Sentara Health Plans

Medicaid

Total Ankle Replacement, Surgical 96

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Effective Date	10/1/2026
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Coverage Policy	Surgical 96
Version	7

All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*.

Description & Definitions:

Total Ankle Replacement (TAR) is a surgical repair removal of the ankle joint and bones and replacement with a Federal Drug Administration (FDA) approved prosthetic device. The implanted device replaces the damaged articulating surfaces of the shin (tibia) and ankle (talus) bones.

Other names: arthroplasty, Revision, implanted device, total ankle arthroplasty (TAA)

Criteria:

Total ankle replacement or revision is considered medical necessary with **1 or more** of the following:

- **Replacement** with **ALL** of the following:
  - Individual is 18 years old or greater and thus is considered skeletally mature
  - Individual has ankle pain that significantly limits daily activity
  - Device to be implanted is approved by the Federal Drug Administration (FDA)
  - Individual has tried and failed at least 6 months of conservative treatment (e.g. Anti-inflammatory medication, physical therapy, splints, orthotic devices, etc.)
  - Individual must have sufficient lower extremity vascular perfusion
  - Individual has **1 or more** of the following conditions:
    - Arthritis in adjacent joints (subtalar or midfoot)
    - Arthrodesis of the contralateral ankle (other ankle)
    - Inflammatory arthritis (rheumatoid)
    - Severe arthritis of the contralateral ankle (other ankle)

- **Revision** of an already implanted device is considered medically necessary with **ALL** of the following:
  - The already implanted device has failed
  - Individual is 18 years old or greater and thus is considered skeletally mature
  - Individual has ankle pain that significantly limits daily activity

- Device to be implanted is approved by the Federal Drug Administration (FDA)
- Individual has tried and failed at least 6 months of conservative treatment (e.g. Anti-inflammatory medication, physical therapy, splints, orthotic devices, etc.)
- Individual must have sufficient lower extremity vascular perfusion
- Individual has **1 or more** of the following conditions:
  - Arthritis in adjacent joints (subtalar or midfoot)
  - Arthrodesis of the contralateral ankle (other ankle)
  - Inflammatory arthritis (rheumatoid)
  - Severe arthritis of the contralateral ankle (other ankle)

Total ankle replacement or revisions are considered **not medically necessary** for any use other than those indicated in clinical criteria.

Document History:

Revised Dates:

- 2022: June
- 2020: January
- 2015: April
- 2014: April
- 2013: April
- 2011: October

Reviewed Dates:

- 2026: June – Annual review. Implementation date of October 1, 2026. No changes to policy.
- 2025: June - Implementation date of September 1, 2025. No changes, references updated.
- 2024: June - no changes references updated
- 2023: June
- 2021: September
- 2020: September
- 2019: September
- 2018: March
- 2017: January
- 2012: April
- 2010: December

Origination Date: January 2011

Coding:

Medically necessary with criteria:

Coding	Description
27702	Arthroplasty, ankle; with implant (total ankle)
27703	Arthroplasty, ankle; revision, total ankle
27704	Removal of ankle implant

Considered Not Medically Necessary:

Coding	Description
	None

U.S. Food and Drug Administration (FDA) - approved only products only.

The preceding codes are included above for informational purposes only and may not be all inclusive. Additionally, inclusion or exclusion of a treatment, procedure, or device code(s) does not constitute or imply member coverage or provider reimbursement.

Special Notes: *

- Coverage:
  - See the appropriate benefit document for specific coverage determination. Member specific benefits take precedence over medical policy.
- Application to products:
  - Policy is applicable to Sentara Health Plan Virginia Medicaid products.
- Authorization requirements:
  - Pre-certification by the Plan is required.
  - **Please refer to Prior Authorization List for most up to date requirement** Search PAL List: Sentara Health Plans
- Special Notes:
  - This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.
  - Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.
  - The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. Department of EPSDT Supplement B (updated 5.19.22) Final.pdf.
  - Service authorization requests must be accompanied by sufficient clinical records to support the request. Clinical records must be signed and dated by the requesting provider withing 60 days of the date of service requested.

References:

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Keywords:

SHP Total Ankle Replacement, SHP Surgical 96, arthroplasty, Arthritis, Arthrodesis, Inflammatory arthritis, rheumatoid arthritis, Hintermann Series H2 Total Ankle System, Invision Total Ankle Revision System, Salto Xt, Vantage Total Ankle System, Integra Total Ankle Replacement System, Infinity Total Ankle System, Inbone Total Ankle, Salto Talaris Total Ankle Prosthesis, Agility LP Total Ankle Replacement System, Eclipse Total Ankle Implant, Topez Total Ankle Replacement