TITLE: CERVICAL SPINE SURGERIES

EFFECTIVE DATE: February 1, 2017

This policy was developed with input from specialists in orthopedic spine surgery and endorsed by the Medical Policy Committee.

IMPORTANT INFORMATION – PLEASE READ BEFORE USING THIS POLICY
These services may or may not be covered by all Medica plans. Please refer to the member’s plan document for specific coverage information. If there is a difference between this general information and the member’s plan document, the member’s plan document will be used to determine coverage. With respect to Medicare and Minnesota Health Care Programs, this policy will apply unless those programs require different coverage. Members may contact Medica Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions about this Medica utilization management policy may call the Medica Provider Service Center toll-free at 1-800-458-5512.

Medica utilization management policies are not medical advice. Members should consult with appropriate health care providers to obtain needed medical advice, care and treatment.

PURPOSE
To promote consistency between reviewers in utilization management decision-making by providing the criteria that generally determine the medical necessity of cervical spine surgeries. The Coverage Issues box below outlines the process for addressing the needs of individuals who do not meet these criteria.

BACKGROUND
I. Disease State
A. Cervical degenerative disease (CDD), aka cervical spondylosis, affects approximately ten percent of all adults who display some degree of neck pain at any given time. Less than one percent develop neurologic deficits. In the majority of cases, individuals recover following conservative treatment, and there remains a lack of consensus regarding use of surgical options and the prognostic factors associated with surgical treatment of CDD.
B. Symptomatic CDD can result in axial neck pain, extremity pain, and/or neurological dysfunction. Causes of axial neck pain include cervical strain, internal disc disruption syndrome, cervical facet-mediated pain, cervical ‘whiplash’ syndrome, and myofascial pain.
C. Cervical radiculopathy is a disorder that involves a combination of pain, numbness, tingling and/or weakness in a particular nerve distribution that correlates with imaging findings showing mechanical compression of the individual nerve by a soft disc herniation or osteophyte (bone spur). It can involve one or more nerves at a time.
D. Cervical myelopathy is a disorder that is caused when a soft disc herniation, hypertrophic ligaments or osteophytes cause mechanical pressure on the spinal cord, which results in a continuum of symptoms ranging from subtle incoordination and spasticity to frank quadraparesis or quadraplegia.

II. Definitions
A. Anterior cervical spine surgery is the preferred method for cervical spine surgery. It is performed by the surgeon approaching the spine from the front of the body, through the throat area. Anterior approaches are performed for correction of CDD including cervical discectomy, corpectomy, fusion, and bone grafting.
B. Artificial cervical intervertebral disc replacement (arthroplasty) is a surgical procedure in which a diseased or damaged intervertebral disc is replaced with an artificial device in individuals with symptomatic degenerative disc disease or herniated disc. They are intended to preserve/restore vertebral alignment, maintain spinal stability and flexibility, and alleviate pain. Surgery is performed in-patient and requires general anesthesia.
C. Artificial cervical intervertebral discs that have received U.S. Food and Drug Administration (FDA) approval include:
   1. Bryan® Cervical Disc (Medtronic Sofamor Danek)
<p>| | |</p>
<table>
<thead>
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<tbody>
<tr>
<td>2.</td>
<td>MOBI-C® Cervical Disc Prosthesis (LDR Spine USA)</td>
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<tr>
<td>3.</td>
<td>PCM® Cervical Disc System (NuVasive, Inc.)</td>
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<td>4.</td>
<td>Prestige® Cervical Disc System (Medtronic Sofamor Danek)</td>
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<tr>
<td>5.</td>
<td>ProDisc™ C (Synthes, Inc.)</td>
</tr>
<tr>
<td>6.</td>
<td>Secure® C Artificial Disc System (Globus Medical).</td>
</tr>
</tbody>
</table>

D. **Atlantoaxial instability or subluxation** occurs when ligaments that hold the C1 (Atlas) and C2 (Axis) vertebrae together become loose, either from traumatic disruption of the ligaments or from degeneration of the joint itself. The degeneration of this joint is most common in patients with rheumatoid arthritis and is relatively uncommon in the normal population. In severe situations, the laxity of the vertebrae may cause spinal cord compression and/or migration of the odontoid resulting in spinal cord or brain stem lesions. This can potentially lead to irreversible neurological damage. The aim of this surgery is to fuse the atlantoaxial joint, in an anatomic position, to prevent any movement and protect the spinal cord and brain stem.

