SPINAL STABILIZATION AND DECOMPRESSION DEVICES

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INSTRUCTIONS FOR USE
This Medical Policy provides assistance in interpreting UnitedHealthcare benefit plans. When deciding coverage, the enrollee specific document must be referenced. The terms of an enrollee’s document (e.g., Certificate of Coverage (COC), or Summary Plan Description (SPD)) may differ greatly. In the event of a conflict, the enrollee’s specific benefit document supersedes this Medical Policy. All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements and the plan benefit coverage prior to use of this Medical Policy. Other Policies and Coverage Determination Guidelines may apply. UnitedHealthcare reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

COVERAGE RATIONALE

Interspinous process decompression (IPD) systems, such as the X STOP® are unproven for the treatment of spinal stenosis.
Clinical evidence is limited to small studies with lack of blinding and long-term follow-up. The available evidence shows no significant difference between use of interspinous process decompression systems and conservative management.

Stabilization systems, such as the Dynesys® Dynamic Stabilization System or the DSS Stabilization System, are unproven for the treatment of degenerative spondylolisthesis.
The available evidence does not establish the efficacy of the system and contains design flaws such as inclusion of patients without degenerative spondylolisthesis and/or had other surgical procedures and the lack of long term follow-up.
Total facet joint arthroplasty, including facetectomy, laminectomy, foraminotomy, vertebral column fixation, or the use of posterior intrafacet implants is unproven. There is insufficient evidence in the peer reviewed literature that use of total facet joint arthroplasty will improve health outcomes. The Total Facet Arthroplasty System™ (TFAS) has not been approved by the U.S. Food and Drug Administration (FDA). A single clinical trial is in progress, but no results have been published.

Centers for Medicare & Medicaid Services (CMS)
Medicare does not have a national coverage policy for X STOP®. However, CMS has approved a $4400 add-on payment for fiscal year 2007 when X STOP implantation is used in place of laminectomy or decompression with fusion surgery. This payment will be provided under International Classification of Diseases, Clinical Modification (ICD-9-CM) code 84.58 in Diagnosis-Related Groups (DRGs) 499 and 500. The add-on payment program provides 2 to 3 years of special payments for new technologies that substantially improve treatment or diagnosis of Medicare patients. Detailed information is available at: http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1921 and http://www.cms.hhs.gov/Transmittals/downloads/R1067CP.pdf.

Local Coverage Determinations (LCDs) for Interspinous Process Decompression exist and compliance with these policies is required where applicable. These LCDs are available at: http://www.cms.hhs.gov/MCD/index_local_alpha.asp?from=alphalmrp&letter=I. (Accessed July 28, 2009)

Medicare does not have a national coverage policy for Dynesys® Dynamic Stabilization System. Local Coverage Determinations (LCDs) do not exist at this time. (Accessed July 28, 2009)

Medicare does not have a national coverage policy for Total Facet Arthroplasty System® (TFAS®). Local Coverage Determinations (LCDs) do not exist at this time. (Accessed July 28, 2009)

BACKGROUND

For degenerative disc disease, an abnormal forward (anterolisthesis) or backward (retrolisthesis) slippage of part of the spine, the usual surgical treatment involves alteration of the spinal tissues to relieve pressure on the spine. This procedure may be combined with removal of the spinal disc and fusion of the affected vertebrae.

Spinal Decompression Device: The X STOP Interspinous Process Decompression (IPD) System has been developed as part of a minimally invasive surgical method to treat lumbar spinal stenosis, an abnormal narrowing or constriction of spaces that provide pathways for spinal nerves. For many patients, this device can be implanted by an orthopedic surgeon under local anesthesia as an outpatient procedure, although in some circumstances, the physician may prefer to admit the patient for an inpatient stay. (Zucherman et al., 2004)

There are several spinal decompression devices such as The Wallis® System (Abbott Spine); the DIAM™ Spinal Stabilization System; the Coflex™ implant (Paradigm Spine) and the ExtendSure and CoRoent (both from NuVasive) are used in Europe but are not currently FDA approved.

