Medical Policy

Blue Cross Blue Shield Blue Care Network of Michigan

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***Current Policy Effective Date: 1/1/23**
(See policy history boxes for previous effective dates)

Title: Subtalar Arthroereisis

Description/Background

Arthroereisis is a surgical procedure that purposely limits movement across a joint. Subtalar arthroereisis (STA) or extraosseous talotarsal stabilization is designed to correct excessive talar displacement and calcaneal eversion by reducing pronation across the subtalar joint. Extraosseous talotarsal stabilization is also being evaluated as a treatment of talotarsal joint dislocation. It is performed by placing an implant in the sinus tarsi, which is a canal located between the talus and the calcaneus.

FLATFOOT

Flexible flatfoot is a common disorder, anatomically described as excessive pronation during weight bearing due to anterior and medial displacement of the talus. It may be congenital in nature or it may be acquired in adulthood due to posterior tibial tendon dysfunction, which in turn may be caused by trauma, overuse, and inflammatory disorders, among others. Symptoms include dull, aching and throbbing, cramping pain, which in children may be described as growing pains. Additional symptoms include refusal to participate in athletics or walking long distances.

Treatment

Conservative treatments include orthotics or shoe modifications. Surgical approaches for painful flatfoot deformities include tendon transfers, osteotomy and arthrodesis. Arthroereisis with a variety of implant designs has also been investigated.

Subtalar arthroereisis (STA) has been performed for more than 50 years, with a variety of implant designs and compositions. The Maxwell-Brancheau Arthroereisis (MBA) implant is the most frequently reported, although other devices such as the HyProCure, STA peg and Kalix are also described in the medical literature. The MBA implant is described as reversible and easy to insert, with the additional advantage that it does not require bone cement. In children,

insertion of the MBA implant may be offered as a stand-alone procedure, although children and adults often require adjunctive surgical procedures on bone and soft tissue to correct additional deformities.

Regulatory Status

A number of implants have been cleared for marketing by the U.S. Food and Drug Administration's (FDA) through the 510(k) process, a sampling of which are summarized in Table 1. In general, these devices are indicated for insertion into the sinus tarsi of the foot, allowing normal subtalar joint motion while blocking excessive pronation. FDA Product Code: HWC.

Table 1. Representative Subtalar Implant Devices Cleared by U.S. Food and Drug Administration[a]

Device	510(k) No	Manufacturer	Date Cleared
Subtalar MBA®	Integra LifeSciences	07/96	K960692
OsteoMed Subtalar Implant System	OsteoMed	08/03	K031155
BioPro Subtalar Implant	BioPro	09/04	K041936
HyProCure Subtalar Implant System	Graham Medical Technologies	09/04	K042030
MBA Resorb Implant	Kinetikos Medical	09/05	K051611
Metasurg Subtalar Implant	Metasurg	05/07	K070441
Subtalar Implant Biomet	Sports Medicine	07/07	K071498
Arthrex ProStop Plus Arthroereisis Subtalar Implant	Arthrex	01/08	K071456
Trilliant Surgical Subtalar Implant	Trilliant Surgical	02/11	K103183
Metasurg Subtalar Implant	Metasurg	08/11	K111265
NuGait™ Subtalar Implant System	Ascension Orthopedic	08/11	K111799
Disco Subtalar Implant	Trilliant Surgical	12/11	K111834
OsteoSpring FootJack Subtalar Implant System	OsteoSpring Medical	12/11	K112658
IFS Subtalar Implant	Internal Fixation Systems	12/11	K113399
The Life Spine Subtalar Implant System	Life Spine	06/16	K160169

[a] FDA 510(k) database search product code HWC (03/08/18)

Medical Policy Statement

Subtalar arthroereisis is considered experimental/investigational. It has not been scientifically demonstrated to be an effective treatment for the condition of flexible flatfoot.

Inclusionary and Exclusionary Guidelines (Clinically based guidelines that may support individual consideration and pre-authorization decisions)

N/A

CPT/HCPCS Level II Codes *(Note: The inclusion of a code in this list is not a guarantee of coverage. Please refer to the medical policy statement to determine the status of a given procedure.)*

Established codes:

N/A

Other codes (investigational, not medically necessary, etc.):

S2117 28899 0335T 0510T 0511T

Rationale

Clinical Context and Therapy Purpose
The purpose of subtalar arthroereisis (STA)in patients who have flatfoot is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The question addressed in this evidence review is: does STA improve the net health outcome in patients with flatfoot?

