Electrical Stimulation of the Spine as an Adjunct to Spinal Fusion Procedures

Either invasive or noninvasive methods of electrical bone growth stimulation may be considered medically necessary as an adjunct to lumbar spinal fusion surgery in patients at high risk for fusion failure, defined as any one of the following criteria:

- Alcoholism
- Current tobacco use
- Diabetes
- Fusion to be performed at more than one level
- Grade III or worse spondylolisthesis
- One or more previous failed spinal fusion(s)
- Renal disease
- Steroid use

Noninvasive electrical bone stimulation may be considered medically necessary as a treatment of patients with failed lumbar spinal fusion. Failed spinal fusion is defined as a spinal fusion that has not healed at a minimum of 6 months after the original surgery, as evidenced by serial x-rays over a course of 3 months.

Semi-invasive electrical stimulation is considered investigational as an adjunct to lumbar fusion surgery and for failed lumbar fusion.

Invasive, semi-invasive, and noninvasive electrical stimulation are considered investigational as an adjunct to cervical fusion surgery and for failed cervical spine fusion.

Related Policies

1.01.05  Ultrasound Accelerated Fracture Healing Device
7.01.07  Electrical Bone Growth Stimulation of the Appendicular Skeleton
7.01.542 Lumbar Spinal Fusion
Policy Guidelines

Coding

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Description

Background
Both invasive and noninvasive electrical bone growth stimulators have been investigated as an adjunct to spinal fusion surgery, with or without associated instrumentation, to enhance the chances of obtaining a solid spinal fusion. Noninvasive Devices have also been investigated to treat a failed fusion.

Electrical and electromagnetic fields can be generated and applied to bones through the following methods:

- Surgical implantation of a cathode at the fracture site with the production of direct current (DC) electrical stimulation. Invasive devices require surgical implantation of a current generator in an intramuscular or subcutaneous space, while an electrode is implanted within the fragments of bone graft at the fusion site. The implantable device typically remains functional for 6 to 9 months after implantation, and, although the current generator is removed in a second surgical procedure when stimulation is completed, the electrode may or may not be removed. Implantable electrodes provide constant stimulation at the nonunion or fracture site but carry increased risks associated with implantable leads.

- Noninvasive electrical bone growth stimulators generate a weak electrical current within the target site using either pulsed electromagnetic fields, capacitive coupling, or combined magnetic fields. In capacitive coupling, small skin pads/electrodes are placed on either side of the fusion site and worn for 24 hours per day until healing occurs or up to 9 months. In contrast, pulsed electromagnetic fields are delivered via treatment coils that are placed into a back brace or directly onto the skin and are worn for 6–8 hours per day for 3 to 6 months. Combined magnetic fields deliver a time-varying magnetic field by superimposing the time-varying magnetic field onto an additional static magnetic field. This device involves a 30-minute treatment per day for 9 months. Patient compliance may be an issue with externally worn devices.

- Semi-invasive (semi-implantable) stimulators use percutaneous electrodes and an external power supply obviating the need for a surgical procedure to remove the generator when treatment is finished.

Regulatory Status

**Implantable Devices**
The following implantable devices have received FDA premarket approval (PMA):

- The OsteoStim® (Electro-Biology, Inc.), which may also be marketed under the trade name SPF (Biomet), has received FDA PMA.

**Noninvasive Devices**
Noninvasive bone growth stimulators that have received FDA PMA include:

- The SpinalPak® bone growth stimulator system from Biolectron (a subsidiary of Electro-Biology Inc.,
Parsippany, NJ) is a capacitive coupling system, received PMA in 1999 for use as an adjunct to primary lumbar spinal fusion at one or two levels.

- The EBI Bone Healing System® from Biolectron (a subsidiary of Electro-Biology Inc., Parsippany, NJ) is a pulsed electromagnetic field system which was first approved in 1979 with FDA PMA and indicated for nonunions, failed fusions, and congenital pseudoarthroses. The device is secured with a belt around the waist.
- SpinaLogic Bone Growth Stimulator® (Regentek, a division of dj Orthopedics - formerly OrthoLogic, Tempe, AZ) received PMA in 1994 as a combined magnetic field portable device. This device is secured with a belt around the waist.
- Spinal-Stim Lite ® (Orthofix Inc., Richardson, TX) received PMA in 1996 as a spinal adjunct to the Physio-Stim®. This device was approved to increase the probability of fusion success and as a non-operative treatment for the salvage of failed spinal fusion, where a minimum of 9 months has elapsed since the last surgery.
- The Cervical-Stim® (Orthofix Inc., Richardson, TX) is a pulsed electromagnetic field system that was approved in 2004 as an adjunct to cervical fusion surgery in patients at high risk for non-fusion. An illustration of how this particular device is worn is available at online site: http://web.orthofix.com/Products/Pages/Cervical-Stim.aspx . Accessed November, 2015.