Spinal Stabilization System: The Dynesys® Dynamic Stabilization System was designed as a means to provide stability during spinal fusion to stabilize the spine; however, is currently being investigated as a substitute for spinal fusion. The Dynesys Dynamic Stabilization System is intended for use in skeletally mature patients as an adjunct to fusion in the treatment of the following acute and chronic instabilities or deformities of the lumbar or sacral spine: degenerative spondylolisthesis with objective evidence of neurologic impairment, fracture dislocation, scoliosis, kyphosis, spinal tumor, and failed previous fusion (pseudoarthrosis).

Total Facet Joint Arthroplasty, such as the Total Facet Arthroplasty System® (TFAS®) is a
non-fusion spinal implant developed to treat patients with moderate to severe spinal stenosis. TFAS replaces the diseased facets (and lamina, if necessary) following surgical removal.

**CLINICAL EVIDENCE**

**Interspinous Process Decompression (IPD) Systems**

Anderson et al. (2006) conducted a randomized controlled study with a cohort of 75 patients with degenerative spondylolisthesis. 42 underwent surgical treatment and 33 control individuals were treated nonoperatively. In this study, they concluded that the X STOP was more effective than nonoperative treatment in the management of NIC secondary to degenerative lumbar spondylolisthesis.

Zucherman et al. (2004) completed a prospective randomized multi-center study of the X STOP IPD System. Patients who had experienced back pain for an average of 4.1 years and who had neurogenic intermittent claudication secondary to lumbar spinal stenosis that was documented by computed tomography (CT) or magnetic resonance imaging (MRI) were randomized to received either the X STOP (n=100) or non-operative therapy (n=91) as a control. The non-operative group received one or more epidural steroid injections and some also underwent treatment with NSAIDs, analgesics, and/or physical therapy. The primary outcome measure was the Zurich Claudication Questionnaire (ZCQ). At 2 years follow-up, mean ZCQ Symptom Severity scores had improved 45% for the X STOP treatment group versus a 7% improvement for the control group. In addition, mean ZCQ Physical Function scores had improved 44% for the X STOP treatment group versus no change for the control group. Concurrent with these findings, 73% of treatment group patients reported they were somewhat or more than somewhat satisfied with treatment versus 36% of control group patients. Differences between groups in ZCQ scores and patient satisfaction were statistically significant ($P<0.001$). During the 2-year follow-up period, 6% of X STOP treatment group patients and 30% of control group patients underwent laminectomy for unresolved symptoms; however, it was not reported whether this difference was statistically significant. At 1 and 2 years follow-up, there were no significant differences between the treatment and control groups in any of eight spinal radiographic measurements. While these results are promising, additional studies are needed to further validate these results.

A prospective study by Siddiqui et al. (2006) concluded that the X STOP device improves the degree of central and foraminal stenosis in vivo. This study was based on twenty-six patients with lumbar spine stenosis who underwent a one- or two-level X STOP procedure. All had preoperative and postoperative positional MRI in standing, supine, and sitting flexion and extension. Measurements were carried out on the images acquired.

In a comparison study, Kondrashov et al. (2006), presented 4-year follow up data on 18 patients. The average follow up was 51 months. Their results suggest that intermediate-term clinical outcomes of X STOP IPD surgery are stable over time as measured by the Oswestry Disability Index (ODI). However, they stated that lower disability at the start made it more difficult to achieve the 15 point-point ODI success criteria.

In a retrospective study by Verhoff et al. (2008) a cohort of 12 consecutive patients with symptomatic lumbar spinal stenosis caused by degenerative spondylolisthesis were treated with the X STOP interspinous distraction device. All patients had low back pain, neuroclaudication and radiculopathy. Pre-operative radiographs revealed an average slip of 19.6%. MRI of the lumbosacral spine showed a severe stenosis. In 10 patients, the X STOP was placed at the L4-5 level, whereas two patients were treated at both, L3-4 and L4-5 level. The mean follow-up was 30.3 months. In 8 patients a complete relief of symptoms was observed post-operatively, whereas the remaining 4 patients experienced no relief of symptoms. Recurrence of pain, neurogenic claudication, and worsening of neurological symptoms was observed in three patients within 24 months. Post-operative radiographs and MRI did not show any changes in the percentage of slip or spinal dimensions. Finally, secondary surgical treatment by decompression with posterolateral laminecmy was performed.
fusion was performed in seven patients (58%) within 24 months. The authors concluded that the X STOP interspinous distraction device showed an extremely high failure rate, defined as surgical re-intervention, after short term follow-up in patients with spinal stenosis caused by degenerative spondylolisthesis.

