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Medical Policy

BlueCross BlueShield Kansas
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Title: Interspinous Fixation (Fusion) Devices

Related Policies:	▪ *Lumbar Spine Fusion* ▪ *Interspinous and Interlaminar Stabilization / Distraction Devices (Spacers)*

Professional / Institutional
Original Effective Date: January 23, 2015
Latest Review Date: May 28, 2024
Current Effective Date: January 23, 2015

Archived Date: May 28, 2024

State and Federal mandates and health plan member contract language, including specific provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. To verify a member's benefits, contact Blue Cross and Blue Shield of Kansas Customer Service.

The BCBSKS Medical Policies contained herein are for informational purposes and apply only to members who have health insurance through BCBSKS or who are covered by a self-insured group plan administered by BCBSKS. Medical Policy for FEP members is subject to FEP medical policy which may differ from BCBSKS Medical Policy.

The medical policies do not constitute medical advice or medical care. Treating health care providers are independent contractors and are neither employees nor agents of Blue Cross and Blue Shield of Kansas and are solely responsible for diagnosis, treatment and medical advice.

If your patient is covered under a different Blue Cross and Blue Shield plan, please refer to the Medical Policies of that plan.

Populations	Interventions	Comparators	Outcomes
Individuals: • Who are undergoing spinal fusion	Interventions of interest are: • Interspinous fixation devices with interbody fusion	Comparators of interest are: • Interspinous fixation device with pedicle screw construct	Relevant outcomes include: • Symptoms • Functional outcomes • Quality of life • Resource utilization

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Populations	Interventions	Comparators	Outcomes
			• Treatment-related morbidity
Individuals: • With spinal stenosis and/or spondylolisthesis	Interventions of interest are: • Interspinous fixation device alone	Comparators of interest are: • Decompression	Relevant outcomes include: • Symptoms • Functional outcomes • Quality of life • Resource utilization • Treatment-related morbidity

DESCRIPTION

Interspinous fixation (fusion) devices are being developed to aid in the stabilization of the spine. They are evaluated as alternatives to pedicle screw and rod constructs in combination with interbody fusion. Interspinous fixation devices are also being evaluated for stand-alone use in patients with spinal stenosis and/or spondylolisthesis.

OBJECTIVE

The objective of this evidence review is to determine whether use of an interspinous fixation device improves the net health outcome when used alone or in combination with interbody fusion to stabilize the spinal segment.

BACKGROUND

Contemporary models of interspinous fixation devices have evolved from spinous process wiring with bone blocks and early device designs (eg, Wilson plate, Meurig-Williams system, Daab plate). The newer devices range from paired plates with teeth to U-shaped devices with wings that are attached to the spinous process. They are intended as an alternative to pedicle screw and rod constructs to aid in the stabilization of the spine with interbody fusion. Interspinous fixation devices are placed under direct visualization, while screw and rod systems may be placed under direct visualization or percutaneously. Use of an interspinous fixation device in combination with a unilateral pedicle screw system has also been proposed. Interspinous fixation devices are not intended for stand-alone use.

For use in combination with fusion, it has been proposed that interspinous fixation devices are less invasive and present fewer risks than pedicle or facet screws. While biomechanics studies have indicated that interspinous fixation devices may be similar to pedicle screw-rod constructs in limiting the range of flexion and extension, they may be less effective than bilateral pedicle screw-rod fixation for limiting axial rotation and lateral bending.[1,] There is a potential for a negative impact on the interbody cage and bone graft due to focal kyphosis resulting from the interspinous fixation device. There is also a potential for spinous process fracture.

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Unlike interspinous fixation devices, interspinous distraction devices (spacers) are used alone for decompression and are typically not fixed to the spinous process. In addition, interspinous distraction devices have been designed for dynamic stabilization, whereas interspinous fixation devices are rigid. However, interspinous fixation devices might also be used to distract the spinous processes and decrease lordosis. Thus, interspinous fixation devices could be used off-label without interbody fusion as decompression (distraction) devices in patients with spinal stenosis. If interspinous fixation devices are used alone as a spacer, there is a risk of spinous process fracture.

REGULATORY STATUS

The following interspinous fixation devices have been cleared for marketing by the U.S. Food and Drug Administration (FDA) through the 510(k) process. This list may not be exhaustive.

