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Reviewed: 05/26/22

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## Subject: Facet Arthroplasty

THIS MEDICAL COVERAGE GUIDELINE IS NOT AN AUTHORIZATION, CERTIFICATION, EXPLANATION OF BENEFITS, OR A GUARANTEE OF PAYMENT, NOR DOES IT SUBSTITUTE FOR OR CONSTITUTE MEDICAL ADVICE. ALL MEDICAL DECISIONS ARE SOLELY THE RESPONSIBILITY OF THE PATIENT AND PHYSICIAN. BENEFITS ARE DETERMINED BY THE GROUP CONTRACT, MEMBER BENEFIT BOOKLET, AND/OR INDIVIDUAL SUBSCRIBER CERTIFICATE IN EFFECT AT THE TIME SERVICES WERE RENDERED. THIS MEDICAL COVERAGE GUIDELINE APPLIES TO ALL LINES OF BUSINESS UNLESS OTHERWISE NOTED IN THE PROGRAM EXCEPTIONS SECTION.

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### DESCRIPTION:

Facet arthroplasty refers to the implantation of a spinal prosthesis to restore posterior element structure and function as an adjunct to neural decompression. This procedure is proposed as an alternative to posterior spinal fusion for those with facet arthrosis, spinal stenosis, and spondylolisthesis.

The objective of facet arthroplasty is to stabilize the spine while retaining normal intervertebral motion of the surgically removed segment following neural decompression. It is proposed that facet arthroplasty should also maintain the normal biomechanics of the adjacent vertebrae. If normal motion patterns are achieved by artificial joints in the spine, the risk of adjacent-level degeneration thought to be associated with fusion may be mitigated.

### POSITION STATEMENT:

Total facet arthroplasty (facet replacement) is considered **experimental or investigational** for all indications. Data in published medical literature are inadequate to permit scientific conclusions on long-term and net health outcomes.

### BILLING/CODING INFORMATION:

#### CPT Coding

0202T	Posterior vertebral joint(s) arthroplasty (e.g. facet joint[s] replacement) including facetectomy, laminectomy, foraminectomy and vertebral column fixation, with or without injection of bone cement, including fluoroscopy, single level, lumbar spine ( <b>investigational</b> )
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0719T	Posterior vertebral joint replacement, including bilateral facetectomy, laminectomy, and radical discectomy, including imaging guidance, lumbar spine, single segment ( <b>investigational</b> )
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### **REIMBURSEMENT INFORMATION:**

Refer to section entitled **POSITION STATEMENT**.

### **PROGRAM EXCEPTIONS:**

**Federal Employee Program (FEP):** Follow FEP guidelines.

**State Account Organization (SAO):** Follow SAO guidelines.

**Medicare Advantage:** No National Coverage Determination (NCD) and/or Local Coverage Determination (LCD) were found at the time of the last guideline review date.

### **DEFINITIONS:**

No guideline specific definitions apply.

### **RELATED GUIDELINES:**

None applicable

### **OTHER:**

#### **Index terms used for facet arthroplasty (facet replacement):**

**Note:** The use of specific product names is illustrative only. It is not intended to be a recommendation of one product over another and is not intended to represent a complete listing of all products available.

ACADIA™ Facet Replacement System

Total Facet Arthroplasty System® (TFAS®)

Total Posterior-element System (TOPS™ System)

### **REFERENCES:**

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3. AHRQ National Guideline Clearinghouse. NGC-6456. Low back disorders. Occupational medicine practice guidelines: evaluation and management of common health problems and functional recovery in workers. 2nd ed. Elk Grove Village (IL): American College of Occupational and Environmental Medicine (ACOEM); 2004. p. 286-326.
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### **COMMITTEE APPROVAL:**

This Medical Coverage Guideline (MCG) was approved by the Florida Blue Medical Policy and Coverage Committee on 05/26/22.

### **GUIDELINE UPDATE INFORMATION:**

11/15/09	New Medical Coverage Guideline.
11/15/10	Scheduled review. No change in position statement; references updated.
10/15/11	Scheduled review; no change in position statement. Updated description section and references.

10/15/12	Scheduled review; no change in position statement. Revised description section and updated references.
10/15/13	Scheduled review; no change in position statement. Revised description section and program exceptions section. Updated references.
02/15/19	Scheduled review. Revised MCG title, description, and program exceptions. Maintained position statement and updated references.
10/15/20	Scheduled review. Maintained position statement and updated references.
06/15/22	Scheduled review. Maintained position statement and updated references.
07/01/22	Quarterly CPT/HCPCS coding update. Added 0719T.