The following PICOs were used to select literature to inform this review.

Populations
The relevant population of interest is individuals with flatfoot.

Flexible flatfoot is a common disorder, anatomically described as excessive pronation during weight-bearing due to anterior and medial displacement of the talus. It may be congenital, or it may be acquired in adulthood due to posterior tibial tendon dysfunction, which in turn may be caused by trauma, overuse, inflammatory disorders, and other factors. Symptoms include dull, aching and throbbing, cramping pain, which in children may be described as growing pains. Additional symptoms include refusal to participate in athletics or walking long distances.

Interventions
The therapy being considered is subtalar arthroereisis (STA).

Arthroereisis is a surgical procedure that limits movement across a joint. STA (also called extraosseous talotarsal stabilization) is designed to correct excessive talar displacement and calcaneal eversion by reducing pronation across the subtalar joint. The stabilization procedure is performed by placing an implant in the sinus tarsi, which is a canal located between the talus and the calcaneus.

Comparators
Surgical approaches for painful flatfoot deformities include tendon transfers, osteotomy, and arthrodesis. Conservative treatments include orthotics or shoe modifications.

Outcomes
The outcomes of interest are symptoms, functional outcomes, and quality of life. The average length of follow-up was 18 to 24 months.

Study Selection Criteria
Methodologically credible studies were selected using the following principles:

- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;
- In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
- To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
- Studies with duplicative or overlapping populations were excluded.

Review of Evidence
Literature searches on STA have identified few published studies, primarily consisting of single-institution case series and individual case reports, reporting on success rates following this procedure. There is a small-controlled trial that has compared STA with alternative treatments.

Chong et al (2015) reported a small prospective nonrandomized trial that compared STA with lateral column calcaneal lengthening for the treatment of 24 painful flatfeet in children.(1) Seven children (13 feet) enrolled at a children's medical center were treated with arthroereisis and 8 children (11 feet) enrolled at another children's hospital were treated with lateral column lengthening. Children who underwent STA received a subdermal implant and were placed in below-knee walking casts for 3 weeks. Children treated with lateral column lengthening had an opening wedge osteotomy with insertion of a wedge of cadaveric bone and were placed in non-weight-bearing casts for 1 month and "walker boots" for another month. Outcomes at a mean of 12.7 months after surgery included radiographs, foot pressure, kinematic analysis and the Oxford Ankle-Foot Questionnaire for Children. The two groups showed similar improvements in the lateral talo-first metatarsal angle and talonavicular coverage and in kinematics. Both groups showed a statistically significant lateralization of the hindfoot and midfoot center of pressure ($p<0.01$). There were no between-group differences in any of the clinical or functional outcomes. On within-group comparison, only the STA group had a statistically significant reduction in time on the hindfoot ($p=0.01$). Both groups had improvements in the parental and child scores on the Oxford questionnaire, but only the STA group had a statistically significant improvement in this small sample. There were 2 complications in each group, with removal of the hardware in 1 patient and removal of the implant in 2 patients. The improvement in pain and foot position was retained following implant removal.

Case Series and Reports
Metcalfe et al (2011) published a systematic review of the literature on STA for pediatric flexible flatfoot.(2) Seventy-six case series or case reports (none controlled) were identified. Ten of the studies (756 feet) provided clinician-based assessment of the surgical result graded from "excellent to poor" with follow-up between 36 and 240 months. Six studies (212 feet) included estimates of overall patient satisfaction using non-validated outcome measures, while one study (16 feet) found significant improvement using a validated foot-specific patient outcome measure. Data from 15 studies that reported radiographic values were combined for

analysis. Although 8 of 9 radiographic parameters showed statistically significant improvements following arthroereisis procedures, the relationship between radiographic and clinical outcomes is uncertain. The procedure was associated with a number of complications including sinus tarsi pain, device extrusion, and under correction. Complication rates ranged from 4.8% to 18.6%, with unplanned removal rates between 7.1% and 19.3% across all device types. The influence of adjunctive procedures on outcomes was not addressed in this review.