- Aerial™ Interspinous Fixation (Globus Medical Inc.)
- Affix™ (NuVasive)
- Aileron™ (Life Spine)
- Aspen™ (Lanx, acquired by BioMet)
- Axle™ (X-Spine)
- BacFuse® (Pioneer Surgical)
- BridgePoint™ (Alphatec Spine)
- coflex-IF® (Paradigm Spine)
- Inspan™ (Spine Frontier)
- InterBRIDGE® Interspinous Posterior Fixation System (LDR Spine)
- Minuteman™ (Spinal Simplicity)
- PrimaLOK™ (OsteoMed Spine)
- Octave™ (Life Spine)
- Spire™ (Medtronic)
- SP-Fix™ (Globus)
- SP-Link™ System (Medical Designs LLC)
- ZIP® MIS Interspinous Fusion System (Aurora Spine).

FDA product code: PEK.

Interspinous fixation devices are intended for use as an adjunct to interbody fusion. For example, the indication for the coflex-IF® implant is as:

"a posterior, nonpedicle supplemental fixation device intended for use with an interbody cage as an adjunct to fusion at a single level in the lumbar spine (L1-S1). It is intended for attachment to the spinous processes for the purpose of achieving stabilization to promote fusion in patients with degenerative disc disease - defined as back pain of discogenic origin with degeneration of the disc confirmed by history and radiographic studies - with up to Grade 1 spondylolisthesis."

A number of interspinous plate systems have also been cleared for marketing by the FDA.

Use of an interspinous fixation device for a stand-alone procedure is considered off-label.

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POLICY

A. Interspinous fixation (fusion) devices are considered **experimental / investigational** for any indication, including, but not limited to, use:

1. in combination with interbody fusion, **OR**

2. alone for decompression in individuals with spinal stenosis.

POLICY GUIDELINES

Clinical input has identified potential exceptions where the devices might be considered medically necessary, such as individuals with small pedicles where pedicle screws could not be safely placed.

Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

RATIONALE

This evidence review was created with searches of the PubMed database. The most recent literature update was performed though March 2, 2024.

Evidence reviews assess the clinical evidence to determine whether the use of technology improves the net health outcome. Broadly defined, health outcomes are the length of life, quality of life, and ability to function, including benefits and harms. Every clinical condition has specific outcomes that are important to patients and managing the course of that condition. Validated outcome measures are necessary to ascertain whether a condition improves or worsens; and whether the magnitude of that change is clinically significant. The net health outcome is a balance of benefits and harms.

To assess whether the evidence is sufficient to draw conclusions about the net health outcome of technology, 2 domains are examined: the relevance, and the quality and credibility. To be relevant, studies must represent 1 or more intended clinical uses of the technology in the intended population and compare an effective and appropriate alternative at a comparable intensity. For some conditions, the alternative will be supportive care or surveillance. The quality and credibility of the evidence depend on study design and conduct, minimizing bias and confounding that can generate incorrect findings. The randomized controlled trial (RCT) is preferred to assess efficacy; however, in some circumstances, nonrandomized studies may be adequate. Randomized controlled trial are rarely large enough or long enough to capture less common adverse events and long-term effects. Other types of studies can be used for these purposes and to assess generalizability to broader clinical populations and settings of clinical practice.

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Promotion of greater diversity and inclusion in clinical research of historically marginalized groups (e.g., People of Color [African-American, Asian, Black, Latino and Native American]; LGBTQIA (Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual); Women; and People with Disabilities [Physical and Invisible]) allows policy populations to be more reflective of and findings more applicable to our diverse members. While we also strive to use inclusive language related to these groups in our policies, use of gender-specific nouns (e.g., women, men, sisters, etc.) will continue when reflective of language used in publications describing study populations.

INTERSPINOUS FIXATION DEVICE WITH FUSION

Clinical Context and Therapy Purpose

The purpose of interspinous fixation devices is to provide a treatment option that is an alternative to or an improvement on existing therapies for individuals who are undergoing spinal fusion.

The question addressed in this evidence review is: Does the use of interspinous fixation improve the net health outcome in individuals who are undergoing spinal fusion?

The following PICO was used to select literature to inform this review.

Populations

The relevant population of interest is individuals who are undergoing spinal fusion.

Interventions

The therapy being considered is interspinous fixation devices with interbody fusion.

Comparators

The following practice is currently being used for individuals who are undergoing spinal fusion: interspinous fixation devices with pedicle screw construct.

Outcomes

The general outcomes of interest include symptoms, functional outcomes, quality of life, resource utilization, and treatment-related morbidity.