E. **Axial neck pain** is musculoskeletal, characterized as neck or soft tissue pain occurring solely along the spinal column. Whiplash, musculoskeletal strain and cervical spondylolysis are three common causes. Non-operative treatment of isolated axial neck pain has been reported to benefit most patients.

F. **Cervical spondylotic myelopathy** is due to compression of the spinal cord by spinal stenosis (e.g., osteophytes), extruded disk material (i.e., herniated disc), metastatic tumor, or fracture fragments. Myelopathy is more common in older individuals and is generally a slowly progressive condition. Symptoms include loss of dexterity in upper and lower extremities, and/or hand incoordination/ heaviness. If the site of compression is applying pressure to nerves, pain at the segment site may be present.

G. **Chronic discogenic pain** is severe, recurring or constant pain originating from the intervertebral disc that limits the individual's ability to function. The term is most frequently used when the patient has relatively mild pathology on imaging studies, and does not have significant spondylolysis, instability, radicular or myelopathic findings. Surgery is rarely indicated to treat this condition.

H. **Corpectomy/hemicorpectomy** is removal of the entire vertebral body and surrounding discs to relieve nerve and/or spinal cord impingement. When the pathology dictates that only a portion of the vertebral body be removed, the procedure is referred to as a *hemicorpectomy*.

I. **Decompression surgery** is a general term that refers to various procedures intended to relieve symptoms caused by pressure, or compression, on the spinal cord and/or nerve roots. Bulging or collapsed disks, thickened joints, loosened ligaments and bony growths can narrow the spinal canal and the spinal nerve openings (foramen), causing irritation. Examples of procedures include: disectomy; laminotomy/laminectomy; foraminotomy; osteophytectomy (i.e., bone spur removal); and corpectomy.

J. **Degenerative disc disease (DDD)** is a general term indicating a progressive drying out and degeneration of the intervertebral disc that leads to loss of spine flexibility and function. DDD is part of the normal aging process and develops over time. It can cause neck pain and stiffness.

K. **Discectomy** is the surgical removal of the intervertebral disc. It can refer to removing the entire disc, as in an anterior discectomy and fusion, or simply a herniated portion of the nucleus pulposus (the central portion of the intervertebral disc), which is pressing on a nerve root or the spinal cord. Infrequently (i.e., 5% – 10% of discectomies), additional nuclear material may extrude through the same annular defect at any time after the primary discectomy surgery. This condition is termed “recurrent disc herniation.”

L. **Facet joints** are small joints that are located on the back of the spine, one on each side. Each vertebra is connected by facet joints. They provide stability to the spine by interlocking two vertebrae.

M. **Laminectomy** is a surgical procedure performed to remove the lamina. It is also referred to as decompression surgery. A laminectomy enlarges the spinal canal and is intended to relieve pressure on the spinal cord and surrounding nerves.

N. The **lamina** is the flat area of bone between the superior process of the facet joint and the spinous process. The lamina is located on either side of the spinous process and forms the back of the central canal through which the spinal cord passes.

O. **Laminoplasty** is also performed to relieve pressure on the spinal cord and nerve roots. However, instead of removing the lamina, the lamina is partially cut on one side, creating a hinge, and completely cut on the other side. The lamina is then opened slightly and held in place with the use of small bone plates and screws. An alternative method creates hinges on both side of the lamina and opens similar to a French-style door.

P. **Laminotomy (hemilaminectomy; laminoforaminotomy)** is a surgical transection of vertebral lamina performed to decompress a nerve. It consists of partially removing of a portion of the lamina overlying the compressed nerve to access and repair a disc herniation or to remove osteophytes. The procedure can be done on one or both sides of the spinous process.

Q. **Myelography** is radiographic imaging that involves injection of contrast material in the subarachnoid space around the spinal cord and nerve roots using a real-time form of x-ray called fluoroscopy. Following injection
of the contrast media, the radiologist is able to view and evaluate the status of the spinal cord, the nerve roots, and the meninges. The radiologist tracks the flow of contrast material in real-time and also takes permanent radiographs to document findings. A myelogram is most often followed by a computed tomography (CT) to further clarify the individual’s anatomy.

