

Interspinous Fixation (Fusion) Devices

Policy # 00679

Original Effective Date: 10/01/2019

Current Effective Date: 08/01/2026

Applies to all products administered or underwritten by Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc. (collectively referred to as the "Company"), unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

Investigational or experimental services are not covered. This includes any drug, device, procedure, or service provided under the investigational arm of a clinical trial or clinical study. These services are excluded from coverage under benefits.

Note: Interspinous and Interlaminar Stabilization/Distracton Devices (Spacers) is addressed separately in medical policy 00221.

Services Are Considered Investigational

Coverage is not available for investigational medical treatments or procedures, drugs, devices or biological products.

Based on review of available data, the Company considers interspinous fixation (fusion) devices to be **investigational*** for **ANY** indication, including but not limited to use:

- In combination with interbody fusion; **OR**
- Alone for decompression in individuals with spinal stenosis.

Policy Guidelines

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

There are no specific codes for spinal instrumentation using the spinous process fixation orthoses. The appropriate code for reporting this procedure is 22899; it is inappropriate to use the posterior pedicle fixation CPT codes 22840-22844 or interspace instrumentation codes 22853, 22854, or 22859. It is also inappropriate to use the CPT codes for conventional spinal fusion 22610-22632 because the procedure for insertion of this device is significantly different than conventional fusion techniques (e.g., pedicle screw fixation).

Background/Overview

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

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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. 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.

Unlike interspinous fixation devices, interspinous distraction devices (spacers) are used alone for decompression and are typically not fixed to the spinous process (see medical policy 00221). 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.

FDA or Other Governmental Regulatory Approval

U.S. Food and Drug Administration (FDA)

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

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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.

Rationale/Source

This medical policy was developed through consideration of peer-reviewed medical literature generally recognized by the relevant medical community, U.S. Food and Drug Administration approval status, nationally accepted standards of medical practice and accepted standards of medical practice in this community, technology evaluation centers, reference to regulations, other plan medical policies, and accredited national guidelines.

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 individuals with spinal stenosis and/or spondylolisthesis.

Summary of Evidence

For individuals who are undergoing spinal fusion who receive an interspinous fixation device with interbody fusion, the evidence includes a systematic review of nonrandomized comparative studies and case series and 2 small RCTs. Relevant outcomes are symptoms, functional outcomes, quality of life, resource utilization, and treatment-related morbidity. 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). The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have spinal stenosis and/or spondylolisthesis who receive an interspinous fixation device alone, the evidence includes a small RCT and 2 retrospective series. Relevant

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outcomes are symptoms, functional outcomes, quality of life, resource utilization, and treatment-related morbidity. There is a lack of evidence on the efficacy of interspinous fixation devices as a stand-alone procedure. Well-designed randomized controlled trials are needed that evaluate health outcomes following use of interspinous fixation devices as a stand-alone for decompression. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Supplemental Information

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 2025, the North American Spine Society updated a coverage position on the use of interspinous devices with lumbar fusion. 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.

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Medicare National Coverage

There is no national coverage determination. In the absence of a national coverage determination, coverage decisions are left to the discretion of local Medicare carriers.

Ongoing and Unpublished Clinical Trials

Several unpublished and ongoing trials that might influence this medical policy are listed in Table 1

Table 1. Summary of Key Trials

NCT No.	Trial Name	Planned Enrollment	Completion Date
<i>Unpublished</i>			
NCT06335511	Decompression Versus Instrumented Fusion for Lumbar Degenerative Disease. Clinical and Biomechanical Outcome Study	50	Dec 2024 (completed)
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)

NCT: national clinical trial.

^a Denotes industry-sponsored or cosponsored trial.

