Sentara Health Plans

Medicaid

Spinal Arthroplasty, Surgical 35

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Implementation	12/1/2025
Next Review Date	8/2026
Coverage Policy	Surgical 35
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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 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. *

Description & Definitions:

Spinal arthroplasty is a procedure that replaces a worn-out disc or facet joint in the spine with a device that moves like a natural disc or joint. The artificial disc or facet joint can also be called a disc prosthetic or disc arthroplasty device or a facet joint arthroplasty/replacement.

Other common names: Cervical disc arthroplasty, Lumbar disc arthroplasty, Cervical Artificial Disc Replacement (CADR), Total Artificial Disc Replacement for the Spine, Single-Level Artificial Disc Replacement, two-level lumbar total disk replacement (LTDR), Multilevel Artificial Disc Replacement, Bryan Cervical Disc, M6-C Artificial Cervical Disc, MOBI-C, the Prestige Cervical Disc, ProDisc-C Total Disc Replacement, Secure-C Artificial Cervical Disc, Prestige LP

An **ambulatory procedure** may include **1** postoperative overnight stay in a facility; therefore, MCG's ambulatory Goal Length of Stay (GLOS) attainment calculation reports the sum of same-day and next-day postoperative discharges. Depending on various patient and procedural factors, some patients undergoing a procedure with an ambulatory GLOS require inpatient care (eg, medical necessity for hospital-based care across **2** or more postoperative midnights). Some of these factors are described in the Extended Stay section of this guideline.

Note: Goal Length of Stay assumes optimal recovery, decision making, and care. Patients may be discharged to a lower level of care (either later than or sooner than the goal) when it is appropriate for their clinical status and care needs.

Criteria:

Spinal arthroplasty (artificial intervertebral disc) replacement is considered medically necessary for **ALL** of the following:

- Procedure is indicated for **1 or more** of the following
  - **Cervical disc arthroplasty (artificial intervertebral disc) replacement for a Single-level** with **ALL** of the following:
    - Device being used is FDA approved (including, but not limited to: Bryan Cervical Disc, M6-C Artificial Cervical Disc, MOBI-C, the Prestige Cervical Disc, ProDisc-C Total Disc Replacement, Secure-C Artificial Cervical Disc)
    - Individual is skeletally mature
    - Individual has **1 or more** of the following:

- Cervical degenerative disc disease or disc herniation at 1 to 2 contiguous levels from C3 to C7 causing debilitating, intractable cervical radicular pain or myelopathy (weakness, sensory deficit, reflex change, gait disturbance, sphincter disturbance) associated with the cervical level to be treated and refractory to at least 6 weeks of conservative treatment (e.g. analgesics, neuropathic medications, physical therapy)
- Nerve root or spinal cord compression requiring hospitalization or immediate surgical treatment

- **Cervical disc arthroplasty (artificial intervertebral disc) replacement for a Multi-level** with **ALL** of the following:
  - Device being used is FDA-approved for 2 or more levels (i.e., Mobi-C, Prestige LP)
  - Individual is skeletally mature
  - Individual has **1 or more** of the following
    - Cervical degenerative disc disease or disc herniation at 1 to 2 contiguous levels from C3 to C7 causing debilitating, intractable cervical radicular pain or myelopathy (weakness, sensory deficit, reflex change, gait disturbance, sphincter disturbance) associated with the cervical level to be treated and refractory to at least 6 weeks of conservative treatment (e.g. analgesics, neuropathic medications, physical therapy)
    - Nerve root or spinal cord compression requiring hospitalization or immediate surgical treatment
- **Lumbar disc arthroplasty (artificial intervertebral disc) replacement for Single or dual levels** are considered medically necessary when **ALL** of the following criteria are met:
  - Initial treatment
  - Individual is between the age of 18 and 60 years
  - Device being used is FDA-approved for Single or dual levels (i.e., Charite, prodisc® L, activL)
  - 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 inquestion) 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
- **Revision of lumbar artificial intervertebral disc** maybe considered medically necessary if imaging (x-ray, CT scan, MRI) shows failure of the implanted device (e.g., loosening, dislodgement, fracture, infection).

