy History/Revision Information

| Date       | Summary of Changes   |
|------------|--|
| 03/01/2026 | <p><b>Coverage Rationale</b></p> <ul style="list-style-type: none"> <li>Revised language pertaining to medical necessity clinical coverage criteria; removed reference to the InterQual® Client Defined, CP: Procedures: <ul style="list-style-type: none"> <li>Arthroplasty, Ankle (Without Implant) (Custom) - UHG</li> <li>Arthroplasty, Removal or Revision, Ankle (Custom) - UHG</li> </ul> </li> <li>Removed language indicating osteochondral allograft or autograft transplantation is unproven and not medically necessary for treating cartilage defects of the ankle due to insufficient evidence of efficacy</li> </ul> <p><b>Medical Records Documentation Used for Reviews</b></p> <ul style="list-style-type: none"> <li>Added language to indicate: <ul style="list-style-type: none"> <li>Benefit coverage for health services is determined by the federal, state, or contractual requirements, and applicable laws that may require coverage for a specific service</li> <li>Medical records documentation may be required to assess whether the member meets the clinical criteria for coverage but does not guarantee coverage of the services requested</li> <li>The patient's medical record must contain documentation that fully supports the medical necessity for the requested services</li> <li>This documentation includes but is not limited to relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures</li> <li>Documentation supporting the medical necessity should be legible, maintained in the patient's medical record, and must be made available upon request</li> </ul> </li> </ul> |

| Date | Summary of Changes  |
|------|---|
|      | <p><b>Applicable Codes</b></p> <ul style="list-style-type: none"> <li>• Removed CPT codes: <ul style="list-style-type: none"> <li><b><i>Arthrotomy, Ankle</i></b> <ul style="list-style-type: none"> <li>○ 28899</li> </ul> </li> <li><b><i>Total Joint Replacement (TJR), Ankle</i></b> <ul style="list-style-type: none"> <li>○ 27700, 27703, and 27704</li> </ul> </li> </ul> </li> </ul> <p><b>Supporting Information</b></p> <ul style="list-style-type: none"> <li>• Removed <i>Description of Services, Clinical Evidence, and References</i> sections</li> <li>• Archived previous policy version CS340KY.09</li> </ul> |

## Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state, or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state, or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state, or contractual requirements for benefit plan coverage govern. Before using this policy, check the federal, state, or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare uses InterQual® for the primary medical/surgical criteria, and the American Society of Addiction Medicine (ASAM) for substance use, in administering health benefits. If InterQual® does not have applicable criteria, UnitedHealthcare may also use UnitedHealthcare Medical Policies, Coverage Determination Guidelines, and/or Utilization Review Guidelines that have been approved by the Kentucky Department for Medicaid Services. The UnitedHealthcare Medical Policies, Coverage Determination Guidelines, and Utilization Review Guidelines 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.