



Medical Coverage Policy

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Manipulation Under Anesthesia

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Related Coverage Resources

[Chiropractic Care](#)

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INSTRUCTIONS FOR USE

The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment where appropriate and have discretion in making individual coverage determinations. Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant criteria outlined in the applicable Coverage Policy, including covered diagnosis and/or procedure code(s). Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this Coverage Policy (see "Coding Information" below). When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under the applicable Coverage Policy

will be denied as not covered. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Overview

This Coverage Policy addresses manipulation under anesthesia (MUA).

Coverage Policy

A single treatment of manipulation under anesthesia* (MUA) is considered as medically necessary for ANY of the following indications:

- adhesive capsulitis (i.e., frozen shoulder) when there is failure of conservative medical management, including medications with or without articular injections, home exercise programs and physical therapy/standard chiropractic treatment (Common Procedural Terminology [CPT] code 23700)
- post-traumatic or postoperative arthrofibrosis of the knee (e.g., total knee replacement, anterior cruciate ligament repair) (CPT code 27570) when there is failure of conservative medical management, including exercise and physical therapy/standard chiropractic treatment
- reduction of a displaced fracture (e.g., vertebral, long bones) (e.g., CPT code 22505)
- reduction of acute/traumatic dislocation (e.g., vertebral, perched cervical facet) (e.g., CPT code 22505)
- chronic contracture of upper or lower extremity joint (e.g., fixed contracture from a neuromuscular condition) when there is failure of conservative medical management including range of motion exercise programs and physical therapy/standard chiropractic treatment

***MUA provided for these indications consists of a SINGLE treatment session. Repeat treatment sessions involving a previously treated bone or joint are subject to medical necessity review. Furthermore, serial treatment sessions (i.e., treatments of the same bone/joint provided subsequently over a period of time) are not in accordance with generally accepted standards of medical practice and are therefore not medically necessary.**

MUA for any other indication, including the treatment of acute or chronic pain conditions, involving one or more of the following joints, is considered not medically necessary:

- ankle (CPT code 27860)
- cervical, thoracic or lumbar spine (e.g., CPT code 22505)
- elbow (CPT code 24300)
- finger (e.g., CPT code 26340, 26675)
- hip (CPT code 27275)
- pelvis, sacroiliac (CPT code 27198)
- temporomandibular (CPT code 21073)
- thumb (CPT code 26340)
- toe (CPT code 28635, 28665)
- wrist (CPT code 25259)

Health Equity Considerations

Health equity is the highest level of health for all people; health inequity is the avoidable difference in health status or distribution of health resources due to the social conditions in which people are born, grow, live, work, and age.

Social determinants of health are the conditions in the environment that affect a wide range of health, functioning, and quality of life outcomes and risks. Examples include safe housing, transportation and neighborhoods; racism, discrimination and violence; education, job opportunities and income; access to nutritious foods and physical activity opportunities; access to clean air and water; and language and literacy skills.

Postoperative stiffness is a common complication following total knee arthroplasty (TKA), affecting 1.3% to 5.8% of patients—approximately 85,000 cases annually in the U.S. (Walsh et al., 2024). It is a significant source of dissatisfaction following TKA. One frequently used treatment for this condition is manipulation under anesthesia (MUA).

Barbera et al. (2022) conducted a retrospective cohort study using Medicare Limited Data Set claims data from 2013 to 2018, which included 836,054 patients who underwent primary TKA. The study aimed to examine racial disparities in MUA rates. The primary outcome was the incidence of MUA within one year after TKA, along with the time from TKA to MUA (measured in days).

The analysis revealed that MUA occurred in 1.7% of White patients, 3.2% of Black patients, and 2.1% of patients categorized as other races. Compared to White patients, Black patients had higher odds of requiring MUA and experienced a longer average time to MUA (64 days vs. 60 days).

General Background

Manipulation under anesthesia (MUA), a treatment modality aimed at reducing pain and improving range of motion, consists of manipulation and stretching procedures performed while an individual receives anesthesia (e.g., conscious sedation, general anesthesia). A chiropractor, osteopathic physician or medical physician may perform this type of manipulation with an anesthesiologist in attendance.

MUA is considered a safe and effective form of treatment for some joint conditions, such as arthrofibrosis of the knee and adhesive capsulitis. It is also used for treatment of fractures (e.g., vertebral, long bones) and dislocations. Although there is limited evidence in the peer-reviewed medical literature supporting safety and efficacy for the treatment of pain conditions, MUA has been recommended as a treatment modality for acute and chronic pain conditions, particularly of the spinal region, when standard chiropractic care and other conservative measures have proved unsuccessful.