Study Selection Criteria

Methodologically credible studies were selected using the following principles:

- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;
- In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
- To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
- Studies with duplicative or overlapping populations were excluded.

No review or update is scheduled on this Medical Policy. Blue Cross and Blue Shield of Kansas will continue to monitor published literature for any updated information. If there are questions about coverage of this service, please contact Blue Cross and Blue Shield of Kansas customer service, or your professional / institutional relations representative.

REVIEW OF EVIDENCE

Systematic Reviews

A systematic review by Lopez et al (2017) evaluated the literature on lumbar spinous process fixation and fusion devices.[2,] Reviewers included both interspinous plates and fixation devices and excluded dynamic devices such as the X-Stop. Fifteen articles met inclusion and exclusion criteria, including 4 comparative studies (level III evidence), 2 case series (level IV evidence), and 9 in vitro biomechanics studies (level V evidence). Two of the nonrandomized studies compared interspinous fixation devices with pedicle screws in patients undergoing interbody fusion and 2 included interspinous fixation devices alone or pedicle screws plus an interspinous fixation device in patients undergoing interbody fusion. Use of an interspinous fixation device decreased surgical time and blood loss compared with pedicle screws. No study showed that interspinous fixation devices reduced the hospital length of stay compared with pedicle screw implantation.

Randomized Controlled Trials

Subsequent to the systematic review by Lopez et al (2017), 2 small RCTs (N = 149) have been published in individuals with single-level lumbar degenerative diseases undergoing spinal fusion who received an interspinous fixation device with interbody fusion as alternatives to pedicle screw and rod constructs (Table 1).[3,4,] The first was a single-center study by Huang et al (2017) that randomized 46 individuals to either an unknown type of interspinous fixation device or pedicle screws and followed them for 24 months.[3,] The second was a multicenter study by Panchal et al (2018) that randomized 103 individuals to either the Aspen MIS Fusion System or pedicle screws and followed them for 12 months.[4,] Compared to the pedicle screw control groups (Table 2), similar or better fusion, disability, and quality of life outcomes were observed for the interspinous fixation device groups. Comparative complication rates were mixed across studies, but comparative treatment effects were not calculated. In the study by Panchal et al (2018), revisions were numerically lower in the interspinous fixation device group, but comparative treatment effects were not calculated. Interpretation of these findings is limited by important weaknesses, however. In the RCT by Panchal et al (2018), weaknesses included insufficient follow-up duration, lack of control for selection bias, and data incompleteness (Tables 3 and 4). In the RCT by Huang et al (2017), weaknesses include unclear blinding of outcome assessors and potential use of a device that is not commercially available in the United States. Larger, longer-term, and more rigorous multicenter RCTs are needed to confirm these findings.

Table 1. Summary of Key RCT Characteristics

Study; Trial	Countries	Sites	Dates	Participants	Interventions	
					Active	*Comparator*
Huang et al (2017)[3,]	China	1	2013-2014	Single-level lumbar degenerative diseases, including lumbar disc herniation, lumbar spinal stenosis, or	PLIF+ISF, N=23	PLIF+pedicle screws, N=23

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Study; Trial	Countries	Sites	Dates	Participants	Interventions	
				lumbar degenerative spondylolisthesis		
Panchal et al (2018)[4,]	United States	9	NR	Single-level lumbar degenerative disc disease and/or spondylolisthesis (grade ≤ 2)	ALIF or LLIF +ISPF, N=66	ALIF or LLIF + pedicle screws, N=37

ALIF: anterior lateral lumbar interbody fusion; ISF: interspinous fastener (Wego, Weihai, China); ISPF: interspinous process fixation; LLIF: lateral lumbar interbody fusion; NR: not reported; PLIF: posterior lumbar interbody fusion; RCT: randomized controlled trial.
[1] Aspen MIS Fusion System, Zimmer Biomet Spine.

