Lumbar Disc Arthroplasty

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Effective Date	7/2023
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Coverage Policy	Surgical 124
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All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to be medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*.

Purpose:

This policy addresses Lumbar Disc Arthroplasty of the spine.

Description & Definitions:

Lumbar Disc Arthroplasty is a surgery that involves replacement of worn or degenerated disk in the lower part of the spine with an artificial disk, made of metal or a combination of plastic and metal.

Criteria:

Lumbar disc arthroplasty is considered medically necessary when **ALL of the following** criteria are met:

- Individual is between the age of 18 and 60 years
- Axial pain determined to be of discogenic origin is the primary complaint
- At least 6 months of symptoms which have not responded to a multifaceted program of conservative management.
- MRI and plain radiographs demonstrating moderate to severe degeneration of the disc with Modic changes (peridiscal bone signal above and below the disc space in question) with presence of single or dual (when using 2-level FDA-approved implant) level, advanced disc disease at L3-L4, L4-L5, or L5-SI.
- Individual reports moderate pain and disability ideally documented by a visual analog scale (VAS) pain score of 40 or higher (out of 100, or 4 out of 10) and individual has functional limitation of one or more IADL
- Any individual with underlying psychiatric disorder, such as depression, should be diagnosed and the management optimized prior to surgical intervention
- Absence of symptomatic degenerative disc disease at all other lumbar levels, as documented by normal X-rays, and MRI confirms no abnormalities or mild degenerative changes
- Implant device is FDA-approved

Lumbar Disc Arthroplasty is considered **not medically necessary** for any use other than those indicated in clinical criteria, to include but not limited to:

- Disc replacement at more than one spinal level (unless FDA approved for more than one level, e.g., prodisc® L Total Disc Replacement)
- Individual has history of prior lumbar fusion
- Individual with isolated radicular compression syndromes, especially due to disc herniation
- Hybrid lumbar total disc arthroplasty/lumbar fusion (lumbar total disc arthroplasty at one level at the same time as lumbar fusion at a different level)
- Arthroplasty using devices that are not FDA approved, or use of an FDA approved device in a manner not intended by FDA requirements.
- Individual requires significant facet arthropathy at the index level
- Depending on FDA-approved levels of diseases above L3-L4 or L4-L5
- Bony lumbar spinal stenosis
- Pars defect
- Prior fusion at intended level
- Individual with poorly managed psychiatric disorder
- Chronic radiculopathy (unceasing pain with leg pain symptoms greater than back pain symptoms for a minimum of one year)
- Clinically compromised vertebral bodies at affected level due to current or past trauma
- Lytic spondylolisthesis or degenerative spondylolisthesis of grade greater than 1
- Individual with allergy or sensitivity to implant materials (cobalt, chromium, molybdenum, polyethylene, titanium)
- Presence of infection or tumor
- Osteopenia or osteoporosis (defined as DEXA bone density measured T-score less than or equal to -1.0)

Coding:

Medically necessary with criteria:

Coding	Description
0163T	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), each additional interspace, lumbar (List separately in addition to code for primary procedure)
0165T	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, lumbar (List separately in addition to code for primary procedure)
0202T	Posterior vertebral joint(s) arthroplasty (eg, facet joint[s] replacement), including facetectomy, laminectomy, foraminotomy, and vertebral column fixation, injection of bone cement, when performed, including fluoroscopy, single level, lumbar spine
22857	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar
22862	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar

Considered Not Medically Necessary:

Coding	Description
	None

U.S. Food and Drug Administration (FDA) - approved only products only.

Document History:

Revised Dates:

- 2023: October

Reviewed Dates:

Effective Date:

- July 2023

References:

Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

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Special Notes: *

This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.

Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect,

physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. *Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*

Keywords:

Lumbar Disc Arthroplasty, SHP Surgical 124, Facet joint implantation, Total Posterior-element System, TOPS, Premia Spine, Total Facet Arthroplasty System, TFAS, Archus Orthopedics, ACADIA Facet Replacement System, Facet Solutions, Globus Medical