An individual's protective reflex mechanism is absent under anesthesia and proponents contend it is less difficult to separate and move the joint when the reflex is absent. During MUA, the chiropractor or physician performs a combination of short manipulations, passive stretches and maneuvers to break up fibrous and scar tissue around the spine and surrounding joint areas. This manipulation typically includes a high velocity thrust (i.e., a technique that adjusts the joints rapidly), which may be followed by a popping or snapping sound.

In a less frequently used technique, manipulation under anesthesia (MUA) may be accompanied by fluoroscopically-guided intra-articular injections with corticosteroid agents to reduce inflammation. This procedure is referred to as manipulation under joint anesthesia/analgesia (MUJA). Manipulation under epidural anesthesia (MUEA) employs an epidural, segmental anesthetic, often with simultaneous epidural steroid injections, followed by spinal manipulation therapy. Some therapies may combine manipulation with cortisone injections into paraspinal tissues. Other forms of manipulation under anesthesia include spinal manipulation under anesthesia (SMUA) performed with or without manipulation of other joints and total body joint manipulation.

MUA is considered safe and effective and is a well-established method of treatment for conditions such as adhesive capsulitis of the shoulder, arthrofibrosis of the knee, and some fractures, dislocations and contractures. When performed for these specific conditions, MUA generally requires a single session of treatment, most often performed unilaterally, involving a single joint. Data supporting the need for, and clinical efficacy of, multiple repeat MUA treatment sessions for these specific conditions is lacking in the peer-reviewed published medical literature.

Adhesive Capsulitis/Frozen Shoulder

Adhesive capsulitis (also known as frozen shoulder or pericapsulitis), is a painful restriction (both passive and active) of shoulder motion in an individual whose radiographs are typically normal. It occurs in approximately 2-5% of the general population. Some authors contend the condition results from synovial inflammation with subsequent reactive capsular fibrosis. Early stages are treated with steroid injections and home therapy. For refractory cases, more aggressive treatment involves manipulation of the shoulder joint under anesthesia or an arthroscopic capsular release (Griffen, 2003). Manipulating the joint under anesthesia breaks up the adhesions surrounding the joint and stretches the fibrotic tissue thereby increasing joint motion and reducing pain. Evidence in the peer-reviewed published scientific literature, including textbook sources, supports the consideration of MUA for refractory cases of adhesive capsulitis of the shoulder (Miller, et al., 2021; Srikesavan, et al., 2021; Kim, et al., 2020; Brealey, et al., 2020; Rangan, et al., 2020; Alsubheen, et al., 2019; Rolle, 2017; Vastamaki, 2013; Maund, et al., 2012; Kivimaki, et al., 2007; Wang, et al., 2007; Sheridan and Hannafin, 2006; Dias, et al., 2005; Farrell, et al., 2005; Hamdan and Essa, 2003; Nirschl and Willet, 2002). MUA is generally recommended for individuals who do not respond to or who demonstrate little improvement after conservative treatment. An UpToDate review titled, "Frozen shoulder (adhesive capsulitis)" (Hudnall, 2024) states, "Manipulation of the shoulder has proven to be effective; however, it does not allow for a controlled release of the pathologic tissue restricting motion and carries an increased risk of humerus fracture and intraarticular shoulder injury. Arthroscopic release is now more commonly performed."

Postoperative/Post-traumatic Arthrofibrosis of the Knee

Arthrofibrosis of the knee is a condition caused by inflammation and proliferation of scar tissue following trauma, surgery or joint replacement. Traumatic injury to the knee can cause the formation of internal scar tissue with shrinking and tightening of the joint capsule. Tendons outside the joint may also shrink and tighten, leading to further decrease of joint mobility. Treatment of arthrofibrosis of the knee begins with physical therapy to improve motion; for refractory cases manipulation of the joint under anesthesia may be performed. In some cases, depending on the severity of adhesion formation and joint weakness, manipulation of the joint may inadvertently result in femoral or tibial fracture. As a precaution, some surgeons perform an arthroscopic internal resection of scar tissue prior to manipulation in order to reduce force and prevent fractures. MUA is indicated, with or without arthroscopy for arthrofibrosis of the knee, when there is < 90° range of motion following surgery or trauma despite physical therapy (Magit, et al. 2007). Published evidence in the medical literature supports MUA as a well-established safe and effective treatment for arthrofibrosis of the knee (Haffar, et al., 2022; Lim, et al., 2021;

Randsborg, et al., 2020; Gu, et al., 2018 ; Issa, et al., 2014a; Issa, et al., 2014b; Pivec, et al., 2013; Ghani, et al., 2012; Ipach, et al., 2011; Fitzsimmons, et al., 2010; Mohammed, et al., 2009; Keating, et al., 2007; Magit, et al., 2007; Namba and Inacio, 2007; D'Amato and Bach, 2003; Esler, et al. 1999).

