Interspinous Fusion and Decompression Devices (for North Carolina Only)

Policy Number: CSNCT0363.02
Effective Date: April 1, 2024

Instructions for Use

Table of Contents **Page**

Related Policies

- Discogenic Pain Treatment
- Epidural Steroid Injections for Spinal Pain (for North Carolina Only)
- Facet Joint and Medial Branch Block Injections for Spinal Pain (for North Carolina Only)
- Spinal Fusion and Bone Healing Enhancement Products
- Total Artificial Disc Replacement for the Cervical Spine (for North Carolina Only)
- Vertebral Body Tethering for Scoliosis

Application

This Medical Policy only applies to the state of North Carolina.

Coverage Rationale

For medical necessity clinical coverage criteria, refer to the North Carolina Medicaid (Division of Health Benefits) Clinical Coverage Policy, Physician: 1A-30, Spinal Surgeries.

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. Benefit coverage for health services is determined by federal, state, or contractual requirements 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
22853	Insertion of interbody biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges), when performed, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace (List separately in addition to code for primary procedure)
22854	Insertion of intervertebral biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges), when performed, to vertebral corpectomy(ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)
22859	Insertion of intervertebral biomechanical device(s) (e.g., synthetic cage, mesh, methylmethacrylate) to intervertebral disc space or vertebral body defect without interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)

CPT Code	Description
22867	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level
22868	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level (List separately in addition to code for primary procedure)
22869	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level
22870	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure)
22899	Unlisted procedure, spine

HCPCS Code	Description
C1821	Interspinous process distraction device (implantable)

U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

A variety of products have received marketing clearance through the FDA's 510(k) process. and decompression. Refer to the following website for more information and search by product name in device name section: http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm.

References

North Carolina Medicaid, Division of Health Benefits, Clinical Coverage Policies, Spinal Surgeries, 1A-30. Available at: https://medicaid.ncdhhs.gov/1a-30-spinal-surgeries/download?attachment. Accessed December 12, 2023.

Policy History/Revision Information

Date	Summary of Changes
11/01/2024	**Template Update** • Modified font style; no change to policy content
04/01/2024	**Coverage Rationale** • Removed language indicating spinal procedures for the treatment of spine pain are proven and medically necessary in certain circumstances **Supporting Information** • Added *FDA* section • Updated *References* section to reflect the most current information • Archived previous policy version CSNCT0363.01

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The UnitedHealthcare Medical Policies are intended to be used in connection with the

independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.