

# Orthopedic Procedures, Devices, and Products

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[➔ Instructions for Use](#)

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Related Commercial Policies
<ul style="list-style-type: none"> <li>• <a href="#">Computer-Assisted Surgical Navigation for Musculoskeletal Procedures</a></li> <li>• <a href="#">Extracorporeal Shock Wave Therapy (ESWT) for Musculoskeletal Conditions and Soft Tissue Wounds</a></li> <li>• <a href="#">Manipulation Under Anesthesia</a></li> </ul>

## Coverage Rationale

### Computer-Assisted Surgical Navigation for Musculoskeletal Procedures

Medicare does not have a National Coverage Determination (NCD) for computer-assisted surgical navigation for musculoskeletal procedures LCDs/LCAs do not exist at this time.

**For coverage guidelines,** refer to the UnitedHealthcare Commercial Medical Policy titled [Computer-Assisted Surgical Navigation for Musculoskeletal Procedures](#).

### Extracorporeal Shock Wave Therapy (ESWT)

Medicare does not have an NCD for ESWT. LCDs/LCAs exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for [Extracorporeal Shock Wave Therapy \(ESWT\)](#).

**For coverage guidelines for states/territories with no LCDs/LCAs,** refer to the UnitedHealthcare Commercial Medical Policy titled [Extracorporeal Shock Wave Therapy \(ESWT\) for Musculoskeletal Conditions and Soft Tissue Wounds](#).

### Manipulation Under Anesthesia (MUA) for the Spine and Pelvis

Medicare does not have an NCD for MUA of the spine and pelvis. LCDs/LCAs do not exist.

**For coverage guidelines,** refer to the UnitedHealthcare Commercial Medical Policy titled [Manipulation Under Anesthesia](#).

## 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; however, language may be included in the listing below to indicate if a code is non-covered. Benefit coverage for health services is determined by the member specific benefit plan document 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>Computer-Assisted Surgical Navigation for Musculoskeletal Procedures</b>	
0054T	Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on fluoroscopic images (List separately in addition to code for primary procedure)

CPT Code	Description
<b>Computer-Assisted Surgical Navigation for Musculoskeletal Procedures</b>	
0055T	Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on CT/MRI images (List separately in addition to code for primary procedure)
20985	Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less (List separately in addition to code for primary procedure) [Refer to the UnitedHealthcare Commercial Medical Policy titled <a href="#">Computer-Assisted Surgical Navigation for Musculoskeletal Procedures</a> ]
<b>Extracorporeal Shock Wave Therapy (ESWT)</b>	
0101T	Extracorporeal shock wave involving musculoskeletal system, not otherwise specified
0102T	Extracorporeal shock wave performed by a physician, requiring anesthesia other than local, and involving the lateral humeral epicondyle
28890	Extracorporeal shock wave, high energy, performed by a physician or other qualified health care professional, requiring anesthesia other than local, including ultrasound guidance, involving the plantar fascia [Refer to the UnitedHealthcare Commercial Medical Policy titled <a href="#">Extracorporeal Shock Wave Therapy (ESWT) for Musculoskeletal Conditions and Soft Tissue Wounds</a> ]
<b>Manipulation Under Anesthesia (MUA) for the Spine and Pelvis</b>	
22505	Manipulation of spine requiring anesthesia, any region [Refer to the UnitedHealthcare Commercial Medical Policy titled <a href="#">Manipulation Under Anesthesia</a> ]
27198	Closed treatment of posterior pelvic ring fracture(s), dislocation(s), diastasis or subluxation of the ilium, sacroiliac joint, and/or sacrum, with or without anterior pelvic ring fracture(s) and/or dislocation(s) of the pubic symphysis and/or superior/inferior rami, unilateral or bilateral; with manipulation, requiring more than local anesthesia (i.e., general anesthesia, moderate sedation, spinal/epidural)

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## Centers for Medicare and Medicaid Services (CMS) Related Documents

After checking the table below and searching the [Medicare Coverage Database](#), if no NCD, LCD, or LCA is found, refer to the criteria as noted in the [Coverage Rationale](#) section above.

