Medical Policy

**Computer-Assisted Navigation for Orthopedic Procedure**

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**Policy Number:** 594

BCBSA Reference Number: 7.01.96

NCD/LCD: Local Coverage Determination (LCD): Category III CPT® Codes (L33392)

**Related Policies**
None

**Policy**

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

Computer-assisted surgery for orthopedic procedures of the pelvis and appendicular skeleton is considered **INVESTIGATIONAL.**

**Medicare HMO BlueSM and Medicare PPO BlueSM Members**

This is not a covered service.

**Local Coverage Determination (LCD): Category III CPT® Codes (L33392)**

For medical necessity criteria and coding guidance for Medicare Advantage members living outside of Massachusetts, please see the Centers for Medicare and Medicaid Services website for information regarding your specific jurisdiction at [https://www.cms.gov](https://www.cms.gov).

**Prior Authorization Information**

**Inpatient**
- For services described in this policy, precertification/preauthorization IS REQUIRED for all products if the procedure is performed inpatient.

**Outpatient**
- For services described in this policy, see below for products where prior authorization might be required if the procedure is performed outpatient.

<table>
<thead>
<tr>
<th></th>
<th>Outpatient</th>
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<tbody>
<tr>
<td>Commercial Managed Care (HMO and POS)</td>
<td>This is not a covered service.</td>
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<tr>
<td>Commercial PPO and Indemnity</td>
<td>This is not a covered service.</td>
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</table>
Medicare HMO Blue℠
This is not a covered service.

Medicare PPO Blue℠
This is not a covered service.

CPT Codes / HCPCS Codes / ICD Codes
Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member’s contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

CPT Codes

<table>
<thead>
<tr>
<th>CPT codes</th>
<th>Code Description</th>
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<tr>
<td>20985</td>
<td>Computer-assisted surgical navigational procedure for musculoskeletal procedures; image-less</td>
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<tr>
<td>0054T</td>
<td>Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image guidance based on fluoroscopic images</td>
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<tr>
<td>0055T</td>
<td>Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image guidance based on CT/MRI images</td>
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Description
The goal of computer-assisted navigation (CAN) is to increase surgical accuracy and reduce the chance of malposition. For total knee arthroplasty (TKA), malalignment is commonly defined as a variation of more than 3° from the targeted position. Proper implant alignment is believed to be an important factor for minimizing long-term wear, risk of osteolysis, and loosening of the prosthesis. In addition to reducing the risk of substantial malalignment, CAN may improve soft tissue balance and patellar tracking. CAN is also being investigated for surgical procedures with limited visibility such as placement of the acetabular cup in total hip arthroplasty, resection of pelvic tumors, and minimally invasive orthopedic procedures. Other potential uses of CAN for surgical procedures of the appendicular skeleton include screw placement for fixation of femoral neck fractures, high tibial osteotomy, and tunnel alignment during reconstruction of the anterior cruciate ligament.

CAN devices may be image-based or non-image-based. Image-based devices use preoperative computed tomography (CT) scans and operative fluoroscopy to direct implant positioning. Newer non-image-based devices use information obtained in the operating room, typically with infrared probes. For TKA, specific anatomic reference points are made by fixing signaling transducers with pins into the femur and tibia. Signal-emitting cameras (eg, infrared) detect the reflected signals and transmit the data to a dedicated computer. During the surgery, multiple surface points are taken from the distal femoral surfaces, tibial plateaus, and medial and lateral epicondyles. The femoral head center is typically calculated by kinematic methods that involve movement of the thigh through a series of circular arcs, with the computer producing a 3-dimensional (3D) model that includes the mechanical, transepicondylar, and tibial rotational axes. CAN systems direct the positioning of the cutting blocks and placement of the prosthetic implants based on the digitized surface points and model of the bones in space. The accuracy of each step of the operation (cutting block placement, saw cut accuracy, seating of the implants) can be verified, thereby allowing adjustments to be made during surgery.

