blue of california

Medical Policy

Unicondylar Interpositional Spacer	
Type: Investigational / Experimental	**Policy Specific Section:** Surgery
Original Policy Date: June 1, 2003	**Effective Date:** January 7, 2011

Definitions of Decision Determinations

Medically Necessary: A treatment, procedure or drug is medically necessary only when it has been established as safe and effective for the particular symptoms or diagnosis, is not investigational or experimental, is not being provided primarily for the convenience of the patient or the provider, and is provided at the most appropriate level to treat the condition.

Investigational/Experimental: A treatment, procedure or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

Split Evaluation: Blue Shield policy review can result in a Split Evaluation, where a treatment, procedure or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

Description

Interpositional unicondylar spacers are metallic implants that are inserted into the joint space between the affected tibial plateau and femoral condyle. Instead of being fixed, the spacers are held in place by the geometry of the curved implant, ligament tension, and surrounding soft tissue structures. Interpositional unicondylar spacers have been developed as possible

alternatives to osteotomy or unicompartmental arthroplasty for treatment of unicompartmental knee arthritis. The UniSpacer™ is one such device.

Policy

Unicondylar interpositional spacers are considered **investigational** as a treatment for unicompartmental arthritis of the knee.

Policy Guideline

There is no specific CPT code for this procedure.

Internal Information

There is an MD Determination Form for this Medical Policy. It can be found on the following Web page:
http://myworkpath.com/healthcareservices/MedicalOperations/PSR_Determination_Pages.htm

Documentation Required for Clinical Review
Post Service • Operative report(s)

The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illness or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract. These Policies are subject to change as new information becomes available.

Click here to view the appendix for this policy

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