Siddiqui et al. (2005) performed a small, uncontrolled study of the X STOP IPD System to evaluate changes in the lumbar spine after device implantation. This study involved preoperative and postoperative MRI studies of 12 patients, 5 of whom underwent implantation of X STOP devices at two spinal levels. Six months after device implantation, at the sites of implantation, patients had statistically significant increases in posterior disc height while standing and in left and right exit foraminal dimensions during extension. These changes resulted in a mean overall increase in the cross-sectional area of the dural sac from 78 to 93 mm2 ($P<0.01$). Despite these changes, there were no significant changes in lumbar posture or in the overall range of lumbar spinal movements. Siddiqui et al. did not report any outcomes related to patients symptoms or physical function.

Another small, uncontrolled study of the X STOP IPD System was performed by Lee et al. (2004). These investigators implanted 11 devices in 10 patients with lumbar spinal stenosis. At a mean of 11 months after implantation, 5 patients were very satisfied and 2 patients were somewhat satisfied with the results of the procedure. Based on the Swiss Spinal Stenosis (SSS) questionnaire, these patients had no improvement in mean symptom severity. Although mean SSS physical function scores improved from 2.71 at baseline to 2.20, the investigators did not report whether this change was statistically significant. Lee et al. also reported an increase in mean dural sac cross-sectional area from 74 to 90 mm2 ($P<0.005$) and other radiographic outcomes similar to those reported by Siddiqui et al. (2005).

In a report published in September of 2007, by ECRI Institute, Emerging Technology (TARGET) Evidence Report, Interspinous Process Decompression to treat spinal stenosis, they outlined the quality and consistency of the current evidence base concerning the X STOP.

- Small evidence base. Only one RCT is available for analysis; results would need to be confirmed by other studies.
- Lack of blinding. Although surgical interventions present logistical barriers to blinding, a lack of blinding may impart a source of bias.
- Limited long-term follow-up. Two-year follow-up is inadequate to determine the durability of results associated with the X STOP implant. Issues such as implant dislodgement or migration may require longer follow-up in greater numbers of patients. The durability of symptom relief is another concern, and longer follow-up is required to determine what percentage of patients either experience recurrent symptoms or ultimately convert to a conventional surgical decompression procedure. Furthermore, implanting an X STOP spacer alters the biomechanics of the back, and longer follow-up could potentially reveal the emergence of new symptoms.
- Comparison to nonoperative treatment but not to other surgical options. The current clinical trial compares the X STOP to nonoperative treatment. Comparison to conventional surgical decompression procedures will be required to clarify where the X STOP procedure lies in the hierarchy of treatment options for spinal stenosis (i.e., Will X STOP implantation be considered an intermediate treatment option between nonoperative management and conventional surgical decompressive procedures or will X STOP implantation emerge as a definitive surgical procedure?).

**National Institute for Health and Clinical Excellence:** In a 2006 guideline regarding interspinous distraction procedures for lumbar spinal stenosis causing neurogenic claudication (such as the X STOP prosthesis), states that although there do not seem to be any major safety concerns related to use of this device, evidence of efficacy is limited and no long-term results have been obtained.

**Dynamic Stabilization System**
In a randomized controlled trial by Welch et al. (2007), the authors present the preliminary clinical outcomes of dynamic stabilization with the Dynesys spinal system as part of a multicenter randomized prospective Food and Drug Administration (FDA) investigational device exemption (IDE) clinical trial. This study included 101 patients from six IDE sites (no participants were omitted from the analysis) who underwent dynamic stabilization of the lumbar spine with the Dynesys construct. Patient participation was based on the presence of degenerative spondylolisthesis or retrolisthesis (Grade I), lateral or central spinal stenosis, and their physician’s determination that the patient required decompression and instrumented fusion for one or two contiguous spinal levels between L-1 and S-1. Participants were evaluated preoperatively, postoperatively at 3 weeks, and then at 3-, 6-, and 12-month intervals. The 100-mm visual analog scale was used to score both lower limb and back pain. Patient functioning was evaluated using the Oswestry Disability Index (ODI), and the participants’ general health was assessed using the Short Form-12 questionnaire. Overall patient satisfaction was also reported. One hundred one patients (53 women and 48 men) with a mean age of 56.3 years (range 27-79 years) were included. The mean pain and function scores improved significantly from the baseline to 12-month follow-up evaluation, as follows: leg pain improved from 80.3 to 25.5, back pain from 54 to 29.4, and ODI score from 55.6 to 26.3%.