Navigation involves 3 steps: data acquisition, registration, and tracking.

Data Acquisition
Data can be acquired in 3 ways: fluoroscopically, guided by CT scan or magnetic resonance imaging (MRI), or guided by imageless systems. These data are then used for registration and tracking.
Registration
Registration refers to the ability of relating images (i.e., radiographs, CT scans, MRI, or patients’ 3D anatomy) to the anatomic position in the surgical field. Registration techniques may require the placement of pins or “fiduciary markers” in the target bone. A surface-matching technique can also be used in which the shapes of the bone surface model generated from preoperative images are matched to surface data points collected during surgery.

Tracking
Tracking refers to the sensors and measurement devices that can provide feedback during surgery regarding the orientation and relative position of tools to bone anatomy. For example, optical or electromagnetic trackers can be attached to regular surgical tools, which then provide real-time information of the position and orientation of tool alignment with respect to the bony anatomy of interest.

VERASENSE (OrthoSense) is a single-use device that replaces the standard plastic tibial trial spacer used in TKA. The device contains microprocessor sensors that quantify load and contact position of the femur on the tibia after resections have been made. The wireless sensors send the data to a graphic user interface that depicts the load. The device is intended to provide quantitative data on the alignment of the implant and on soft tissue balancing in place of intraoperative “feel.”

iASSIST (Zimmer) is an accelerometer-based alignment system with a user interface built into disposable electronic pods that attach onto the femoral and tibial alignment and resection guides. For the tibia, the alignment guide is fixed between the tibial spines and a claw on the malleoli. The relation between the electronic pod of the digitizer and the bone reference is registered by moving the limb into abduction, adduction, and neutral position. Once the information has been registered, the digitizer is removed and the registration data are transferred to the electronic pod on the cutting guide. The cutting guide can be adjusted for varus/valgus alignment and tibial slope. A similar process is used for the femur. The pods use wireless exchange of data and display the alignment information to the surgeon within the surgical field. A computer controller must also be present in the operating room.

Summary
Computer-assisted navigation (CAN) in orthopedic procedures describes the use of computer-enabled tracking systems to facilitate alignment in a variety of surgical procedures, including fixation of fractures, ligament reconstruction, osteotomy, tumor resection, preparation of the bone for joint arthroplasty, and verification of the intended implant placement.

For individuals who are undergoing orthopedic surgery for trauma or fracture, ligament reconstruction, hip arthroplasty and periacetabular osteotomy, or total knee arthroplasty who receive CAN, the evidence includes randomized controlled trials (RCTs) and nonrandomized comparative studies. Relevant outcomes are symptoms, morbid events, and functional outcomes. Overall, the literature supports a decrease in variability of alignment with CAN, particularly with respect to the number of outliers. Although some observational data have suggested that malalignment may increase the probability of early failure, recent RCTs with short- to mid-term follow-up have not shown improved clinical outcomes with CAN. Given the low short-term revision rates associated with conventional procedures and the inadequate power of the available studies to detect changes in function using CAN, studies are needed that assess health outcomes using CAN in a larger number of subjects with longer follow-up to permit greater certainty on the impact of this technology. The evidence is insufficient to determine the effects of the procedure on health outcomes.

Policy History

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<tr>
<th>Date</th>
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<tbody>
<tr>
<td>3/2017</td>
<td>BCBSA National medical policy review.</td>
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<tr>
<td></td>
<td>Title changed. New references added. 3/1/2017</td>
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<tr>
<td>8/2015</td>
<td>New references added from BCBSA National medical policy.</td>
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<tr>
<td>9/2014</td>
<td>New references added from BCBSA National medical policy.</td>
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Information Pertaining to All Blue Cross Blue Shield Medical Policies

Medical Policy Terms of Use
Managed Care Guidelines
Indemnity/PPO Guidelines
Clinical Exception Process
Medical Technology Assessment Guidelines

References