Graham et al (2012) published a case series that was not confounded by adjunctive procedures and that had a relatively long follow-up.(3) This study reported mean 51-month follow-up of talotarsal stabilization in 117 feet using the HyProCure device. Patients who received adjunctive procedures affecting the talotarsal joint were excluded from the analysis. Adult patients who met the inclusion/exclusion criteria were invited to participate in the study. Eighty-three patients gave consent to participate, and 78 completed the Maryland Foot Score Questionnaire; 5 patients did not complete the questionnaire because they had seven implants (6%) removed. There were 16 revision surgeries with HyProCure; 9 of the surgeries called for the repositioning of a partially displaced device or a change in size of the device altogether. Of the patients who retained the device, 52% reported complete alleviation of foot pain, 69% had no limitations in their foot functional abilities, and 80% reported complete satisfaction with the appearance of their feet. This case series is notable for its assessment of functional outcomes at medium-term follow-up in patients who did not have adjunct procedures.

Other case series have generally not excluded the use of other adjunctive treatments. For example, Vedantam et al (1998) reported on a series of 78 children (140 feet) with neuromuscular disease who underwent STA with an STA-peg.(4) The stem of this implant is placed into the calcaneous with the collar abutting the inferior surface of the lateral aspect of the talus, thus limiting motion. All but 5 of the children had additional procedures to balance the foot. Satisfactory results were reported in 96.4% of patients, although the contribution of the STA-peg cannot be isolated. In 2004, Nelson et al (2004) reported on 37 patients (67 feet) who underwent Maxwell-Brancheau Arthroereisis (MBA) implant with an average of 18.4 months of follow-up.(5) While this study reported various improvements in anatomic measurements, there were no data on improvement in symptoms. In another series, Needleman (2006) reported significant improvements in pain and function in 78% of patients (23 patients, 28 feet) with use of a subtalar implant as a component of reconstructive foot and ankle surgery.(6) However, because results were not compared with controls receiving reconstructive surgery without STA, the contribution of the implants to these outcomes is unclear. Also, Needleman (2006) reported an overall complication rate of 46%, with surgical removal of 39% of the implants due to sinus tarsi pain. The authors also commented that postoperative sinus tarsi pain was unpredictable.

Cicchinelli et al (2008) reported on radiographic outcomes in a retrospective analysis of 28 feet in 20 pediatric patients treated with STA combined with gastrocnemius recession or with STA combined with gastrocnemius recession and medial column reconstruction.(7) Lucaccini et al (2008) analyzed clinical and radiographic results of 14 patients (16 feet) with hallux valgus in abnormal pronation syndrome treated with distal osteotomy of the first metatarsal bone and STA performed in one stage.(8) In a 2010 study, Scharer et al conducted a retrospective radiographic evaluation of 39 patients (68 feet) who received the MBA implant to treat painful pediatric flatfoot deformities.(9) The patients' average age of the patients at the time of surgery was 12 years (range: 6-16 years). Additional procedures included 12 (18%) gastrocnemius recessions, 6 (9%) Achilles tendon lengthening, and 4 (6%) Kidner procedures. At an average

24-month follow-up (range: 6-61 months), there were 10 (15%) complications requiring reoperation, including implant migration, under correction, overcorrection, and persistent pain. The implants were exchanged for a larger or a smaller implant. None of these case series permitted comparison with nonsurgical interventions or with other surgical interventions.

An example of a case series with longer follow-up is the retrospective study by Brancheau et al (2012), which reported mean 36-month follow-up (range 18 to 48 months) in 35 patients (60 feet) after use of the Maxwell-Brancheau Arthroereisis (MBA) implant with adjunct procedures.(10) The patients' mean age was 14.3 years (range, 5-46 years). Significant changes were observed in radiographic measures (talocalcaneal angle, calcaneocuboid angle, first to second intermetatarsal angle, calcaneal inclination angle, and talar declination angle). Seventeen percent of patients reported that 9 implants (15%) were removed after the initial surgery. Of the 24 patients (68.6%) who answered a subjective questionnaire (in person or by telephone at a mean of 33 months postoperatively), 95.8% reported resolution of the chief presenting complaint, and 79.2% said they were 100% satisfied with their surgical outcome. The contribution of the MBA implant to these results cannot be determined by this study design.

