

# Interspinous Fusion and Decompression Devices (for North Carolina Only)

**Policy Number:** CSNCT0363.04  
**Effective Date:** January 1, 2026

[Instructions for Use](#)

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Related Policies
<ul style="list-style-type: none"> <li><a href="#">Epidural Steroid Injections for Spinal Pain (for North Carolina Only)</a></li> <li><a href="#">Facet Joint and Medial Branch Block Injections for Spinal Pain (for North Carolina Only)</a></li> <li><a href="#">Spinal Fusion and Bone Healing Enhancement Products (for North Carolina Only)</a></li> <li><a href="#">Total Artificial Disc Replacement for the Cervical Spine (for North Carolina Only)</a></li> <li><a href="#">Vertebral Body Tethering for Scoliosis (for North Carolina Only)</a></li> </ul>

## Application

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

## Coverage Rationale

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

## Medical Records Documentation Used for Reviews

Benefit coverage for health services is determined by the federal, state, or contractual requirements, and applicable laws that may require coverage for a specific service. Medical records documentation may be required to assess whether the member meets the clinical criteria for coverage but does not guarantee coverage of the services requested.

The patient's medical record must contain documentation that fully supports the medical necessity for the requested services. This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures. Documentation supporting the medical necessity should be legible, maintained in the patient's medical record, and must be made available upon request.

## Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
22853	Insertion of interbody biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges), when performed, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace (List separately in addition to code for primary procedure)
22854	Insertion of intervertebral biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges), when performed, to vertebral corpectomy(ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)
22859	Insertion of intervertebral biomechanical device(s) (e.g., synthetic cage, mesh, methylmethacrylate) to intervertebral disc space or vertebral body defect without interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)
*22867	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level
*22868	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level (List separately in addition to code for primary procedure)
*22869	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level
*22870	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure)
*22899	Unlisted procedure, spine

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Codes labeled with an asterisk (\*) are not on the State of North Carolina Medicaid Fee Schedule and therefore may not be covered by the State of North Carolina Medicaid Program.

## U.S. Food and Drug Administration (FDA)

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

A variety of products have received marketing clearance through the FDA's 510(k) process. and decompression. Refer to the following website for more information and search by product name in device name section:

<http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm>.

## References

North Carolina Medicaid, Division of Health Benefits, Clinical Coverage Policies, Spinal Surgeries, 1A-30. Available at: <https://medicaid.ncdhhs.gov/1a-30-spinal-surgeries/download?attachment>. Accessed October 16, 2025.

## Policy History/Revision Information

Date	Summary of Changes
01/01/2026	<p><b>Related Policies</b></p> <ul style="list-style-type: none"> <li>Removed reference link to the Medical Policy titled <i>Discogenic Pain Treatment (for North Carolina Only)</i></li> </ul> <p><b>Medical Records Documentation Used for Reviews</b></p> <ul style="list-style-type: none"> <li>Added language to indicate: <ul style="list-style-type: none"> <li>Benefit coverage for health services is determined by the federal, state, or contractual requirements, and applicable laws that may require coverage for a specific service</li> <li>Medical records documentation may be required to assess whether the member meets the clinical criteria for coverage but does not guarantee coverage of the service requested</li> <li>The patient's medical record must contain documentation that fully supports the medical necessity for the requested services</li> </ul> </li> </ul>

Date	Summary of Changes
	<ul style="list-style-type: none"> <li>○ This documentation includes but is not limited to relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures</li> <li>○ Documentation supporting the medical necessity should be legible, maintained in the patient's medical record, and must be made available upon request</li> </ul> <p><b>Supporting Information</b></p> <ul style="list-style-type: none"> <li>● Archived previous policy version CSNCT0363.03</li> </ul>

## Instructions for Use

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

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.