References

1. Wu JC, Mummaneni PV. Using lumbar interspinous anchor with transforaminal lumbar interbody fixation. *World Neurosurg.* May 2010; 73(5): 471-2. PMID 20920928
2. Lopez AJ, Scheer JK, Dahdaleh NS, et al. Lumbar Spinous Process Fixation and Fusion: A Systematic Review and Critical Analysis of an Emerging Spinal Technology. *Clin Spine Surg.* Nov 2017; 30(9): E1279-E1288. PMID 27438402
3. Huang WM, Yu XM, Xu XD, et al. Posterior Lumbar Interbody Fusion with Interspinous Fastener Provides Comparable Clinical Outcome and Fusion Rate to Pedicle Screws. *Orthop Surg.* May 2017; 9(2): 198-205. PMID 28544495
4. Panchal R, Denhaese R, Hill C, et al. Anterior and Lateral Lumbar Interbody Fusion With Supplemental Interspinous Process Fixation: Outcomes from a Multicenter, Prospective, Randomized, Controlled Study. *Int J Spine Surg.* Apr 2018; 12(2): 172-184. PMID 30276077
5. Baranidharan G, Bretherton B, Feltbower RG, et al. 24-Month Outcomes of Indirect Decompression Using a Minimally Invasive Interspinous Fixation Device versus Standard Open Direct Decompression for Lumbar Spinal Stenosis: A Prospective Comparison. *J Pain Res.* 2024; 17: 2079-2097. PMID 38894862
6. Sclafani JA, Liang K, Ohnmeiss DD, et al. Clinical outcomes of a polyaxial interspinous fusion system. *Int J Spine Surg.* 2014; 8. PMID 25694912

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7. Soto E, Esposito MF. Safety and Efficacy of Interspinous Fixation Device via Lateral Transverse Approach in Patients with Lumbar Spinal Stenosis: A Single Center, Retrospective, Observational Study. J Pain Res. 2025; 18: 4431-4441. PMID 40901384
8. North American Spine Society (NASS). NASS coverage policy recommendations: Interspinous fixation with fusion. 2025; <https://www.spine.org/Product-Details?productid=%7B7D67EEB8-4CC7-E411-9CA5-005056AF031E%7D>.

Policy History

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07/03/2019	Medical Policy Committee review
07/18/2019	Medical Policy Implementation Committee approval. New policy.
07/02/2020	Medical Policy Committee review
07/08/2020	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
07/01/2021	Medical Policy Committee review
07/14/2021	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
07/07/2022	Medical Policy Committee review
07/13/2022	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
06/21/2023	Coding update
07/06/2023	Medical Policy Committee review
07/12/2023	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
07/02/2024	Medical Policy Committee review
07/10/2024	Medical Policy Implementation Committee approval. Added a second paragraph to Policy Guidelines regarding no specific codes for spinal instrumentation using the spinous process fixation orthoses. Coverage eligibility unchanged.
07/03/2025	Medical Policy Committee review
07/09/2025	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
07/02/2026	Medical Policy Committee review
07/08/2026	Medical Policy Implementation Committee review
07/16/2026	Medical Quality Management Committee approval. Coverage eligibility unchanged.

Next Scheduled Review Date: 07/2027

Coding

The five character codes included in the Louisiana Blue Medical Policy Coverage Guidelines are obtained from Current Procedural Terminology (CPT®)†, copyright 2025 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character

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identifying codes and modifiers for reporting medical services and procedures performed by physician.

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CPT is a registered trademark of the American Medical Association.

Codes used to identify services associated with this policy may include (but may not be limited to) the following:

Code Type	Code
CPT	22899
HCPCS	No codes
ICD-10 Diagnosis	All related diagnoses

*Investigational – A medical treatment, procedure, drug, device, or biological product is Investigational if the effectiveness has not been clearly tested and it has not been incorporated into standard medical practice. Any determination we make that a medical treatment, procedure, drug, device, or biological product is Investigational will be based on a consideration of the following:

- A. Whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or
- B. Whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:
 1. Consultation with technology evaluation center(s);
 2. Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
 3. Reference to federal regulations.

‡ Indicated trademarks are the registered trademarks of their respective owners.

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NOTICE: If the Patient's health insurance contract contains language that differs from the BCBSLA Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

NOTICE: Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Company recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.

NOTICE: Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

NOTICE: If an authorization for an ongoing course of treatment has been provided to a member and the member changes from one health plan to another health plan (e.g., a member moves from carrier A to Louisiana Blue), Louisiana Blue may honor the previous health plan's authorization for the same service under the same type of in-network benefit for a 90-day transition period. Documentation of the authorization for the ongoing course of treatment from the previous health plan must be provided to us by the member or their provider and the services provided for the course of treatment must otherwise be a covered service under the Louisiana Blue health plan. This provision does not apply to medications covered under the plan's pharmacy benefit.