R. **Myelopathy** is due to compression of the spinal cord by spinal stenosis (e.g., osteophytes), extruded disk material (i.e. herniated disc), metastatic tumor, or fracture fragments. Myelopathy is more common in older individuals and is generally a slowly progressive condition. Symptoms include hand incoordination, heaviness in the legs, or numbness/tingling in the legs. If the site of compression is applying pressure to nerves, pain at the segment site may be present.

S. **Neck Disability Index (NDI) Score** was developed as a modification of the Oswestry Disability Index (ODI) for low back pain with the permission of the original author. The NDI is a standard self-administered, low back pain disability questionnaire used by clinicians and researchers to measure a patient’s functional disability at a certain point in time.

T. **Nerve conduction testing** measures how well and how fast the nerves can send electrical signals within the peripheral nervous system. They are performed mainly for evaluation of numbness, tingling (i.e., paresthesias), burning, and/or weakness of the arms and legs. The type of study performed depends on the symptoms presented.

U. **Os odontoideum (hypoplastic dens)** results when the “peg” of the first cervical vertebra has persisted over time, usually secondary to a traumatic event at an early age. The cause of os odontoideum remains uncertain, but there is now emerging consensus regarding its traumatic etiology, which may cause the C1-2 stabilizing ligaments to be underdeveloped and predisposes this section to hypermobility and instability.

V. **Post laminectomy syndrome** is characterized by persistent neck pain or neck and arm pain following otherwise successful cervical spine surgery, most often following a laminectomy. Following spine surgery, major pain relief is expected, but rarely is there total pain relief. A fraction of post-surgical pain is normal. However, the term post laminectomy syndrome is reserved for individuals who continue to suffer from a majority of their pain symptoms following surgery.

W. **Posterior surgical spine surgery** is performed by the surgeon approaching the spine through the back of the neck. Posterior approaches for correction of cervical conditions include laminectomy, laminoplasty, and posterior fusion.

X. **Pseudoarthrosis** is a term that is used to describe the situation where the spinal segment does not grow together after an attempted surgical fusion.

Y. Cervical **radiculopathy** (also called radiculitis) refers to a loss of sensory, motor or reflex function or pain in a specific region within the upper extremity secondary to irritation and/or compression of a spinal nerve root in the neck. Radiculopathy often presents clinically as pain traveling from the neck into the arm, forearm and/or hand. In many cases, this will be accompanied by numbness in the limb.

Z. **Skeletal (bone) maturity** occurs when bone growth ceases after puberty and refers to demonstration of fusion of skeletal bones. Females reach skeletal maturity at approximately 16 years of age, while males reach skeletal maturity around 18 years of age. Radiographs of either the knee or of the hand and wrist with subsequent mathematical calculations are often used when exact measurement of skeletal maturity is warranted.

AA. **Spinal fusion** (also known as spinal arthrodesis) is a procedure that permanently fuses two or more vertebrae. A bone graft (autograft, allograft, or synthetic graft) is placed between the vertebrae or facet joints to stimulate the growth of bone across the joint, with the intent of improving stability and decreasing pain.

BB. **Spinal instability** refers to loss of motion segment stiffness which results in excessive motion within a spinal segment that could result in neurological deficit, deformity, or pain. Instability can be categorized as acute (e.g., spine fractures, spinal dislocations) or chronic (i.e., caused by degeneration of the joint through the normal aging process or diseases such as rheumatoid arthritis). Instability can be clinically simulated when force applied to the painful spine segment produces abnormally excessive motion (e.g., flexion, extension, lateral angulation, translation) compared to the same force applied to a non-affected segment. Instability can also be demonstrated on radiographic images by seeing damage to the spine’s restraining structures (i.e., facet joint, spinous process, transverse process, disk, ligaments, and/or muscles). Conditions or diseases associated with spinal instability include, but are not limited to, trauma, tumors, infections, connective tissue disorders, congenital disorders, degenerative disorders, and postsurgical events.

CC. **Spinal instrumentation** refers to devices that surgeons implant in the spine during spinal surgery, often made of titanium, titanium-alloy, stainless steel, or plastic. These implants are available in many shapes and sizes and include rods, hooks, braided cable, plates, screws, and interbody cages.