Section Summary: Flatfoot
The evidence evaluating the use of STA for treatment of flatfoot consists mainly of single-arm case series and a small nonrandomized controlled trial comparing STA with lateral column calcaneal lengthening. The small nonrandomized comparative trial (n=24 feet) is considered preliminary, and interpretation of the case series evidence is limited by the use of adjunctive procedures in addition to STA, creating difficulties in determining the extent to which each modality contributed to the outcomes. Another limitation of the published data is the lack of long-term outcomes, which is of particular importance because the procedure is often performed in growing children. Also, some studies have reported high rates of complications and implant removal.

TALOTARSAL JOINT DISLOCATION

Clinical Context and Therapy Purpose
The purpose of subtalar arthroereisis in patients who have talotarsal joint dislocation is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The question addressed in this evidence review is: Does subtalar arthroereisis improve the net health outcome in patients with talotarsal joint dislocation?

The following PICO was used to select literature to inform this review.

Populations
The relevant population of interest is individuals with talotarsal joint dislocation.

Talotarsal joint dislocation means that the joint surfaces of the talus are abnormally aligned on the heel and/or navicular bones

Interventions
The therapy being considered is subtalar arthroereisis.

Arthroereisis is a surgical procedure that limits movement across a joint. Subtalar arthroereisis (also called extraosseous talotarsal stabilization) is designed to correct excessive talar displacement and calcaneal eversion by reducing pronation across the subtalar joint. The stabilization procedure is performed by placing an implant in the sinus tarsi, which is a canal located between the talus and the calcaneus.

Comparators
Alternative surgical approaches for talotarsal joint dislocation.

Outcomes
The outcomes of interest are symptoms, functional outcomes, and quality of life. The follow-up was up to one year.

Study Selection Criteria
Methodologically credible studies were selected using the following principles:

- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;
- In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
- To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
- Studies with duplicative or overlapping populations were excluded.

Review of Evidence
Bresnahan et al (2013) reported a prospective study of talotarsal stabilization using HyProCure® in 46 feet of 35 patients diagnosed with recurrent and/or partial talotarsal joint dislocation.(11) No procedures besides insertion of the HyProCure® device were performed to address the talotarsal joint dislocation. At one year postoperatively, scores on the Maryland Foot Score (/100) for 30 patients had improved from 69.53 preoperatively to 89.27 postoperative. Foot pain decreased by 37.0%, foot functional activities improved by 14.4%, and foot appearance improved by 29.5%. Implants were removed from 2 feet with no unresolved complications.

Section Summary: Talotarsal Joint Dislocation
The evidence evaluating the use of subtalar arthroereisis for treatment of talotarsal joint dislocation consists of 1 prospective single arm study of talotarsal stabilization using HyProCure. Although improvements in pain and function were observed, Current evidence on the use of STA for treatment of talotarsal joint dislocation is insufficient to draw conclusions about treatment efficacy with certitude.

ADVERSE EVENTS
Complications are frequently reported in the literature. Scher et al (2007) reported on 2 cases of extensive implant reaction in 2 children 2 years after a STA-peg procedure.(12) Due to the commonly seen complication of severe postoperative pain with failure to reconstitute the longitudinal arch on weight bearing and a residual flatfoot deformity, the authors do not recommend subtalar arthroereisis in the treatment of painful flatfoot in children. A radiographic study (2007) on a bioabsorbable STA found poor outcomes in 3 of 6 patients who met the inclusion criteria and consented to additional imaging.(13) Two patients requested implant removal; a third patient had persistent pain but refused explantation. Radiographic

measurement (magnetic resonance imaging or computed tomography) found that these 3 patients had smaller tarsal canal widths than the diameter of the inserted interference screw. The authors noted that the implant length also had to be reduced before implantation.

Cook et al (2011) conducted a retrospective case-control study to identify factors that may contribute to failure (explantation) of titanium arthroereisis implants.(14) All patients who required removal of a self-locking wedge-type subtalar arthroereisis (n=22) were compared in a 1:2 ratio (n=44) with patients with non-explanted arthroereisis who were treated during the same time period. Subjects were matched for preoperative radiographic measurements, age, sex, presenting diagnosis, and length of follow-up. Multivariate logistic regression showed no significant effect of age, gender, implant size, shape, length of follow-up, implant position, surgeon experience, or concomitant procedures. Patients who required explantation had slightly greater odds of radiographic under correction (odds ratio, 1.175) or residual transverse plane-dominant deformities (odds ratio, 1.096). The percentage of explantations in this retrospective analysis was not described.