Postoperative/Post-traumatic Arthrofibrosis of the Elbow

Arthrofibrosis of the elbow often occurs following injury (e.g., operative, fracture). The elbow becomes stiff as a result of soft-tissue contracture of the ligaments, muscles and/or tendons. Early management generally involves bracing and splinting (Araghi, et al, 2010). MUA may be recommended when there is failure to improve and progress following the use of bracing. Operative release may be considered a treatment option depending on the cause of the contracture, the presence of pain or other symptoms, and decrease in functional level.

Published evidence in the peer reviewed scientific literature supporting the safety and effectiveness of using MUA of the elbow is limited to retrospective case series, involve small sample populations and lack control groups (Rotman, et al, 2019; Spitler, et al., 2018; Araghi, et al, 2012, Duke, et al., 1991, Davilia, Johnston-Jones, 2006; Tan, et al., 2006; Chao, et al, 2002; Gaur, et al, 2003). Few studies lend support to clinical effectiveness for the treatment of joint stiffness/fibrosis when other conservative measures, such as bracing and splinting, have failed to improve range of motion. In addition, evidence-based clinical practice guidelines supporting MUA for arthrofibrosis of the elbow are not available. There is insufficient evidence in the peer-reviewed published literature and lack of consensus among professional societies to support the effectiveness of MUA as treatment for arthrofibrosis of the elbow.

Fracture and/or Dislocation

MUA is considered a well-established and successful treatment for some types of fractures (e.g., vertebral, long bones) and acute/traumatic dislocations (e.g., perched cervical facet). It is typically performed with surgical repair and other medically necessary procedures such as arthroscopy. When performed in this context, MUA is considered incidental to the base procedure.

Chronic Contracture of Upper or Lower Extremity Joint

A joint contracture is a limitation in the passive range of motion of a joint. Joint contractures prevent normal movement of the associated body part and can result from a variety of causes such as spasticity or prolonged immobilization. Intra-articular adhesions and peri-articular adhesions, as well as capsular, ligament and muscle shortening and tightness may develop. As a result, activities of daily living and other skills may be adversely affected due to decreased mobility. In many cases, contractures can be successfully treated nonoperatively with aggressive physical therapy or splinting with restoration of functional range of motion. When conservative treatment fails, more aggressive treatment may necessary. More aggressive treatment includes anesthetic block, maximal stretching, and in some cases, serial casting (Garden, 2002). For joint contracture deformities, extra-articular and intra-articular soft tissue releases are considered standard treatment (Paley, 2003). Surgical treatments include tenotomy, tendon lengthening and joint capsule release. Manipulation under anesthesia, involving maximal passive stretching may be considered standard treatment and is often performed in combination with serial casting and/or surgical release when less aggressive treatments have failed.

Pain Management

Although not well-supported in the peer-reviewed published scientific literature, MUA has been proposed as a treatment for spine-related pain conditions, including but not limited to, acute or chronic cervical pain, cervicobrachial, cervicocranial, lumbar, pelvis, or lower extremity syndromes with somatic dysfunctions that have not responded to conservative management. Manipulation under anesthesia for pain management often involves the spine and/or other major body joints in addition to the spine. Individuals typically undergo a 4 to 8 week trial of conservative

manipulation management (e.g., chiropractic care) prior to more aggressive approaches, such as MUA. Authors contend failure of a trial of conservative therapy is thought to be the primary basis for more aggressive MUA approaches (Kohlbeck, et al., 2002).

When used for pain management, MUA treatment typically consists of one to five consecutive daily sessions (with an average of three), followed by additional outpatient chiropractic sessions which may be accompanied by steroid injections. During treatment, manipulation of various joints, including the spine, may be performed as part of the overall therapy plan. Cremata and associates (2005) identified three distinct stages to MUA: sedation of the patient, specific chiropractic adjustments, and passive stretching and traction procedures of the spine, sacroiliac and pelvis. While the literature suggests maneuvers are predetermined for each individual patient, all regions of the spine (i.e., cervical, thoracic, lumbar) and distal extremities are typically involved. The need for serial manipulations is determined by the degree of biomechanical function following the initial procedure. However, there is insufficient evidence in the peer-reviewed published scientific literature to support safety and efficacy of MUA for the management of acute or chronic pain conditions, when performed as single or multiple treatment sessions.