Table 2. Summary of Key RCT Results

Study	Fusion	Disability	Quality of life	Revisions	Overall Complications
Huang et al (2017)[3,]	43	43	N/A	N/A	43
Outcome definition	24-mo: radiograph/CT-scan	% of patients achieved MCID on ODI[1]	N/A	N/A	
PLIF+ISF	17 (77%)/15 (68%)	33 (77%) overall[2]	NR	NR	2 (9%)
PLIF+pedicle screws	17 (81%)/16 (76%)		NR	NR	1 (5%)
p-value	1.000/0.736	NR	N/A	N/A	NR
Panchal et al (2018)[4,]	88	88	88	88	88
Outcome definition	12-mo radiographic fusion based on BSF-3/BSF-2/BSF-1 (95% CI)	ODI mean improvement ± SD at 12 mo	SF-36 physical component mean improvement ± SD at 12 mo	Required secondary surgical intervention	Rated as device-related/NOT device-related
ALIF or LLIF +ISPF	45.5% (32.7%–59.6%)/45.5% (32.7%–59.6%) /9.1% (0.0%–23.2%)	25.97±4.23	10.87±2.79	1 (1.5%)	5 (7.5%) / 14 (21.2%)
ALIF or LLIF + pedicle screws	50% (33.3%–67.8%)/50%	22.38±5.84	9.10±3.89	4 (10.8%)	6 (16.2%) / 7 (18.9%)

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Study	Fusion	Disability	Quality of life	Revisions	Overall Complications
	(3.3%–67.8%)/0% (0.0%–17.8%)				
p-value	0.33	<0.01	≥0.22	NR	NR

ALIF: anterior lateral lumbar interbody fusion; BSF criteria: Brantigan, Stelfee, Fraser criteria: BSF-1, radiographic pseudoarthrosis with loss of intervertebral height with lucency around the implant; BSF-2, radiographic locked pseudoarthrosis with lucency within the cage but solid bone growth into the cage from each vertebral endplate; and BSF-3, radiographic fusion with bony bridges in at least half of the fusion area; CI: confidence interval; ISF: interspinous fastener (Wego, Weihai, China); ISPF: interspinous process fixation; LLIF: lateral lumbar interbody fusion; MCID: minimally important clinical difference; N/A: not available; NR: not reported; ODI: Oswetry Disability Index; PLIF: posterior lumbar interbody fusion; RCT: randomized controlled trial; SD: standard deviation; SF-36: 36-Item Short Form Health Survey.
[1] MCID was prespecified as an 8-point difference.
[2] Did not stratify by group.

Table 3. Study Relevance Limitations

Study	Population[a]	Intervention[b]	Comparator[c]	Outcomes[d]	Follow-Up[e]
Huang et al (2017)[3,]		2. Version used unclear			
Panchal et al (2018)[4,]					1. Not sufficient duration for benefit; 2. Not sufficient duration for harms

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.
[a] Population key: 1. Intended use population unclear; 2. Clinical context is unclear; 3. Study population is unclear; 4. Study population not representative of intended use.
[b] Intervention key: 1. Not clearly defined; 2. Version used unclear; 3. Delivery not similar intensity as comparator; 4.Not the intervention of interest.
[c] Comparator key: 1. Not clearly defined; 2. Not standard or optimal; 3. Delivery not similar intensity as intervention; 4. Not delivered effectively.
[d] Outcomes key: 1. Key health outcomes not addressed; 2. Physiologic measures, not validated surrogates; 3. No CONSORT reporting of harms; 4. Not establish and validated measurements; 5. Clinical significant difference not prespecified; 6. Clinical significant difference not supported.
[e] Follow-Up key: 1. Not sufficient duration for benefit; 2. Not sufficient duration for harms.

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Table 4. Study Design and Conduct Limitations

Study	Allocation[a]	Blinding[b]	Selective Reporting[c]	Data Completeness[d]	Power[e]	Statistical[f]
Huang et al (2017)[3,]	3. Allocation concealment unclear; "using closed envelopes"	3. Blinding unclear	1. Not registered			
Panchal et al (2018)[4,]	4. Inadequate control for selection bias: More males (53% vs. 30%), on sick leave (23% vs. 5%) and with degenerative disk disease (55% vs. 43%)			1. High loss to follow-up or missing data (excluded 13% vs. 21% from 12-mo analysis); 6. Not intent to treat analysis (per protocol for noninferiority trials)		

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.
[a] Allocation key: 1. Participants not randomly allocated; 2. Allocation not concealed; 3. Allocation concealment unclear; 4. Inadequate control for selection bias.
[b] Blinding key: 1. Not blinded to treatment assignment; 2. Not blinded outcome assessment; 3. Outcome assessed by treating physician. 3. Blinding unclear
[c] Selective Reporting key: 1. Not registered; 2. Evidence of selective reporting; 3. Evidence of selective publication.
[d] Data Completeness key: 1. High loss to follow-up or missing data; 2. Inadequate handling of missing data; 3. High number of crossovers; 4. Inadequate handling of crossovers; 5. Inappropriate exclusions; 6. Not intent to treat analysis (per protocol for noninferiority trials).
[e] Power key: 1. Power calculations not reported; 2. Power not calculated for primary outcome; 3. Power not based on clinically important difference.
[f] Statistical key: 1. Analysis is not appropriate for outcome type: (a) continuous; (b) binary; (c) time to event; 2. Analysis is not appropriate for multiple observations per patient; 3. Confidence intervals and/or p values not reported; 4. Comparative treatment effects not calculated