- Individual ***smoking requirement*** of **1 or more** of the following:
  - Single level Anterior Cervical Discectomy and Fusion or posterior Foraminotomy may be performed in patients that smoke
  - The individual must be a nonsmoker and in the absence of progressive neurological compromise will refrain from use of tobacco products for at least 6 weeks prior to the planned surgery and 6 weeks after the surgery
  - If individual is a smoker, cessation must be confirmed by a negative urine nicotine test, prior to surgery approval.
- Procedure will be approved as ambulatory (outpatient) unless additional criteria are met by the **1 or more** following:
  - No anticipated length of stay beyond ambulatory (outpatient) time frame.

- Procedure on 2 or more vertebral segments (Expect brief (1 to 3 days) stay extension)
- Neoplasm, vascular malformation, or other intraspinal lesion necessitating procedure (Expect brief (1 to 3 days) stay extension)
- Pathologic fracture
- Spinal abscess or osteomyelitis
- Vertebral corpectomy (vertebral body resection) in patient age 65 years or older
- Nerve root or cauda equina injury
- Visual loss (eg, ischemic optic retinopathy)
- Combined (anterior and posterior) procedures
- Infectious cause by **ALL** of the following:
  - Patient with infectious basis for cervical disease may require longer observation on parenteral antibiotics and confirmation of culture results.
- Severe deficit or injury evidence by **1 or more** of the following:
  - Patient with significant neurologic compromise
  - Multiple injuries will require longer acute care and recovery times
- Complications related to procedure as evidence by **1 or more** of the following:
  - Postoperative hematoma causing cord compression
  - Dural tear or CSF fistula
- Vertebral artery injury evidence by **1 or more** of the following:
  - Vertebral artery injury requires surgical repair, stent placement, or (if adequate collateral flow is present) ligation or embolization.
  - Anticipate ICU monitoring and post repair imaging
- High patient risk identified preoperatively, as indicated by **1 or more** of the following:
  - American Society of Anesthesiologists class IV or greater American Society of Anesthesiologists (ASA) Physical Status Classification System
  - Active comorbidities requiring prolonged hospital-based treatment or monitoring (eg, COPD, heart failure)
  - Other patient condition or finding that places patient at increased anesthetic risk such that prolonged postoperative inpatient monitoring or treatment is anticipated

Spinal arthroplasty (artificial intervertebral disc) replacement is considered **not medically necessary** and/or not covered for any use other than those indicated in clinical criteria, to include but not limited to:

- ACADIA Facet Replacement System (Facet Solutions/Globus Medical)
- Artificial intervertebral disc placement for 1 or more of the following:
- Hybrid fusion with artificial disc replacement
- Individual has 1 or more of the following:
- Absence of neck and/or arm pain
- Active infection or malignancy
- Auto-immune disease (Rheumatoid arthritis, Ankylosing Spondylitis)
- Facet joint disease/degeneration which is moderate to severe
- Had a prior surgery at the requested spinal level
- Metabolic bone disease (e.g., osteoporosis, osteopenia, osteomalacia, Paget's disease)
- Neck or arm pain of unknown etiology
- Progressive neurological deficit or deterioration
- Scoliosis
- Spinal fracture
- Spinal instability (spondylolisthesis of Grade 2 or greater in the lumbar spine and >11 degree angular or >3.5 mm subluxation in the cervical spine) is noted on lateral or
- flexion/extension x-rays
- Request is for combined artificial disc placement and fusion
- Request is for disc placement at more than two levels in the cervical spine and more than one level in the lumbar spine

- Facet joint implantation (Total Posterior-element System (TOPS) (Premia Spine)
- Posterior Vertebral (facet) Joint Replacement
- Total Facet Arthroplasty System (TFAS) for the treatment of spinal stenosis
- Lumbar disc arthroplasty is NOT COVERED for ANY of the following:
- 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)

Document History:

Revised Dates:

- 2025: August – Implementation date of December 1, 2025. Annual review completed – housekeeping, add smoking policy, add MCG's Ambulatory Surgery or Procedure GRG PG-AS (ISC GRG): New format
- 2024: August – Annual review completed – criteria updated, exceptions clarified and updated. Title changed and coding updated.
- 2022: July
- 2020: August (Unarchived)
- 2016: April
- 2015: February, May, September
- 2014: January, April, June (Archived and added to Surgical 78), August, November
- 2012: January
- 2011: May, June