Spine: Theoretically, spinal manipulation as a method of treatment for subluxation stretches the joint capsules and resets the spinal cord and nerve position, allowing the nervous system to function optimally. Evidence in the published, peer-reviewed scientific literature has failed to demonstrate the safety and efficacy of MUA when used for the treatment of pain associated with the spine (SMUA) and some sources indicate the treatment may be hazardous and obsolete (Kohatsu, 2007; Lindsey, et al., 2003). In addition, anesthesia itself carries a small but clinically significant risk. Overall, the evidence evaluating SMUA consists mainly of case reports, case series, few controlled clinical trials and literature reviews (Peterson, et al., 2014; Taber, et al., 2013; Cremata, et al., 2005; Kohlbeck, et al., 2005; Palmieri and Smoyak, 2002; Kohlbeck and Haldeman, 2002; West, et al., 1999). Some of the study results support improvement in pain and function following SMUA when compared to traditional manipulation (Kohlbeck, et al., 2005; Palmieri and Smoyak, 2002); however, these studies are limited by lack of randomization, small sample populations and measurement of short-term outcomes. Follow-up assessments were generally conducted from three months to one year post-MUA treatment, some of which consisted of self-reported outcomes and questionnaires. Patient selection criteria are poorly defined and treatment protocols vary making comparisons difficult. Much of the evidence evaluating SMUA is low quality and reliable conclusions cannot be drawn regarding efficacy and improvement of health outcomes. Further well-designed clinical trials are needed to support the safety and effectiveness of the procedure for the management of acute or chronic pain conditions related to the spine.

Other Joints: Evidence in the medical literature evaluating the use of MUA for management of pain conditions involving one or more (i.e., multiple joints, whole body MUA) of other major joints such as the hip, ankle, toe, elbow, wrist and temporomandibular joint, is lacking. Due to insufficient evidence, conclusions cannot be made regarding the clinical utility, safety, or efficacy of MUA involving other single or multiple joints for pain management.

Other Conditions

There is insufficient evidence in the peer-reviewed published scientific literature to support safety and efficacy of manipulation under anesthesia of any joint such as the hip, ankle, toe, elbow, wrist and temporomandibular joint for the treatment of any other condition.

Professional Societies/Organizations

The American College of Occupational and Environmental Medicine (ACOEM) published practice guidelines regarding physical methods of treatment for low back disorders (Hegmann, 2007; Hegmann, et al., 2008; Hegmann, et al., 2020). The authors determined that manipulation under

anesthesia (MUA) and medication-assisted spinal manipulation (MASM) are not recommended for acute, subacute, or chronic low back pain due to a lack of evidence.

The International Chiropractors Association issued a policy statement on Manipulation Under Anesthesia in 2017. The group stated, "within the armamentarium of chiropractic techniques efficient methods exist that address the pain profiles of even the most sensitive patient. Furthermore, the chiropractic adjustment relies on the body's own inherent constructive survival mechanisms to innately accomplish adjustive correction." They concluded that anesthesia is inappropriate and unnecessary to the delivery of chiropractic adjustment.

The American Association of Oral and Maxillofacial Surgeons (Bouloux et al., 2024) published a position paper on the contemporary management of Temporomandibular joint (TMJ) pain and dysfunction. The AAOMS Special Committee on TMJ Care recommended initiation of the least invasive evidence-based nonsurgical or surgical treatment. Recommendations for the initial care of intra-articular pain and dysfunction (IPD) with or without symptomatic disc displacement (SDD) include: rest, heat, ice, nonsteroidal anti-inflammatory drugs, muscle relaxants, physical therapy and orthotics. They stated the documented success of nonsurgical treatment as well as minimally invasive surgical options, arthroplasty and total joint replacement (TJR), provide the patient and surgeon with sound treatment choices. Treatment with manipulation under anesthesia was not included in their recommendations.

Medicare Coverage Determinations

	Contractor	Determination Name/Number	Revision Effective Date
NCD	National	National Coverage Determination (NCD) for Manipulation (150.1)	Longstanding national coverage determination. The effective date of this version has not been posted.
LCD		No Local Coverage Determination found	

Note: Please review the current Medicare Policy for the most up-to-date information.
(NCD = National Coverage Determination; LCD = Local Coverage Determination)

Coding Information

Notes:

1. This list of codes may not be all-inclusive since the American Medical Association (AMA) and Centers for Medicare & Medicaid Services (CMS) code updates may occur more frequently than policy updates.
2. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Coverage is limited to a SINGLE treatment session of an isolated joint condition.