Section Summary: Interspinous Fixation Device With Fusion

The evidence for use of an interspinous fixation device with interbody fusion for those undergoing spinal fusion consists of a systematic review of nonrandomized comparative studies and case series and 2 small RCTs. The randomized trials found comparable benefits for interspinous fixation devices with interbody fusion for those undergoing spinal fusion compared with interbody fusion with pedicle screws, but the comparative safety was less clear. One risk is spinous process fracture, while a potential benefit is a reduction in adjacent segment degeneration. Additionally, the RCTs had important methodological and relevancy weaknesses that limited their interpretation. Randomized trials with longer follow-up are needed to evaluate the risks and benefits following use of interspinous fixation devices compared with the established standard (pedicle screw with rod fixation).

INTERSPINOUS FIXATION DEVICE AS A STAND-ALONE

No review or update is scheduled on this Medical Policy. Blue Cross and Blue Shield of Kansas will continue to monitor published literature for any updated information. If there are questions about coverage of this service, please contact Blue Cross and Blue Shield of Kansas customer service, or your professional / institutional relations representative.

Clinical Context and Therapy Purpose

The purpose of interspinous fixation devices is to provide a treatment option that is an alternative to or an improvement on existing therapies for individuals with spinal stenosis and/or spondylolisthesis

The question addressed in this evidence review is: Does the use of interspinous fixation alone improve the net health outcome in individuals who have spinal stenosis and/or spondylolisthesis?

The following PICO was used to select literature to inform this review.

Population

The relevant population of interest is individuals who have spinal stenosis and/or spondylolisthesis.

Intervention

The therapy being considered is an interspinous fixation device alone.

Comparator

The following practice is currently being used to treat spinal stenosis and/or spondylolisthesis: decompression.

Outcomes

The general outcomes of interest include symptoms, functional outcomes, quality of life, resource utilization, and treatment-related morbidity.

Study Selection Criteria

Methodologically credible studies were selected using the following principles:

- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;
- In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
- To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
- Studies with duplicative or overlapping populations were excluded.

REVIEW OF EVIDENCE

Case Series

Sclafani et al (2014) reported on an industry-sponsored, retrospective series of the polyaxial PrimaLOK interspinous fusion device.[5,] Thirty-four patients were implanted with interspinous fixation devices alone, 16 patients received the PrimaLOK plus an interbody cage, and 3 patients received the PrimaLOK plus pedicle screw instrumentation and an interbody cage. Evaluation at 6 weeks found no cases of fracture or device migration, although there were 4 cases of hardware removal and 2 cases of reoperation for adjacent-level disease during follow-up. At a mean 22

months after the index surgery, the average pain score had improved from 7.2 to 4.5 on a 10-point scale (method of collection, eg, visual analog scale, were not specified). There was a statistically significant improvement in pain score for patients with degenerative disc disease with lumbar stenosis (2.8; n=25; $p<0.001$) and spondylolisthesis (4.6; n = 6; p = 0.01), but not for patients with lumbar disc herniation (2.2; n=10; $p>0.05$).

Section Summary: Interspinous Fixation Device as a Stand-Alone
There is a lack of evidence (only a retrospective series) on the efficacy of interspinous fixation devices as a stand-alone procedure for those who have spinal stenosis and/or spondylolisthesis. RCTs are needed that evaluate health outcomes following use of interspinous fixation devices as a stand-alone for decompression.

SUPPLEMENTAL INFORMATION

The purpose of the following information is to provide reference material. Inclusion does not imply endorsement or alignment with the evidence review conclusions.

Clinical Input From Physician Specialty Societies and Academic Medical Centers
While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

In response to requests, input was received from 3 physician specialty societies (2 reviewers) and 2 academic medical centers while this policy was under review in 2012. Input was mixed. Some indications where the devices might be medically necessary were noted, such as patients with small pedicles where pedicle screws could not be safely placed.