DD. **Spinal stenosis** is a reduction in the diameter of the spinal canal caused by bone spur formation, disc herniation, hypertrophic (thickened) ligaments, or traumatic displacement of bone or soft tissue. Some
individuals are born with small or stenotic spinal canals. Stenosis often results in pressure on the spinal cord and/or nerve root compression leading to significant pain and nerve-related symptoms or paralysis.

EE. **Spondylolisthesis** can occur when one vertebra slips forward and out of alignment with the vertebra lying below it. It is commonly seen in the fourth over the fifth lumbar vertebra or the fifth over the sacrum. The causes can be congenital, due to stress fractures, facet degeneration, injury, or after decompression surgery. The condition may be asymptomatic, or cause significant pain and nerve-related symptoms. If the slippage occurs backwards, it is referred to as **retrolisthesis** and lateral slippage is called **listhesis**.

FF. **Tobacco/Nicotine products** can result in nicotine addiction and health problems, including a negative effect on bone healing. This includes delayed unions, nonunions and other complications (e.g., decreased blood flow to the discs; wound complications). Products containing nicotine include, but are not limited to, (1) smoked tobacco (e.g., cigarettes, cigars, cigarillos, kreteks, pipe tobacco), (2) smokeless tobacco (e.g., chewing tobacco, snuff), (3) electronic cigarettes (E-cigarettes), (5) nicotine vaping, (5) dissolvable tobacco, and (6) nicotine patches. Nicotine or its primary metabolite, cotinine, is most often tested to evaluate use. Both can be measured qualitatively or quantitatively for determination of: (1) active use, (2) users who have recently quit, or (3) exposure in non-tobacco/nicotine users. Urine or blood testing is most commonly performed, although cotinine can also be measured in saliva.

III. Medical Management

A. Individuals presenting with mild to moderate cervical pain are often treated with conservative medical management. Measures commonly used include, but are not limited to:
   1. Activity modification adjustment to "low risk" activity levels
   2. Anti-inflammatory medication regimen
   3. Epidural steroid injections
   4. Physical therapy
   5. Chiropractic care
   6. Cervical traction
   7. Neck immobilization (e.g., cervical collar)
   8. Transcutaneous electrical stimulation.

B. Conservative management is not recommended when there is evidence of:
   1. Infectious condition of the spine
   2. Significant or progressive neurological deficit
   3. Progressive spinal deformity
   4. Some degree of traumatic injury
   5. Unstable fracture or dislocation.

MEDICAL NECESSITY CRITERIA

Refer to the section below which corresponds with the surgical procedure(s), *initial or repeat/revision*, being requested:
- Section I: Emergent surgical need
- Section II: Decompression, stabilization, or fusion
- Section III: Cervical intervertebral artificial disc replacement (arthroplasty)

I. Prior authorization **is not required** when the procedure is **emergent in nature**. These indications include, but are not limited to:
   A. Acute traumatic cervical spine fracture or dislocation with neural compression and/or radiographic evidence of instability
   B. Acute, unremitting radicular pain resulting in severe rapid-onset/progression of neurological impairment arising from cervical cord compression, stenosis, or nerve root compression and requiring emergent hospitalization within a few days post-onset/progression.
   C. Tumor-related nerve or spinal cord compression, vertebral destruction, instability, or pathologic fracture
   D. Infection-related instability, nerve or spinal cord compression, vertebral destruction, instability, or pathologic fracture
   E. Spinal tuberculosis
   F. Atlantoaxial subluxation (C1-C2 vertebrae) with odontoid migration and/or cord compression related to **one of the following**:
      1. Congenital abnormality at C1-C2
      2. Os odontoideum
      3. Rheumatoid arthritis
4. Trauma.

NOTE: Surgery will be considered on an individual basis following medical director review when C1-C2 malalignment is confirmed but signs of odontoid migration and/or cord compression are not documented.

II. Prior Authorization is required for initial and repeat/revision cervical decompression, stabilization, or fusion for treatment of radiculopathy or myelopathy and is considered medically necessary when documentation in the medical record shows that all of the following criteria are met:

A. Individual is undergoing one of the following procedures:

NOTE: Use Section III if cervical artificial disc replacement is being done.

1. Cervical decompression surgery employing at least one of the following procedures:
   a. Corpectomy/hemicorpectomy
   b. Discectomy
   c. Foraminectomy/foraminoplasty
   d. Foraminotomy
   e. Laminectomy/laminoplasty
   f. Laminotomy (i.e., laminoforamonotomy, hemilaminectomy)
   g. Osteophyte removal (i.e., bone spur removal).