SHOULDER

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
23655	Closed treatment of shoulder dislocation, with manipulation; requiring anesthesia
23700	Manipulation under anesthesia, shoulder joint, including application of fixation apparatus (dislocation excluded)

SPINE

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
22505	Manipulation of spine requiring anesthesia, any region

PELVIS

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
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)

ARM

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
24300	Manipulation, elbow, under anesthesia
24605	Treatment of closed elbow dislocation; requiring anesthesia

WRIST

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
25259	Manipulation, wrist, under anesthesia
25690	Closed treatment of lunate dislocation, with manipulation
26641	Closed treatment of carpometacarpal dislocation, thumb, with manipulation
26675	Closed treatment of carpometacarpal dislocation, other than thumb, with manipulation, each joint; requiring anesthesia

HAND / FINGERS

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
26340	Manipulation, finger joint, under anesthesia, each joint
26705	Closed treatment of metacarpophalangeal dislocation, single, with manipulation; requiring anesthesia
26775	Closed treatment of interphalangeal joint dislocation, single, with manipulation; requiring anesthesia
26989 [†]	Unlisted procedure, hands or fingers
28665	Closed treatment of interphalangeal joint dislocation; requiring anesthesia

[†]Note: Covered when medically necessary when used to report MUA of a finger or thumb requiring anesthesia.

HIP

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
27252	Closed treatment of hip dislocation, traumatic; requiring anesthesia
27275	Manipulation, hip joint, requiring general anesthesia

LEG

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
27831	Closed treatment of proximal tibiofibular joint dislocation; requiring anesthesia

KNEE

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
27552	Closed treatment of knee dislocation; requiring anesthesia
27562	Closed treatment of patellar dislocation; requiring anesthesia
27570	Manipulation of knee joint under general anesthesia (includes application of traction or other fixation devices)

ANKLE

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
27860	Manipulation of ankle under general anesthesia (includes application of traction or other fixation apparatus)
28545	Closed treatment of tarsal bone dislocation, other than talotarsal; requiring anesthesia

FOOT/TOES

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
28635	Closed treatment of metatarsophalangeal joint dislocation; requiring anesthesia
28899	Unlisted procedure, foot or toes

Considered Not Medically Necessary when used to report manipulation under anesthesia of a single joint or multiple body joints for any other condition, including the management of acute or chronic pain conditions:

CPT®* Codes	Description
21073	Manipulation of temporomandibular joint(s) (TMJ), therapeutic, requiring an anesthesia service (i.e., general or monitored anesthesia care)
22505	Manipulation of spine requiring anesthesia, any region
23655	Closed treatment of shoulder dislocation, with manipulation; requiring anesthesia
23700	Manipulation under anesthesia, shoulder joint, including application of fixation apparatus (dislocation excluded)
24300	Manipulation, elbow, under anesthesia
25259	Manipulation, wrist, under anesthesia
25690	Closed treatment of lunate dislocation, with manipulation
26340	Manipulation, finger joint, under anesthesia, each joint
26641	Closed treatment of carpometacarpal dislocation, thumb, with manipulation
26675	Closed treatment of carpometacarpal dislocation, other than thumb, with manipulation, each joint, requiring anesthesia
26705	Closed treatment of metacarpophalangeal dislocation, single, with manipulation; requiring anesthesia
26775	Closed treatment of interphalangeal joint dislocation, single, with manipulation; requiring anesthesia
26989	Unlisted procedure, hands or fingers
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)
27275	Manipulation, hip joint, requiring general anesthesia

CPT®* Codes	Description
27570	Manipulation of knee joint under general anesthesia (includes application of traction or other fixation devices)
27860	Manipulation of ankle under general anesthesia (includes application of traction or other fixation apparatus)
28635	Closed treatment of metatarsophalangeal joint dislocation; requiring anesthesia
28665	Closed treatment of interphalangeal joint dislocation; requiring anesthesia
28899	Unlisted procedure, foot or toes

***Current Procedural Terminology (CPT®) ©2024 American Medical Association: Chicago, IL.**

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Revision Details

Type of Revision	Summary of Changes	Date
Annual Review	No clinical policy statement changes.	9/15/2025
Annual review	No clinical policy statement changes.	10/15/2024
Annual review	- Updated to new template and formatting standards. - No changes to criteria.	10/15/2023

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