Artificial Disc Replacement and Treatment

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Effective Date	1/2011
Next Review Date	8/1/2024
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 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 artificial disc is replacements of the spine.

Description & Definitions:

An **artificial disc replacement** is a device that can be inserted into the spine. Artificial disc can also be called a disc prosthetic or disc arthroplasty device.

Criteria:

Artificial disc replacement is considered medically necessary for **1 or more** of the following:

- Cervical artificial intervertebral disc placement may be considered medically necessary 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 artificial intervertebral disc placement at a second contiguous level simultaneously for **all of the** following:
  - 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
    - The device being used is FDA-approved for 2 levels (i.e., Mobi-C, Prestige LP)
- Subsequent cervical artificial intervertebral disc placement at an adjacent level with **all of the** following:
    - 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
    - The device being used is FDA-approved for 2 levels
    - The initial artificial disc placement has fully healed
    - The planned subsequent procedure is at a different cervical level than the initial artificial disc placement
- Lumbar artificial intervertebral disc placement with **all of the following**:
    - Device being used is FDA approved
    - Individual is skeletally mature
    - Individual has **1 or more** of the following:
        - Single level lumbar degenerative disc disease from L3 to S1 causing debilitating, intractable low back pain associated with the lumbar level to be treated and refractory to at least 6 months of conservative treatment (e.g. analgesics, physical therapy, exercise, lifestyle modification, muscle relaxers, epidural steroid injections)
        - 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).

Artificial intervertebral disc placement is considered **not medically necessary** for any use other than those indicated in clinical criteria, to include but not limited to:

- Hybrid fusion with artificial disc replacement
- 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 previous fusion surgery at any other spinal level
- 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
- Lumbar and cervical partial disc prosthetics (e.g., Nubac, DASCOR Disc Arthoplasty System)

Coding:

Medically necessary with criteria:

Coding	Description

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
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)

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)

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

Document History:

Revised Dates:

- 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

Effective Date:

- January 2011

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:

Artificial Disc Replacement and Treatment, 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