Reviewed Dates:

- 2023: August
- 2022: August
- 2021: September
- 2018: November
- 2017: December
- 2016: May
- 2013: January

Origination Date: January 2011

Coding:

Medically necessary with criteria:

Coding	Description
0095T	Removal of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, cervical (List separately in addition to code for primary procedure)
0098T	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, cervical (List separately in addition to code for primary procedure)
22856	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); single interspace, cervical
22857	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar
22858	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); second level, cervical (List separately in addition to code for primary procedure)
22861	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical)
22862	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar
22864	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical
22865	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar

Considered Not Medically Necessary:

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)
0164T	Removal of total disc arthroplasty, (artificial disc), anterior approach, 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
0219T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; cervical
0220T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; thoracic
0221T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; lumbar
0222T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; each additional vertebral segment (List separately in addition to code for primary procedure)
0719T	Posterior vertebral joint replacement, including bilateral facetectomy, laminectomy, and radical discectomy, including imaging guidance, lumbar spine, single segment

The preceding codes are included above for informational purposes only and may not be all inclusive. Additionally, inclusion or exclusion of a treatment, procedure, or device code(s) does not constitute or imply member coverage or provider reimbursement.

Policy Approach and Special Notes: *

- Coverage
  - See the appropriate benefit document for specific coverage determination. Member specific benefits take precedence over medical policy.
- Application to products
  - Policy is applicable to Sentara Health Plan Virginia Medicaid Products
- Authorization requirements
  - Precertification required by Plan
- 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. EPSDT Supplement B (updated 5.19.22)_Final.pdf
  - Service authorization requests must be accompanied by sufficient clinical records to support the request. Clinical records must be signed and dated by the requesting provider withing 60 days of the date of service requested.

References:

References used include but are not limited to the following: Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

(2025). Retrieved 6 2025, from MCG: https://careweb.careguidelines.com/ed29/index.html

(2025). Retrieved 7 2025, from CMS: https://www.cms.gov/medicare-coverage-database/search-results.aspx?keyword=Artificial+Disc&keywordType=starts&areaId=all&docType=NCA,CAL,NCD,MEDCAC,TA,MCD,6,3,5,1,F,P&contractOption=all

(2025). Retrieved 7 2025, from Hayes: https://evidence.hayesinc.com/search?q=%257B%2522text%2522:%2522disc%2520arthroplasty%2520%2522,%2522title%2522:null,%2522termsource%2522:%2522searchbar%2522,%2522page%2522:%257B%2522page%2522:0,%2522size%2522:50%257D,%2522type%2522:%2522all%2522,%2522sou

(2025). Retrieved 7 2025, from Cigna- EviCore: https://www.evicore.com/cigna

Cervical Artificial Disc Replacement. (2015). Retrieved 7 2025, from North American Spine Society (NASS) Coverage Policy Recommendations: https://www.spine.org/

Provider Manual. (2025). Retrieved 7 2025, from DMAS: https://www.dmas.virginia.gov/for-providers/

Subacute and chronic low back pain: Surgical treatment. (2023, 9). Retrieved 7 2025, from UpToDate: https://www.uptodate.com/contents/subacute-and-chronic-low-back-pain-surgical-treatment?search=Lumbar%20Discectomy&source=search_result&selectedTitle=1~3&usage_type=default&display_rank=1

Treatment and prognosis of cervical radiculopathy. (2025, 4). Retrieved 7 2025, from UpToDate 2: https://www.uptodate.com/contents/treatment-and-prognosis-of-cervical-radiculopathy?search=Artificial%20Disc&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1#H17

Keywords:

SHP Artificial Disc Replacement and Treatment, SHP Surgical 35, Cervical artificial intervertebral disc, Bryan Cervical Disc, M6-C Artificial Cervical Disc, MOBI-C, the Prestige Cervical Disc, ProDisc-C Total Disc Replacement, Secure-C Artificial Cervical Disc, Cervical degenerative disc disease, Nerve root compression, spinal cord compression, Lumbar artificial intervertebral disc placement,