The early clinical outcomes of treatment with Dynesys are promising, with lessening of pain and disability found at follow-up review. Dynesys may be preferable to fusion for surgical treatment of degenerative spondylolisthesis and stenosis because it decreases back and leg pain while avoiding the relatively greater tissue destruction and the morbidity of donor site problems encountered in fusion. However, long-term follow-up is still recommended. (Welch, 2007)

Stoll et al. (2002) conducted a clinical trial and is the largest of the three reviewed studies. Although these investigators enrolled 83 patients, only 39 (47%) of these patients had a diagnosis of degenerative spondylolisthesis, which was secondary. Primary indications for Dynesys device implantation were: spinal stenosis (60%), degenerative discopathy (24%), disc herniation (8%), revision surgery (6%), or not reported (1%). In addition to implantation of 1 or more Dynesys devices, 56 (75%) patients underwent direct decompression, 3 (4%) underwent nucleotomy, and 8 (10%) underwent other procedures that were not described. At a mean of 38 months after implantation, 8 (10%) patients had undergone implant removal, in some cases due to persistent pain. In the 73 patients who were available for follow-up, low-back pain on a 1 to 10 scale improved from 7.4 at baseline to 3.1 at final report. Likewise, Oswestry Disability Index scores improved from 55% to 23%. However, results were not reported separately for patients who had degenerative spondylolisthesis and 5 (6%) patients underwent additional procedures after Dynesys implantation including extension of implantation to an adjacent spinal level, decompression of an adjacent segment, spinal fusion, or laminectomy of the index segment.

The only available study in which all patients had degenerative spondylolisthesis was a clinical trial conducted by Schnake et al. (2006). These investigators enrolled 26 patients who had spinal stenosis that was treated with interlaminar decompression combined with implantation of a single Dynesys device. Outcomes were not reported for 1 (4%) patient who died of unrelated causes and 1 (4%) patient who fell and had a traumatic vertebral fracture. In the other 24 patients, pain on a 100-point scale improved from a mean score of 80 at baseline to a score of 23 at a mean of 26 months, a statistically significant difference ($P<0.00001$). Statistically significant improvements relative to baseline were also observed in mean walking distance, which improved from 250 meters to > 1000 meters ($P<0.00001$) and in number of patients using analgesics, which decreased from 19 to 6 ($P<0.02$). Of the 24 patients whose surgery outcomes were reported, 21 (88%) stated that they would undergo the operative procedure again. In spite of these improvements, the implant showed signs of failure in 4 (17%) patients, 5 (21%) patients still had claudication, 7 (29%) patients had degeneration of adjacent spinal segments, and mean overall spondylolisthesis increased by 2% (range 0% to 12%). Although this change in spondylolisthesis was not statistically significant, it did show a strong trend toward significance ($P=0.056$).

Scarfo and Muzii (2003) conducted a small, uncontrolled study of Dynesys device implantation for
lumbar vertebral instability. These investigators enrolled 26 patients but 13 (50%) of these patients also underwent microsurgical decompression and only 14 (54%) of these patients had spondylolisthesis or pseudospondylolisthesis. Outcomes reported at an average of 24 months after surgery indicated that back pain ceased in 20 (77%) patients and decreased in the other 6 (23%) patients. Neurological symptoms decreased and nerve root pain disappeared; however, these improvements were not reported quantitatively. Moreover, pain and neurological outcomes do not seem to have been reported separately for patients with spondylolisthesis. Although standard radiographs indicated that spondylolisthesis disappeared in 9 (64%) patients and improved in the other 5 (36%), the extent of spondylolisthesis at baseline was not reported and it was not reported whether the overall improvement was statistically significant compared with baseline.