**Semi-invasive Devices**

No semi-invasive electrical bone growth stimulator devices were identified with FDA approval or clearance.

FDA product codes: LOE, LOF

### Scope

Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.

### Benefit Application

Invasive electrical stimulation will be billed as a component of the hospital bill. Noninvasive devices may be adjudicated according to the member’s benefits for durable medical equipment.

### Rationale

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The evidence review regarding electrical bone stimulation as an adjunct to spinal fusion surgery or as a treatment of failed spinal fusion surgery (i.e., salvage therapy) was initially based on 2 TEC Assessments (1, 2). The policy has subsequently been updated on a regular basis using MEDLINE literature searches; the searches have focused on review of controlled trials. The most recent literature review was conducted through February 11, 2016. The initial TEC Assessments (1,2) offered the following conclusions:

- Data from a randomized controlled clinical trial of patients meeting the criteria for high risk for development of failed fusion suggest that invasive or noninvasive electrical bone stimulation as an adjunct to spinal fusion surgery is associated with a significantly higher spinal fusion success rate in the treated group compared with the control group. (3, 4)
- Data from uncontrolled studies of patients with failed spinal fusion suggest that noninvasive electrical stimulation results in a significantly higher fusion rate. The lack of controlled clinical trials is balanced by the fact that these patients served as their own control.

A 2014 systematic review by Park et al offered a different conclusion. Six RCTs through October 2013 were included, and investigated the effect of electrical stimulation versus no electrical stimulation on fusion rates after lumbar spinal fusion for the treatment of degenerative disease. The following types of electrical stimulation were included in the studies: direct current (3 studies), pulsed electromagnetic field (3 studies), and capacitive coupling (1 study). Control groups consisted of no stimulation (2 studies) or placebo (4 studies). A meta-analysis was not performed due to marked heterogeneity in the study populations, characteristics, and designs. Regardless of the type of electrical stimulation used, the cumulative incidences of fusion varied widely across RCTs and ranged from about 35% to 91% in the intervention groups and from about 33% to 82% in the control groups. Follow-up ranged from 9 to 24 months.

### Implantable (Invasive) Electrical Bone Growth Stimulation

#### Lumbar Spine Instrumented Spinal Fusion

Kucharzyk reported on a controlled prospective nonrandomized trial of implantable electrical stimulation in patients undergoing instrumented posterior spinal fusion with pedicle screws. A series of 65 patients who did not use electrical stimulation were compared with a later series of similar patients who did receive implantable electrical stimulation. Fusion success was 95.6% in the stimulated group compared with 87% in the nonstimulated group, a statistically significant difference. It appears that all patients had at least one or more high-risk factors for failed fusion, i.e., smoking history, prior surgery, multiple fusion levels, diabetes, etc. While this trial supports the use of electrical stimulation as an adjunct to instrumented posterior lumbar fusion, it did not specifically identify the outcomes in patients considered to be at low risk for failed fusion. Rogozinski and Rogozinski reported on the outcomes of two consecutive series of patients undergoing posterolateral fusions with autologous bone graft and pedicle screw fixation. The first series of 41 patients were treated without electrical stimulation, while the second group of 53 patients received invasive electrical stimulation. Those receiving electrical stimulation reported a 96% fusion rate, compared with an 85% fusion rate in the unstimulated group. The fusion rate for patients receiving stimulation versus no stimulation was also significantly higher among those considered at high risk due to previous back surgery or multiple fusion levels. No significant increase in the fusion rate was noted among non-smokers (i.e., without a risk factor), but the comparative fusion rates for all patients without high-risk factors is not presented.