SUMMARY OF EVIDENCE

For individuals who have flatfoot who receive STA, the evidence includes mainly single-arm case series and a small nonrandomized controlled trial comparing STA with lateral column calcaneal lengthening. Relevant outcomes are symptoms, functional outcomes, and quality of life. The small nonrandomized comparative trial (n=24 feet) is considered preliminary, and interpretation of the case series evidence is limited by the use of adjunctive procedures in addition to STA, creating difficulties in determining the extent to which each modality contributed to the outcomes. Another limitation of the published data is the lack of long-term outcomes, which is of particular importance because the procedure is often performed in growing children. In addition, some studies have reported high rates of complications and implant removal. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have talotarsal joint dislocation who receive subtalar arthroereisis, the evidence consists of 1 prospective single arm study of talotarsal stabilization using HyProCure. Relevant outcomes are symptoms, functional outcomes, and quality of life. Although improvements in pain and function were observed, the current evidence on the use of subtalar arthroereisis for treatment of talotarsal joint dislocation is insufficient to draw conclusions about treatment efficacy with certitude. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Supplemental Information

CLINICAL INPUT RECEIVED THROUGH PHYSICIAN SPECIALTY SOCIETIES AND ACADEMIC MEDICAL CENTERS

While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

2012 Input
In response to requests, BCBSA received input from two physician specialty societies and two academic medical centers while this policy was under review in 2012. Input was mixed, with most reviewers considering this procedure to be investigational.

2009 Input
In response to requests, BCBSA received input from one physician specialty society (three reviews) and five academic medical centers while this policy was under review in 2009. The input of reviewers was mixed regarding the medical necessity of arthroereisis.

PRACTICE GUIDELINES AND POSITION STATEMENTS

National Institute for Health and Care Excellence
Guidance from the National Institute for Health and Care Excellence (2009) concluded that current evidence on the safety and efficacy of sinus tarsi implant insertion for mobile flatfoot was inadequate in quality and quantity.(15)

American College of Foot and Ankle Surgeons
The American College of Foot and Ankle Surgeons (ACFAS; 2004) published practice guidelines for the diagnosis and treatment of adult and pediatric flatfoot (neither is included in the ACFAS library of current clinical practice guidelines).(16,17)

The ACFAS guideline on adult flatfoot have stated:

> "In the adult, arthroereisis is seldom implemented as an isolated procedure. Because of the long-term compensation and adaptation of the foot and adjunctive structures for flatfoot function, other ancillary procedures are usually used for appropriate stabilization. Long-term results of arthroereisis in the adult flexible flatfoot patient have not been established. Some surgeons advise against the subtalar arthroereisis procedure because of the risks associated with implantation of a foreign material, the potential need for further surgery to remove the implant, and the limited capacity of the implant to stabilize the medial column sag directly."

The ACFAS guidelines on pediatric flatfoot have stated: "proponents of this procedure (arthroereisis) argue that it is a minimally invasive technique that does not distort the normal anatomy of the foot. Others have expressed concern about placing a permanent foreign body into a mobile segment of a child's foot. The indication for this procedure remains controversial in the surgical community."

Piraino et al (2020) published the following Clinical Consensus Statement on the appropriate clinical management of adult-acquired flatfoot deformity: "Subtalar arthroereisis should not be considered as a single corrective procedure for stage IIB AAFD [adult flatfoot]."(18)

U.S. PREVENTIVE SERVICES TASK FORCE RECOMMENDATIONS
Not applicable.

Government Regulations

National:

Consultation Services Rendered by a Podiatrist in a Skilled Nursing Facility (70.2). Pub 100-3; version 1; Manual section number 70.2. Effective date: Longstanding – date has not been posted.

Section 1862(a)(13) of the Act excludes payment for the treatment of FLAT FOOT conditions, the treatment of subluxations of the foot, and routine foot care.

Local:

There is no local coverage determination for subtalar arthroereisis.

(The above Medicare information is current as of the review date for this policy. However, the coverage issues and policies maintained by the Centers for Medicare & Medicare Services [CMS, formerly HCFA] are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. For the most current information, the reader should contact an official Medicare source.)