Results of these studies provide little evidence concerning the efficacy of the Dynesys Dynamic Stabilization System for degenerative spondylolisthesis. In all three available studies, 50% to 100% of the patients underwent surgical procedures other than Dynesys device implantation so it is not possible to determine which treatment effects could be attributed to the Dynesys device. Furthermore, in two of the reviewed studies, approximately half of the patients did not have spondylolisthesis and most or all of the outcomes were not reported separately for patients with and without spondylolisthesis. One of the three reviewed studies enrolled patients only if they had degenerative spondylolisthesis and this study found that overall, mean spondylolisthesis worsened by 2%. Although this change was not statistically significant, it did show a strong trend toward significance (Schnake, 2006). In contrast, an uncontrolled trial with a small number of patients who had spondylolisthesis and who underwent Dynesys device implantation reported that spondylolisthesis improved or disappeared in all patients; however, this study did not report the extent of spondylolisthesis at baseline, nor did it report whether improvements in spondylolisthesis were statistically significant (Scarfo, 2003). Controlled studies with adequate follow-up and thorough assessment of outcomes are needed to determine if the Dynesys Dynamic Stabilization System provides clinically significant benefits for patients who have degenerative spondylolisthesis.

Grob et al. (2005) reported on a retrospective case series involving 50 consecutive patients instrumented with Dynesys®. Patients were asked to respond to a questionnaire after Dynesys implantation, and 31 (64%) patients responded. After 2 years of follow-up, 19% were scheduled for further surgical intervention. Only 50% of the patients indicated that the surgery had helped and improved overall quality of life and less than half reported improvement in functional capacity. The authors concluded that the results did not support the premise that semi-rigid fixation of the lumbar spine results in better patient-oriented outcomes than typical fusion.

Total Facet Arthroplasty System™ (TFAS)
A clinical trial of the TFAS™ (2007) is currently being conducted as a multi-center, prospective, randomized controlled clinical trial comparing the safety and efficacy of the TFAS™ to spinal fusion surgery in the treatment of moderate to severe degenerative lumbar spinal stenosis. The study plans to enroll 450 participants at approximately 20 investigative sites meeting the following inclusion criteria:

- Degenerative spinal stenosis, central or lateral, at spinal levels L3-L4 or L4-L5;
- Skeletally mature male or female between the ages of 50 and 85 years of age inclusive;
- No greater than Grade I degenerative spondylolisthesis at the index level;
- Persistent leg symptoms, including pain, numbness, burning or tingling for a minimum duration of six months;
- Operative candidates with no more than three levels of degenerative lumbar spinal stenosis requiring decompression;
- Failed to respond to non-operative treatment modalities for a minimum duration of six months.

Study participants will be placed into one of two groups: 1) treatment with the investigational artificial facet replacement device (TFAS®2) treatment with posterior instrumented fusion, considered the current standard of care for stenosis patients and likely the treatment that would
be carried out on these patients, regardless of their participation in the trial. Patient enrollment in the trial will be randomized such that two thirds will receive the TFAS® and one third will receive the standard instrumented fusion treatment.

**U.S. FOOD AND DRUG ADMINISTRATION (FDA)**

The FDA regulates the X STOP IPD System as a spinous process spacer/plate prosthesis. It received premarket approve (PMA) on November 21, 2005. No spinous process spacer/plate prosthesis other than the X STOP IPD System has been approved by the FDA.

As stated in labeling approved by the FDA, the X STOP implant is indicated for treatment of patients aged 50 or older suffering from pain or cramping in the legs (neurogenic intermittent claudication) secondary to a confirmed diagnosis of lumbar spinal stenosis. The X STOP is indicated for those patients with moderately impaired physical function who experience relief in flexion from their symptoms of leg/buttock/groin pain, with or without back pain, and have undergone a regimen of at least 6 months of nonoperative treatment. The X STOP may be implanted at one or two lumbar levels. Additional information is available at: [http://www.accessdata.fda.gov/cdrh_docs/pdf4/P040001b.pdf](http://www.accessdata.fda.gov/cdrh_docs/pdf4/P040001b.pdf). Accessed July 28, 2009.