NCD	LCD	LCA	Contractor Type	Contractor Name
<b>Extracorporeal Shock Wave Therapy (ESWT)</b>				
N/A	<a href="#">L38775 Extracorporeal Shock Wave Therapy (ESWT)</a>	<a href="#">A58367 Billing and Coding: Extracorporeal Shock Wave Therapy (ESWT)</a>	Part A and B MAC	Palmetto**

<b>Medicare Administrative Contractor (MAC) With Corresponding States/Territories</b>	
MAC Name (Abbreviation)	States/Territories
CGS Administrators, LLC (CGS)	KY, OH
First Coast Service Options, Inc. (First Coast)	FL, PR, VI
National Government Services, Inc. (NGS)	CT, IL, ME, MA, MN, NH, NY, RI, VT, WI
Noridian Healthcare Solutions, LLC (Noridian)	AS, AK, AZ, CA, GU, HI, ID, MT, NV, ND, Northern Mariana Islands, OR, SD, UT, WA, WY
Novitas Solutions, Inc. (Novitas)	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX, VA**
Palmetto GBA (Palmetto)	AL, GA, NC, SC, TN, VA**, WV
Wisconsin Physicians Service Insurance Corporation (WPS)*	IA, IN, KS, MI, MO, NE

## Medicare Administrative Contractor (MAC) With Corresponding States/Territories

MAC Name (Abbreviation)

States/Territories

### Notes

\*Wisconsin Physicians Service Insurance Corporation: Contract Number 05901 applies only to WPS Legacy Mutual of Omaha MAC A Providers.

\*\*For the state of Virginia: Part B services for the city of Alexandria and the counties of Arlington and Fairfax are excluded for the Palmetto GBA jurisdiction and included within the Novitas Solutions, Inc. jurisdiction.

## Policy History/Revision Information

Date	Summary of Changes
04/01/2025	<p><b>Related Policies</b></p> <ul style="list-style-type: none"><li>Removed reference link to the UnitedHealthcare Commercial Medical Policy titled:<ul style="list-style-type: none"><li><i>Athletic Pubalgia Surgery</i></li><li><i>Omnibus Codes</i></li><li><i>Unicondylar Spacer Devices for Treatment of Pain or Disability</i></li></ul></li></ul> <p><b>Coverage Rationale</b></p> <ul style="list-style-type: none"><li>Removed content/language addressing:<ul style="list-style-type: none"><li>Athletic pubalgia surgery</li><li>Kinesio taping</li><li>Unicondylar spacer devices for treatment of pain or disability</li></ul></li></ul> <p><b>Applicable Codes</b></p> <ul style="list-style-type: none"><li>Removed list of applicable CPT/HCPCS codes: 27299, 27599, 29799, 49659, 49999, 97139, 97799, and A9999</li></ul> <p><b>Supporting Information</b></p> <ul style="list-style-type: none"><li>Archived previous policy version MMP068.06</li></ul>

## Instructions for Use

The Medicare Advantage Policy documents are generally used to support UnitedHealthcare coverage decisions. It is expected providers retain or have access to appropriate documentation when requested to support coverage. This document may be used as a guide to help determine applicable:

- Medical necessity coverage guidelines; including documentation requirements, and/or
- Medicare coding or billing requirements.

Medicare Advantage Policies are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates. This Policy is provided for informational purposes and does not constitute medical advice. It is intended to serve only as a general reference and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes this policy. For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the [Administrative Guide](#).

Medicare Advantage Policies are developed as needed, are regularly reviewed, and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policies at any time by publishing a new version on this website. Medicare source materials used to develop these policies may include, but are not limited to, CMS statutes, regulations, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and manuals. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. The information presented in this Policy is believed to be accurate and current as of the date of publication. Where there is a conflict between this document and Medicare source

materials, the Medicare source materials apply. Medicare Advantage Policies are the property of UnitedHealthcare. Unauthorized copying, use, and distribution of this information are strictly prohibited.

UnitedHealthcare follows Medicare coverage guidelines found in statutes, regulations, NCDs, and LCDs to determine coverage. The clinical coverage criteria governing certain items or services referenced in this Medical Policy have not been fully established in applicable Medicare guidelines because there is an absence of any applicable Medicare statutes, regulations, NCDs, or LCDs setting forth coverage criteria and/or the applicable NCDs or LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD. As a result, in these circumstances, UnitedHealthcare applies internal coverage criteria as referenced in this Medical Policy. The internal coverage criteria in this Medical Policy was developed through an evaluation of the current relevant clinical evidence in acceptable clinical literature and/or widely used treatment guidelines. UnitedHealthcare evaluated the evidence to determine whether it was of sufficient quality to support a finding that the items or services discussed in the policy might, under certain circumstances, be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Providers are responsible for submission of accurate claims. Medicare Advantage Policies are intended to ensure that coverage decisions are made accurately. UnitedHealthcare Medicare Advantage Policies use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

For members in UnitedHealthcare Medicare Advantage plans where a delegate manages utilization management and prior authorization requirements, the delegate's requirements need to be followed.