2. Cervical fusion

B. Individual has one of the following diagnoses, exclusive of those listed in I., above:

1. Spondylolisthesis, anterolisthesis, or retrolisthesis
2. Non-acute radiculopathy (e.g., symptomatic cervical stenosis; osteophytes) causing continued pain, motor weakness, paresthesia, and/or compromised neurological function indicative of nerve root compression.
3. Post laminectomy syndrome
4. Recurrent disc herniation (i.e., remaining disc material following initial cervical discectomy).

C. Skeletal maturity has been reached.

D. Surgery is not to exceed two contiguous levels from C2 to C7. An example of three cervical levels would be C2-C3 & C3-C4 & C4-C5.

Note: If either cervical fusion or decompression is being requested at more than two levels, send for medical director review.

E. Documentation of osteoporosis status demonstrates one of the following:

1. Significant anatomical and/or neurological compromise
2. Bone structure has ability to support instrumentation.

F. Documentation of tobacco or nicotine status for individuals undergoing spinal fusion (only) indicating one of the following:

1. The individual is a non-tobacco or non-nicotine user.
2. The individual has been tobacco-free and nicotine free for a minimum of one month prior to date of the prior authorization request.

G. Documentation of continued episodes of severe, radiating, neurological pain and/or impairment (e.g., extremity weakness or stiffness, lack of arm and/or hand coordination, numbness and/or decreased sensation, back and/or lower extremity involvement) demonstrating compromised ability to perform routine activities of daily living (e.g., writing and other small motor skills, household maintenance, bathing/grooming, food preparation).

H. Radiologic or electrodiagnostic testing documenting one of the following:

1. For central myelopathy only, radiographic imaging (computed tomography; magnetic resonance imaging) demonstrating myelopathy at a level correlating with clinical presentations mentioned in G., above
2. For persistent radiculopathy, one of the following is met:
   a. Radiographic imaging (computed tomography; magnetic resonance imaging) demonstrating persistent radiculopathy at a level correlating with clinical presentations mentioned in H., above.
   b. Radiographic imaging (computed tomography; magnetic resonance imaging; myelography) and electrodiagnostic testing (e.g., electromyogram; nerve conduction testing) when no objective evidence of radiculopathy is identified and documented during physical examination.

I. Documentation of either Neck Disability Index (NDI) scores or Oswestry Disability Index (ODI) scores demonstrating one of the following:

1. Completion of a minimum of six weeks conservative management documenting one of the following:
   a. An increase on the disability index (DI) scores documenting progression of pain/disability indicating
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a DI score of at least moderate disability (i.e., NDI score of at least 15; ODI score of at least 40%).

2. For individuals unable to complete a minimum of six weeks conservative management, documentation of all of the following is required:
   a. Continued DI score indicating at least moderate disability (i.e., NDI score of at least 15; ODI score of at least 40%) following course of conservative management
   b. Inability to perform routine activities of daily living, as defined in G, above.

3. If an individual has not had conservative medical management, documentation within one month of prior authorization request all the following is required:
   a. DI score indicating at least moderate disability (i.e., NDI score of at least 15; ODI score of at least 40%).
   b. Inability to perform routine activities of daily living, as defined in H, above.

Note: An NDI and ODI questionnaire with scoring and interpretation directions are found in Appendix 2 and 3, below.

J. Documentation indicates an FDA approved bone graft or fusion material is being used, as applicable.
Note: Medica considers any of the following standard graft material: (1) autograft (i.e., bone from individual) or cadaver-derived bone allograft or (2) demineralized bone matrices. Examples include [not all inclusive]: Accell, AlloFuse, Allogor DBM, Allomatrix, DBX, DynaGraft, Exactech Resorbable Bone Paste, Grafton DBM, Intergeo DBM, Magnifuse, Optefil, Opteform, Origen DBM, OrthoBlast, Ostefil, OsteoSelect, OsteoSponge, and Progenix.

Note: Medica considers (1) recombinant human bone morphogenic protein-2 (rhBMP-2)/InFuse™ Bone Graft/LT-CAGE™ for cervical spine indications, (2) OsteoAmp™ allogenic morphgenic protein (3) autologous blood-derive biologics (e.g., platelet-rich plasma, autologous conditioned serum, autologous whole blood), and (4) stem cell therapy (e.g. AlloStem®, Cellentra™ VCBM, Osteocon® Plus, Trinity® Evolution™) investigative and therefore not covered.