#### Non-instrumented Spinal Fusion

In 2009, Andersen et al. published 2-year radiographic and functional outcomes from a European multicenter randomized controlled trial (RCT) of direct current (DC) stimulation with the SpF-XL IIb for posterolateral lumbar spinal fusion (PLF) in 98 patients older than age 60 years. This age group has decreased fusion potential. In
addition, instrumentation was not used due to risks related to longer operating times and screw loosening due to osteoporosis. All patients received fresh frozen allograft bone mixed with autograft obtained from the decompresion procedure and were braced for 3 months after surgery. Dummy electrodes were placed in the control group to allow blinded radiographic evaluation, but patients, and surgeons were not blinded to treatment group. Stimulator-specific complications included 3 cases of hematoma after removal of the battery and 2 patients who had pain at the site of the subcutaneous pocket. Three patients dropped out before the 1-year radiologic evaluation, 1 patient died, and an additional 25 patients did not complete the functional outcome questionnaires, resulting in 70% follow-up at 2-years. The percentage of dropouts was similar for the 2 treatments; patients who missed their 2-year evaluation had poorer outcomes on the Dallas Pain Questionnaire at the 1-year follow-up. Blinded evaluation of fusion by computed tomography (CT) scan indicated the same low percentage of cases with fusion in the 2 groups (33%). Fusion rates by plain radiographs were 57% in the control group (24/42) and 64% in the standard DC-stimulation group (27/42). Patients who achieved a solid fusion had better functional outcome and pain scores at their latest follow-up. At 2-year follow-up, electrical stimulation was associated with improved functional outcomes on 3 of 4 Dallas Pain Questionnaire subscales (daily activity, work/leisure, social interest) but not for the Low Back Pain Rating Scale or the validated 36-Item Short -Form Health Survey. These functional results have a high potential for bias due to the dropout of patients who had poorer outcomes and unequal patient expectation in this unblinded study.

In a 2010 publication, Anderson et al. evaluated bone quality of the fusion mass in 80 of the patients previously described (82% of 98) who underwent dual energy x-ray absorptiometry scanning to evaluate bone mineral density (BMD) at the 1-year follow-up. (10) This report describes 40 (n=46) and 100 (n=8) microAmp DC stimulation compared with a non-stimulated control condition (n=36). Fusion rates determined by CT scanning at the 2-year follow-up were 34% in the control group and 33% and 43% in the 40 and 100 microAmp groups, respectively (not significantly different). Patients classified as fused after 2 years had significantly higher fusion mass BMD at 1 year (0.592 vs. 0.466 g/cm²), but DC electrical stimulation did not improve fusion mass bone quality (0.483 g/cm² for 40 microAmp, 0.458 g/cm² for 100 microAmp, 0.512 g/cm² for controls). Using linear regression, fusion mass bone quality was significantly influenced by sex, age of the patient, bone density of the remaining part of the lumbar spine, amount of bone graft applied, and smoking.

Noninvasive Electrical Bone Growth Stimulation

**Lumbar Spine**

Goodwin et al. reported on the results of a study that randomly assigned 179 patients undergoing lumbar spinal fusions to receive or not receive capacitively coupled electrical stimulation. (11) A variety of surgical procedures both with and without instrumentation were used, and subjects were not limited to high-risk patients. The overall successful fusion rate was 84.7% for those in the active group compared with 64.9% in the placebo group, a statistically significant difference. While the actively treated group reported increased fusion success for all stratification groups (i.e., according to fusion procedure, single or multilevel fusion, smoking or nonsmoking group), in many instances, the differences did not reach statistical significance because of small numbers. For example, the subgroups in which there was not a significant difference in fusion between the active and placebo groups included patients who had undergone previous surgery, smokers, and those with multilevel fusion. In addition, there were numerous dropouts in the study and a 10% noncompliance rate with wearing the external device for up to 9 months.

Mooney et al. reported on the results of a double-blind study that randomly assigned 195 patients undergoing initial attempts at interbody lumbar fusions with or without fixation to receive or not receive pulsed electromagnetic field electrical stimulation. (4) Patients were not limited to high-risk groups. In the active treatment group, the success rate was 92%, compared with 65% in the placebo group. On subgroup analysis, the treated group consistently reported an increased success rate. Subgroups included graft type, presence or absence of internal fixation, or presence or absence of smoking.