The DSS Stabilization System (Paradigm Spine, LLC) received 501(k) approval on May 2, 2008 as a Class III device. The rigid design, to be used with autograft and/or allograft, is intended as a single-level system for non-cervical pedicle fixation from the T4 to S1 vertebrae in skeletally mature patients to help provide immobilization and stabilization of spinal segments, as an adjunct to fusion. The slotted design is intended to provide immobilization and stabilization of spinal segments as an adjunct to fusion in the treatment of acute and chronic instabilities or deformities of the thoracic, lumbar, and sacral spine. Additional information is available at: [http://www.accessdata.fda.gov/cdrh_docs/pdf9/K090099.pdf](http://www.accessdata.fda.gov/cdrh_docs/pdf9/K090099.pdf). Accessed July 28, 2009.


The 510(k) approval letter from the FDA to Zimmer Spine was dated March 11, 2005. The indications of use for the Dynesys® Spinal System (#K043565) are as follows: When used as a pedicle screw fixation system in skeletally mature patients, the Dynesys Spinal System is intended to provide immobilization and stabilization of spinal segments as an adjunct to fusion in the treatment of the following acute and chronic instabilities or deformities of the thoracic, lumbar, and sacral spine: Degenerative spondylolisthesis with objective evidence of neurologic impairment, and failed previous fusion (pseudarthrosis). Additional information is available at: [http://www.accessdata.fda.gov/cdrh_docs/pdf4/K043565.pdf](http://www.accessdata.fda.gov/cdrh_docs/pdf4/K043565.pdf). Accessed July 28, 2009.

In addition, when used as a pedicle screw fixation system, the Dynesys Spinal System is indicated for use in patients:

- Who are receiving fusions with autogenous graft only;
- Who are having the device fixed or attached to the lumbar or sacral spine;
- Who are having the device removed after the development of a solid fusion mass.

The Total Facet Arthroplasty System™ (Archus Orthopedics, Inc.) device is currently limited by the FDA to investigational use within the U.S.

**Additional Medical Products**

BioFlex System with Nitinol spring rod and memory loops; FASS (Fulcrum Assisted Soft
Stabilization); REVERE™ Stabilization System; Graf ligament Leeds-Keio Ligamentoplasty Loop system; NFlex™ Controlled Motion System (indicated for non-fusion only); Stabilmax NZ® Dynamic Spine Stabilization System; The X10 CROSSLINK® Plate Spinal System

APPLICABLE CODES

The codes listed in this policy are for reference purposes only. Listing of a service or device code in this policy does not imply that the service described by this code is a covered or non-covered health service. Coverage is determined by the benefit document. This list of codes may not be all inclusive.

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<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>0219T</td>
<td>Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; cervical</td>
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<td>0220T</td>
<td>Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; thoracic</td>
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<td>Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; lumbar</td>
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<td>0222T</td>
<td>Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; each additional vertebral segment (List separately in addition to code for primary procedure)</td>
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<td>0171T</td>
<td>Insertion of posterior spinous process distraction device (including necessary removal of bone or ligament for insertion and imaging guidance), lumbar; single level</td>
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<tr>
<td>0172T</td>
<td>Insertion of posterior spinous process distraction device (including necessary removal of bone or ligament for insertion and imaging guidance), lumbar; each additional level (List separately in addition to code for primary procedure)</td>
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<td>0202T</td>
<td>Posterior vertebral joint(s) arthroplasty (e.g., facet joint[s] replacement) including facetectomy, laminectomy, foraminotomy and vertebral column fixation, with or without injection of bone cement, including fluoroscopy, single level, lumbar spine</td>
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<td>Unlisted procedure, spine</td>
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ICD-9 Procedure Code | Description
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84.80 | Insertion or replacement of interspinous process device(s)
84.81 | Revision of interspinous process device(s)
84.82 | Insertion or replacement of pedicle-based dynamic stabilization device(s)
84.83 | Revision of pedicle-based dynamic stabilization device(s)
84.84 | Insertion or replacement of facet replacement device(s)
84.85 | Revision of facet replacement device(s)

REFERENCES


ECRI Institute. Health Technology Information Service. Emerging Technology (TARGET)


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<th>Date</th>
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| 01/01/2010 | • Expanded list of unproven indications for total facet joint arthroplasty to include posterior intrafacet implants  
• Added 0219T, 0220T, 0221T and 0222T to list of applicable CPT codes  
• Archived previous policy version 2009T0501D |