III. Prior authorization is required for initial or repeat/revision cervical intervertebral artificial disc replacement (arthroplasty) for treatment of radiculopathy or myelopathy and is considered medically necessary when documentation in the medical record indicates all of the following criteria are met:

A. Individual has documented symptomatic degenerative disc disease (DDD) with radiculopathy, usually with radiculopathy, resulting in unremitting pain, exclusive of those listed in I., above.

Note: Examples of associated underlying causes include, but are not limited to: (1) degenerative disc disease, (2) unstable spinal stenosis, (3) segmental instability.

B. Procedure will be performed using an FDA-approved device (e.g., Prestige® Cervical Disc Systems; ProDisc™ C; Bryan® Cervical Disc; Secure® C Artificial Disc System; PCM® Cervical Disc System; MOBI-C® Cervical Disc Prosthesis).

NOTE: The MOBI-C® Cervical Disc Prosthesis (LDR USA) and the Prestige LP Cervical Disc (Medtronic) are the only artificial discs FDA approved for use at both one and two contiguous levels. Two-level arthroplasty using a device other than Mobi-C or Prestige LP is considered investigative.

C. Individual does not present with any of the following:
   1. Spinal instability
   2. Moderate to severe facet arthritis
   3. Localized or systemic infection
   4. Spinal tumor or other active malignancy.

D. Procedure will be performed at one or two contiguous levels from C3 to C7. Note: Two level replacements using a device other than the MOBI-C or Prestige LP Cervical Disc is considered investigative and therefore not covered. See A, above.

E. Individual has reached skeletal maturity.

F. Documentation of either Neck Disability Index (NDI) scores or Oswestry Disability Index (ODI) scores management demonstrating one of the following:
   1. Completion of a minimum of six weeks conservative management documenting one of the following
      a. An increase on the disability index (DI) scores documenting progression of pain/disability indicating a DI score of at least moderate disability (i.e., NDI score of at least 15; ODI score of at least 40%).
      b. Continued DI score indicating at least moderate disability (i.e., NDI score of at least 15; ODI score of at least 40%).

   2. For individuals unable to complete a minimum or six weeks conservative management, documentation of
one of the following is required:

a. Continued DI score indicating at least moderate disability (i.e., NDI score of at least 15; ODI score of at least 40%) following course of conservative management
b. Inability to perform routine activities of daily living, as defined in II.G., above.

3. If an individual has not had conservative medical management documentation within one month of prior authorization all of the following are required:

a. DI score indicating at least moderate disability (i.e., NDI score of at least 15; ODI score of at least 40%).

b. Inability to perform routine activities of daily living, as defined in II.G., above.

Note: An NDI and ODI questionnaire with scoring and interpretation directions are found in Appendix 2 and 3, below.

COVERAGE ISSUES

1. With the exception of conditions listed in Medical Necessity Criteria section I., above, prior authorization is required for initial cervical spinal surgery and for any subsequent surgery as defined in the Medical Necessity Criteria sections II - III., above, including the following procedures:

a. Cervical decompression surgery:
   i. Corpectomy/hemicorpectomy
   ii. Discectomy
   iii. Foraminectomy/foraminoplasty
   iv. Foraminotomy
   v. Laminectomy/laminoplasty
   vi. Laminotomy (laminoforaminotomy, hemilaminectomy)
   vii. Osteophyte removal (bone spur removal)

b. Cervical fusion
c. Cervical intervertebral artificial disc replacement (arthroplasty).

2. Prior authorization is not required for the type of access and associated instrumentation used to gain entry to the surgical site.

NOTE: Exception is laparoscopic anterior spinal surgery (e.g., fusion), which has been determined to be investigative and therefore not covered.

3. Intervertebral cervical artificial disc replacement (arthroplasty) is investigative and therefore not covered for all other indications not listed above, including but not limited to: (1) treatment in combination with concurrent cervical spinal fusion or (2) in an individual with a previous fusion at another cervical level.

4. Spinal instrumentation and/or tissue grafting are considered a covered benefit when all of the medical necessity criteria listed above are met, and not otherwise excluded according to terms in Coverage Issue5., below.