Linovitz et al. conducted a double-blind clinical trial that randomly assigned 201 patients undergoing 1- or 2-level posterolateral fusion without instrumentation to undergo active or placebo electrical stimulation using a combined magnetic field device. (12) Unlike capacitively coupled or pulsed electromagnetic field devices, the combined magnetic field device requires a single 30-minute treatment per day with the device centered over the fusion site. Patients were treated for 9 months. Among all patients, 64% of those in the active group showed fusion at 9 months compared with 43% of those with placebo devices, a statistically significant difference. On subgroup analysis, there was a significant difference among women, but not men.
The 2 separate studies by Mooney and Linovitz both excluded from their studies patients with severe osteoporosis, and Goodwin et al. excluded patients with osteoporosis of unspecified severity. (4, 11, 12) None of the studies mentioned steroid use; however, authors of 2 articles summarizing the available evidence on inhibition of bone healing (13) and the effects of drugs on bone healing (14) agree that long-term (longer than 1 week) steroid use has an inhibitory effect on bone healing. Thus, steroid use is added as an additional condition that results in high risk of non-fusion.

**Cervical Spine**

In 2008, Foley et al. published results of the industry-sponsored investigational device exemption (IDE) study of pulsed electromagnetic field (PEMF) stimulation as an adjunct to anterior cervical discectomy and fusion (ACDF) with anterior cervical plates and allograft interbody implants. (15, 16) This study described results using the Cervical-Stim device from Orthofix that received premarket approval (PMA) from FDA in 2004. A total of 323 patients were randomized, 163 to PEMF and 160 to no stimulation. All patients were active smokers (more than one pack of cigarettes per day, 164 patients) or were undergoing multilevel ACDF (192 patients). Patients with pertinent history of trauma, previous posterior cervical approach or revision surgery, and certain systemic conditions or steroid use, and regional conditions such as Paget's disease or spondylitis were excluded. Beginning 1 week after surgery, patients in the treatment group wore the Cervical-Stim device for 4 hours per day for 3 months.

Efficacy was measured by radiographic analysis at 1, 2, 3, 6, and 12 months. At 6 months, 122 patients in the treatment group and 118 in the control group were evaluable; 15 in the PEMF group and 13 in the control group voluntarily withdrew, 7 in the PEMF group and 1 control violated study protocol, and 19 in the PEMF group and 28 controls had radiographs that were not evaluable or radiographs that were not done within 2 weeks of the 6-month postoperative window. Fusion rates for the 240 (74%) evaluable patients at 6 months were 83.6% for the PEMF group and 68.6% for the control group (p=0.007). By intention-to-treat (ITT) analysis, assuming that non-evaluable patients did not have fusion, PEMF and control groups fusion rates were 65.6% and 56.3%, respectively; these rates were not significantly different (p=0.084). (FDA analysis, however, indicated that the results at 6 months were still statistically different in sensitivity analysis performed with the last observation carried forward or with all missing data imputed as non-fusion.) Of 245 patients available for follow-up at 12 months, fusion was achieved in 116 of 125 (92.8%) PEMF patients and 104 of 120 (86.7%) control patients; these rates were not significantly different (p=0.113). Patient compliance, which was automatically monitored by the device, was assessed at each visit; however, compliance data were not included in the article.

Clinical outcomes were not reported in the 2008 publication but were reported to FDA. With clinical success defined as no worsening in neurologic function, an improvement in visual analog scale pain assessment, and no worsening in Neck Disability Index, the study found no significant difference between groups in the percent of subjects considered a clinical success at 6 months (p=0.85) or 12 months (p=0.11). The marginal difference in fusion rates by ITT analysis at 6 months, non-significant difference in fusion rates at 12 months, and lack of difference in functional outcomes at either 6 or 12 months do not support the efficacy of this device.

The single other report of electrical stimulation as an adjunct to cervical fusion identified in searches of the MEDLINE database performed through August 2012 is a case report from 2004 that describes treatment with pulsed electromagnetic field stimulation for delayed union of anterior cervical fusion. (17)

Due to methodologic limitations in the only controlled trial published to date, the efficacy of electrical stimulation has not yet been established. Therefore, this technology is considered investigational for the cervical spine.

**Clinical Input Received 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 2 physician specialty societies and 3 academic medical centers while this policy was under review for January 2011. Clinical input agreed with the criteria for high risk of fusion.
failure of the lumbar spine. The input on electrical stimulation for the cervical spine was mixed; specifically, some of those providing input agreed that data do not demonstrate improved outcomes with use of electrical stimulation in cervical spine fusion surgery. Most reviewers agreed that the large number of dropouts, non-significant difference in fusion rates by ITT analysis, and lack of data on functional outcomes (e.g., pain, return to usual activity) limited interpretation of the published study results.

Ongoing and Unpublished Clinical Trials
A search of ClinicalTrials.gov in March 2016 did not identify any ongoing or unpublished trials that would likely influence this review.

