



# Clinical Policy: Bone Morphogenic Proteins for Use in Spinal Fusion

Reference Number: WA.CP.MP.530

Date of Last Review: 05/25

Effective Date: 07/01/25

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

## Description

This policy describes the medical necessity guidelines for bone morphogenic proteins used in spinal fusion surgery.

## Policy/Criteria

- I. It is the policy of Coordinated Care of Washington, Inc., and Coordinated Care Corporation, in accordance with the Health Care Authority's Health Technology Assessment and Health Care Authority Billing Guidelines, that bone morphogenic protein-2 (rhBMP-2) is considered **medically necessary** when all the following are met:
  - A. Used in the lumbar spine, and
  - B. Member/Enrollee is 18 years of age or over, and
  - C. One of the following:
    - i. Procedure is primary anterior open or laparoscopic fusion at **one** level between L4 and SI, or
    - ii. Revision lumbar fusion on a compromised patient for whom autologous bone and bone marrow harvest are not feasible or not expected to result in fusion.
- II. It is the policy of Coordinated Care of Washington, Inc., in accordance with the Health Care Authority's Health Technology Assessment and Health Care Authority Billing Guidelines, that bone morphogenic protein-7 (rhBMP-7) is **not medically necessary**.

## Background

This policy is based entirely on Washington State Health Care Authority (HCA) Health Technology Assessment (HTA) and Health Care Authority Billing Guidelines.

## Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2023, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

## CLINICAL POLICY

### Bone Morphogenic Proteins for Use in Spinal Fusion



CPT® Codes	Description
20930	Allograft, morselized, or placement of osteopromotive material, for spine surgery only
20931	Allograft, structural, for spine surgery only

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy developed.		9/24
Updated logo and added “Coordinated Care Corporation”. Struck coverage statement regarding lumbar fusion.	05/25	05/25

#### References

1. Hashimoto, R., Raich, A., Yoder, E., McMullen, K., Dettori, J., Spectrum Research. *On- and off-label uses of rhBMP-2 or rhBMP-7 for spinal fusion*. Washington Health Technology Assessment. February 14, 2012.
2. Washington State Health Care Authority. *Physician-related Services/Health Care Billing Guide*. [Physician-Related Services/Health Care Professional Services billing guide \(wa.gov\)](https://www.wa.gov/health-care/billing-guide) Revision effective July 1, 2024.

#### **Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or



regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/Enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

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**Note: For Medicaid members/enrollees**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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