5. Cervical spine surgery otherwise meeting medical necessity criteria defined in this policy, including cervical artificial intervertebral disc replacement, is not covered when performed in combination with any cervical disc procedure Medica considers investigative and therefore not covered, including, but not limited to, treatment of degenerative disc disease at more than one level or treatment in combination with cervical spinal fusion (e.g., concurrently or sequentially).

6. Examples of procedures considered investigative and therefore not covered include, but are not limited to: autologous blood-derived products; stem cell therapy for orthopedic applications; OsteoAmp™ allogenic morphgenic protein; cervical use of recombinant human bone morphogenic protein-2 (rhBMP-2)/InFUSE; interspinous process decompression procedures; laparoscopic anterior interbody fusion; laser spine surgery; and selected percutaneous and minimally invasive lumbar spine procedures. See the following Medica coverage policies.

b. Stem Cell Therapy for Orthopedic Applications.
c. Human Bone Morphogenic Protein-2 (rhBMP-2)/InFUSE and Allogeneic Morphogenic Protein (e.g., OsteoAMP™). NOTE: Some indications are covered services and others are non-covered services, Refer to the coverage policy for details.
d. Laser Spine Surgery.
e. Percutaneous Disc Decompression Procedures (Manual, Automated or Laser Discectomy, and Plasma Disc Decompression [PDD]).
f. Percutaneous Radiofrequency Ablation/Denervation of Facet Joint and Sacroiliac Joint.

7. If medical necessity criteria are not met as defined in this policy, any associated procedures (e.g.,
instrumentation, device implantation) will not be covered. This includes, but is not limited to, facility and anesthesia services, professional fees, and associated supplies.

8. Coverage may vary according to the terms of the member's plan document.


10. If the Medical Necessity and Coverage Criteria are met, Medica will authorize benefits within the limits in the member's plan document.

11. If it appears that the Medical Necessity and Coverage Criteria are not met, the individual's case will be reviewed by the medical director or an external reviewer. Practitioners are reminded of the appeals process in their Medica Provider Administrative Manual.

DOCUMENT HISTORY

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<tr>
<th>Original Effective Date</th>
<th>September 1, 2013</th>
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<tr>
<td>Administrative Updates</td>
<td>02/2017; 05/01/2017</td>
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</table>

References:

Pre-11/2014 Medical Policy Committee (MPC) and Pre-09/2015 Medical Technology Assessment Committee (MTAC):


**11/2016 MPC and 04/2016 & 10/2016 MTAC:**


Vertebral Structure

- There are seven vertebrae comprising the cervical spine, C1 – C7.
- The lamina of each vertebra forms the back of the spinal canal.
- A foramen is a small opening. This is where a nerve leaves the spinal canal.
- The transverse process is the wing of bone on either side of each vertebra.
- The spinous process is the part of each vertebra you can feel through your skin.
- A disk lies between each of the vertebrae.

Cervical Spine Problems


Examples of Disc Problems

Appendix 2

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<th>Neck Disability Index</th>
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<td><strong>Section 1 – Pain Intensity</strong></td>
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<tr>
<td>- I have no pain at the moment. (0)</td>
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<tr>
<td>- The pain is very mild at the moment. (1)</td>
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<tr>
<td>- The pain is moderate at the moment. (2)</td>
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<tr>
<td>- The pain is fairly severe at the moment. (3)</td>
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<tr>
<td>- The pain is very severe at the moment. (4)</td>
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<tr>
<td>- The pain is the worst imaginable at the moment. (5)</td>
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| **Section 2 – Personal Care (Washing, Dressing, etc.)** |
| - I can look after myself normally without causing extra pain. (0) |
| - I can look after myself normally but it causes extra pain. (1) |
| - It is painful to look after myself and I am slow and careful. (2) |
| - I need some help but manage most of my personal care. (3) |
| - I do not get dressed, I wash with difficulty and stay in bed. (5) |

| **Section 3 – Lifting** |
| - I can lift heavy weights without extra pain. (0) |
| - I can lift heavy weights but it gives extra pain. (1) |
| - Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table. (2) |
| - Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. (3) |
| - I can lift very light weights. (4) |
| - I cannot lift or carry anything at all. (5) |