Summary of Evidence
The evidence for invasive or noninvasive methods of electrical bone growth stimulation as an adjunct to lumbar spine fusion surgery in individuals who have a high risk for lumbar spinal fusion failure includes a systematic review, a TEC Assessment, and randomized controlled trials (RCTs). Relevant outcomes are symptoms, change in disease status, and functional outcomes. Results from these trials indicate that in patients with risk factors for failed fusion, either invasive or noninvasive electrical bone stimulation increases the fusion rate. The evidence is sufficient to determine qualitatively that the technology results in a meaningful improvement in the net health outcome.

The evidence for noninvasive electrical bone growth stimulation in individuals who are at normal risk for lumbar spinal fusion failure includes RCTs. Relevant outcomes are symptoms, change in disease status, and functional outcomes. Several RCTs have shown increased fusion rates with noninvasive bone stimulation in patient populations that include both high risk and normal risk groups. No studies were identified that studied a population of patients who were all at normal risk for fusion failure. The evidence is insufficient to determine the effects of the technology on health outcomes.

The evidence for noninvasive methods of electrical bone growth stimulation in individuals who have failed lumbar spinal fusion includes a TEC Assessment and studies where patients served as their own controls. Relevant outcomes are symptoms, change in disease status, and functional outcomes. Data indicate that noninvasive electrical stimulation improves the fusion rate in this population. The evidence is sufficient to determine qualitatively that the technology results in a meaningful improvement in the net health outcome.

The evidence for invasive or noninvasive electrical bone growth stimulation in individuals who are undergoing cervical spinal fusion surgery or who have failed cervical spine fusion surgery or who have failed cervical spine fusion includes an RCT. Relevant outcomes are symptoms, change in disease status, and functional outcomes. The only controlled trial published to date had methodologic limitations and the efficacy of electrical stimulation in the cervical spine has not been established. The evidence is insufficient to determine the effects of the technology on health outcomes.

The evidence for invasive, semi-invasive, or noninvasive electrical bone growth stimulation in individuals with lumbar spondylolysis (also known as pars inter-articularis fracture) consists of only a few cases reviewing the efficacy of external electrical bone growth stimulation. Stasinopoulos 2004 reports studies have shown that treatment for spondylolysis should include some type of immobilization or activity restriction. The evidence is insufficient to determine the effects of this treatment on health outcome. (18)

Practice Guidelines and Position Statements

American Association of Neurological Surgeons and the Congress of Neurological Surgeons (AANS/CNS)
Updated 2014 guidelines from the AANS/CNS state that there is no evidence published after their 2005 guidelines that conflicts with the previous recommendations regarding bone growth stimulation. (19) Based on a single level II study from 2009, the routine use of direct current stimulation (DCS) in patients older than age 60 years was not recommended. Use of DCS was recommended as an option for patients younger than 60 years of age, based on Level III and IV studies showing a positive impact on fusion rate. However, comments regarding the level III study were that it was a poorly designed and poorly conducted cohort study consisting of an exceedingly small heterogeneous population of patients, and the overall recommendation was level C. There was insufficient
evidence to recommend for or against the use of pulsed electromagnetic field stimulation (PEMFS) as a treatment alternative to revision surgery in patients presenting with pseudoarthrosis following posterolateral lumbar fusion (PLF, single level IV study). No additional studies investigating the efficacy of capacitive coupled electrical stimulation were identified.

The 2005 AANS/CNS guideline stated that there is class II and III evidence (nonrandomized comparative trials and case series) “to support the use of direct current stimulation or capacitative coupled stimulation for enhancing fusion rates in high-risk patients undergoing lumbar PLF. A beneficial effect on fusion rates in patients not at “high risk” has not been convincingly demonstrated, nor has an effect been shown for these modalities in patients treated with interbody fusion. There is limited evidence both for and against the use of PEMFS for enhancing fusion rates following PLF. Class II and III medical evidence supports the use of PEMFS for promoting arthrodesis following interbody fusion. Although some studies have purported to demonstrate functional improvement in some patient subgroups, other studies have not detected differences. All of the reviewed studies are significantly flawed by the use of a four-point patient satisfaction scale as the primary outcome measure. This outcome measure is not validated. Because of the use of this flawed outcome measure and because of the conflicting results reported in the better-designed studies that assess functional outcome, there is no consistent medical evidence to support or refute use of these devices for improving patient outcomes.” (20)

U.S. Preventive Services Task Force Recommendations
Electrical stimulation of the spine is not a preventive service.