Practice Guidelines and Position Statements
Guidelines or position statements will be considered for inclusion in 'Supplemental Information' if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

North American Spine Society
In 2019, the North American Spine Society issued a coverage position on the use of interspinous devices with lumbar fusion.[6,] The North American Spine Society noted that although there is still limited evidence, interspinous fixation with fusion for stabilization may be considered when utilized in the context of lumbar fusion procedures for patients with diagnoses including stenosis, disc herniations, or synovial facet cysts in the lumbar spine, as an adjunct to cyst excision which involves removal of greater than 50 percent of the facet joint and when utilized in conjunction with a robust open laminar and/or facet decortication and fusion, and/or a robust autograft inter- and extra-spinous process decortication and fusion, and/or an interbody fusion of the same motion segment. The North American Spine Society also noted that "No literature supports the

use of interspinous fixation without performing an open decortication and fusion of the posterior bony elements or interbody fusion."

U.S. Preventive Services Task Force Recommendations
Not applicable.

Ongoing and Unpublished Clinical Trials
Several unpublished and ongoing trials that might influence this evidence review are listed in Table 5.

Table 5. Summary of Key Trials

NCT No.	Trial Name	Planned Enrollment	Completion Date
Ongoing			
NCT01455805[a]	Efficacy and Quality of Life Following Treatment of Lumbar Spinal Stenosis, Spondylolisthesis or Degenerative Disc Disease With the Minuteman Interspinous Interlaminar Fusion Implant Versus Surgical Decompression	50	March 2024
Unpublished			
NCT01560273[a]	A Multi-Center Prospective Study Evaluation Aspen Spinous Process Fixation System for Use in Posterolateral Fusion (PLF) in Patients With Spondylolisthesis	25	Sep 2015 (terminated)
NCT01549366[a]	System Versus Pedicle Screw Fixation, in Lateral Lumbar Interbody Fusion (LLIF) or Anterior Lumbar Interbody Fusion (ALIF)	64	Jan 2016 (completed)

NCT: national clinical trial.
[a] Denotes industry-sponsored or cosponsored trial.

No review or update is scheduled on this Medical Policy. Blue Cross and Blue Shield of Kansas will continue to monitor published literature for any updated information. If there are questions about coverage of this service, please contact Blue Cross and Blue Shield of Kansas customer service, or your professional / institutional relations representative.

CODING

The following codes for treatment and procedures applicable to this policy are included below for informational purposes. This may not be a comprehensive list of procedure codes applicable to this policy.

Inclusion or exclusion of a procedure, diagnosis or device code(s) 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 of these services as it applies to an individual member.

The code(s) listed below are medically necessary ONLY if the procedure is performed according to the "Policy" section of this document.

CPT/HCPCS	
22899	Unlisted procedure, spine

REVISIONS	
01-23-2015	Policy added to the bcbsks.com web site on 12-24-2014; effective 01-23-2015, 30 days after posting.
11-24-2015	Updated Description section.
	Updated Rationale section.
	Updated References section.
01-01-2017	In Coding section: ▪ Added CPT codes: 22853, 22854, 22859 *(New codes, effective January 1, 2017).* ▪ Removed CPT code: 22851 *(Termed code, effective December 31, 2016).* ▪ Removed coding bullet.
05-24-2017	Updated Description section.
	Updated Rationale section.
	Updated References section.
06-06-2018	Updated Description section.
	Updated Rationale section.
06-05-2019	Updated Rationale section.
	Updated References section.
04-16-2021	Updated Rationale section.
	Updated References section.
10-01-2021	In Coding section: • Added HCPCS code C1831 Effective 10-01-2021
06-01-2022	Updated Description Section
	Updated Rationale Section
	Updated Coding Section ▪ Removed CPT codes 22853, 22854, 22859, C1831
	Update References Section
05-23-2023	Updated Description Section
	Updated Rationale Section

No review or update is scheduled on this Medical Policy. Blue Cross and Blue Shield of Kansas will continue to monitor published literature for any updated information. If there are questions about coverage of this service, please contact Blue Cross and Blue Shield of Kansas customer service, or your professional / institutional relations representative.

REVISIONS	
	Updated Coding Section ▪ Removed ICD-10 Diagnoses box
	Update References Section
05-28-2024	Updated Description Section
	Updated Rationale Section
	Updated Coding Section ▪ Removed 22840 ▪ Added 22899
	Update References Section
05-28-2024	Archived

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