Related Policies

N/A

References

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7. Cicchinelli LD, Pascual Huerta J, Garcia Carmona FJ et al. Analysis of gastrocnemius recession and medial column procedures as adjuncts in arthroereisis for the correction of pediatric pes planovalgus: a radiographic retrospective study. J Foot Ankle Surg 2008; 47(5):385-91.

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9. Scharer BM, Black BE, Sockrider N. Treatment of painful pediatric flatfoot with Maxwell-Brancheau subtalar arthroereisis implant a retrospective radiographic review. Foot Ankle Spec 2010; 3(2):67-72.
10. Brancheau SP, Walker KM, Northcutt DR. An analysis of outcomes after use of the Maxwell- Brancheau Arthroereisis implant. J Foot Ankle Surg 2012; 51(1):3-8.
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12. Scher DM, Bansal M, Handler-Matasar S et al. Extensive implant reaction in failed subtalar joint arthroereisis: report of two cases. HSS J 2007; 3(2):177-81.
13. Saxena A, Nguyen A. Preliminary radiographic findings and sizing implications on patients undergoing bioabsorbable subtalar arthroereisis. J Foot Ankle Surg 2007; 46(3):175-80.
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16. Harris EJ, Vanore JV, Thomas JL et al. Clinical Practice Guideline Pediatric Flatfoot Panel: American College of Foot and Ankle Surgeons (ACFAS). Diagnosis and treatment of pediatric flatfoot. J Foot Ankle Surg 2004; 43(6):341-73.
17. Lee MS, Vanore JV, Thomas JL et al. Clinical Practice Guideline Adult Flatfoot Panel: American College of Foot and Ankle Surgeons (ACFAS). Diagnosis and treatment of adult flatfoot. J Foot Ankle Surg 2005; 44(2):78-113.
18. Piraino JA, Theodoulou MH, Ortiz J, et al. American College of Foot and Ankle Surgeons Clinical Consensus Statement: Appropriate Clinical Management of Adult-Acquired Flatfoot Deformity. J Foot Ankle Surg. Mar 2020; 59(2): 347-355. PMID 32131002

The articles reviewed in this research include those obtained in an Internet based literature search for relevant medical references through 7/22/22, the date the research was completed.

Joint BCBSM/BCN Medical Policy History

Policy Effective Date	BCBSM Signature Date	BCN Signature Date	Comments
5/1/09	3/12/09	2/10/09	Joint medical policy established
9/1/10	6/15/10	6/29/10	Routine maintenance
7/1/12	4/10/12	5/18/12	Routine maintenance
3/1/14	12/10/13	1/6/14	Routine maintenance; added CPT code 0335T
5/1/15	2/17/15	2/27/15	Routine maintenance
7/1/16	4/19/16	4/19/16	Routine maintenance
1/1/17	10/11/16	10/11/16	Routine maintenance
1/1/18	10/19/17	10/19/17	Routine maintenance
1/1/19	10/16/18	10/16/18	Routine maintenance; added CPT 0510T and 0511T; revised 0335T
1/1/20	10/15/19		Routine maintenance
1/1/21	10/20/20		Routine maintenance
1/1/22	10/19/21		Routine maintenance
1/1/23	10/18/22		Routine maintenance (slp)

Next Review Date: 4th Qtr, 2023

BLUE CARE NETWORK BENEFIT COVERAGE
POLICY: SUBTALAR ARTHROEREISIS

I. Coverage Determination:

Commercial HMO (includes Self-Funded groups unless otherwise specified)	Non-covered.
BCNA (Medicare Advantage)	Refer to the Medicare information under the Government Regulations section of this policy.
BCN65 (Medicare Complementary)	Coinsurance covered if primary Medicare covers the service.

II. Administrative Guidelines:

- The member's contract must be active at the time the service is rendered.
- Coverage is based on each member's certificate and is not guaranteed. Please consult the individual member's certificate for details. Additional information regarding coverage or benefits may also be obtained through customer or provider inquiry services at BCN.
- The service must be authorized by the member's PCP except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Services must be performed by a BCN-contracted provider, if available, except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Payment is based on BCN payment rules, individual certificate and certificate riders.
- Appropriate copayments will apply. Refer to certificate and applicable riders for detailed information.
- CPT - HCPCS codes are used for descriptive purposes only and are not a guarantee of coverage.