Medicare National Coverage
Medicare covers noninvasive electrical stimulators for the following (21):

- Failed fusion, where a minimum of 9 months has elapsed since the last surgery AND
- As an adjunct to spinal fusion surgery for patients at high risk of pseudoarthrosis due to previously failed spinal fusion at the same site or for those undergoing multiple level fusion. A multiple level fusion involves three or more vertebrae (e.g., L3-L5, L4-S1, etc.).

Medicare covers invasive electrical stimulators:
- As an adjunct to spinal fusion surgery for patients at high risk of pseudoarthrosis due to previously failed spinal fusion at the same site or for those undergoing multiple level fusion. A multiple level fusion involves three or more vertebrae (e.g., L3-L5, L4-S1, etc.).

References


Appendix

N/A

History

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<td>Replace policy - Policy updated with literature search; no change in policy statement. Status changed from BC to AR.</td>
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<td>Disclaimer and Scope update - No other changes.</td>
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<td>10/14/08</td>
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American Association of Neurological Surgeons/Congress of Neurological Surgeons Treatment Guidelines. Reference added.

08/11/09 Replace policy - Policy updated with literature search; no change to the policy statement.
11/10/09 Cross Reference Update - No other changes.
New BC, Replaces PR

06/08/10 Replace policy - Replaces PR.7.01.534. On hold for 90 days, release to publish in November 2010.
11/01/10 Policy Published - Subsequent to release from 90-day hold; effective date 11/1/2010.
03/08/11 Replace policy - Policy updated with literature search through July 2010; references added and reordered; clinical input reviewed, no change in policy statement

01/11/12 Codes 0282T-0285T added.
12/19/12 Replace policy. Added 7.01.542 Lumbar fusion policy to related policies section. Rationale updated based on a literature search through August 2012. References 15-16 added, others rennumbered or removed. Policy statement unchanged.
12/09/13 Replace policy. A literature search through August 26, 2013 did not prompt the addition of new references. Policy statement unchanged.
03/17/14 Update Related Policies. Remove 7.01.100 as it was archived.
08/12/14 Update Related Policies. Change title to 7.01.542.
04/17/15 Update Related Policies. Remove 7.01.529 as it was deleted and replaced with new policy 7.01.07.
05/27/15 Coding update: CPT codes 0282T, 0283T, 0284T and 0285T removed; these apply specifically to another policy (7.01.139).
12/08/15 Annual Review. Literature search done with no resultant change to the policy statement.
06/14/16 Annual Review. Policy updated with literature review. Reference 5, 18 added. Policy statements unchanged.

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Hmoob (Hmong):

Iloko (Ilocano):
Daytoy a Pakdaar ket naglaon iti Napateg nga Impormasen. Daytoy a pakdaar mabalin nga adda ket naglaon iti napateg nga impormasen maipangegge iti aplikasyonono weno coverage babaen iti Premera Blue Cross. Daytoy ket mabalin dagiti importante a pelta iti daytoy a pakdaar. Mabalin nga adda rumbeng nga aramidono nga addang sakbay dagiti partikularen a naituing nga adda aldaw tapno mapagalaitedeyo ti coverage ti salun-atyo wenno tulong kadagiti gastos. Adda karbengano a mangala iti daytoy nga impormasen ken tulong ti bukodyo a pagasasao nga awan ti bayadanyo. Tumawag ti numero nga 800-722-1471 (TTY: 800-842-5357).

Italiano (Italian):

中文 (Chinese):
本通知有重要的讯息。本通知可能關於您透過 Premera Blue Cross 提交的申請或保險的重要訊息。本通知內可能有重要日期，您可能需要在截止日期之前採取行動，以保留您的健康保險或費用補貼。您有權利免費以您的母語得到本訊息和幫助。請接電話 800-722-1471 (TTY: 800-842-5357).
Due to the importance of the information contained in this notification, please contact us at
800-722-1471 (TTY: 800-842-5357) for more information.

Spanish (Spanish): Este aviso contiene información importante. Si desea más información, puede comunicarse con nosotros en el teléfono 800-722-1471 (TTY: 800-842-5357).

Polski (Polish): To ogłoszenie może zawierać ważne informacje. Jeśli jesteś zainteresowany bardziej szczegółową informacją, prosimy o skontaktowanie się z nami po numerze 800-722-1471 (TTY: 800-842-5357).