| **Section 4 – Reading** |
| - I can read as much as I want to with no pain in my neck. (0) |
| - I can read as much as I want to with slight pain in my neck. (1) |
| - I cannot read as much as I want because of moderate pain in my neck. (3) |
| - I can hardly read at all because of severe pain in my neck. (4) |
| - I cannot read at all. (5) |

| **Section 5 – Headaches** |
| - I have no headaches at all. (0) |
| - I have slight headaches that come infrequently. (1) |
| - I have moderate headaches which come infrequently. (2) |
| - I have moderate headaches which come frequently. (3) |
| - I have severe headaches which come frequently. (4) |
| - I have headaches almost all the time. (5) |

| **Section 6 – Concentration** |
| - I can concentrate fully when I want to with no difficulty. (0) |
| - I can concentrate fully when I want to with slight difficulty. (1) |
| - I have a fair degree of difficulty in concentrating when I want to. (2) |
| - I have a lot of difficulty in concentrating when I want to. (3) |
| - I have a great deal of difficulty in concentrating when I want to. (4) |
| - I cannot concentrate at all. (5) |

| **Section 7 – Work** |
| - I can do as much work as I want to. (0) |
| - I can do my usual work, but no more. (1) |
| - I can do most of my usual work, but no more. (2) |
| - I cannot do my usual work. (3) |
| - I can hardly do any work at all. (4) |
| - I cannot do any work at all. (5) |

| **Section 8 – Driving** |
| - I can drive my car without any neck pain. (0) |
| - I can drive my car as long as I want with slight pain in my neck. (1) |
| - I can drive my car as long as I want with moderate pain in my neck. (2) |
| - I cannot drive my car as long as I want because of moderate pain in my neck. (3) |
| - I can hardly drive at all because of severe pain in my neck. (4) |
| - I cannot drive my car at all. (5) |

| **Section 9 – Sleeping** |
| - I have no trouble sleeping. (0) |
| - My sleep is slightly disturbed (less than 1 hour sleepless). (1) |
| - My sleep is mildly disturbed (1-2 hours sleepless). (2) |
| - My sleep is moderately disturbed (2-3 hours sleepless). (3) |
| - My sleep is greatly disturbed (3-5 hours sleepless). (4) |
| - My sleep is completely disturbed (5-7 hours sleepless). (5) |

| **Section 10 – Recreation** |
| - I am able to engage in all my recreation activities with no neck pain at all. (0) |
| - I am able to engage in all my recreation activities, with some pain in my neck. (1) |
| - I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck. (2) |
| - I am able to engage in a few of my usual recreation activities because of pain in my neck. (3) |
| - I can hardly do any recreation activities because of pain in my neck. (4) |
| - I cannot do any recreation activities at all. (5) |

| **Evaluation:** |
| 0-4 No disability |
| 5-14 Mild disability |
| 15-24 Moderate disability |
| 25-34 Severe disability |
| > 35 Complete disability |

Scoring and Interpretation:

Each of the 10 items is scored from 0 - 5. The maximum raw score is therefore 50. The obtained score can be multiplied by 2 to produce a percentage score. Occasionally, a respondent will not complete one question or another. The average of all other items is then added to the completed items.

Interpretation, as follows:
- 0 - 4 = no disability
- 5 - 14 = mild
- 15 - 24 = moderate
- 25 - 34 = severe
- Above 34 = complete disability.

Appendix 3

Oswestry Disability Index (ODI)

Version 2.1a

This questionnaire is designed to provide information as to how your back (or leg) trouble affects your ability to manage in everyday life.

Please answer every section. Mark one box only in each section that most closely describes you today.

Section 1 - Pain intensity

I have no pain at the moment.
The pain is very mild at the moment.
The pain is moderate at the moment.
The pain is fairly severe at the moment.
The pain is very severe at the moment.
The pain is the worst imaginable at the moment.

Section 2 - Personal care (washing, dressing, etc.)

I can look after myself normally without causing extra pain.
I can look after myself normally but it is very painful.
It is painful to look after myself and I am slow and careful.
I need some help but manage most of my personal care.
I need help every day in most aspects of self care.
I do not get dressed, wash with difficulty and stay in bed.

Section 3 - Lifting

I can lift heavy weights without extra pain.
I can lift heavy weights but it gives extra pain.
Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g. on a table.
Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
I can lift only very light weights.
I cannot lift or carry anything at all.

Section 4 - Walking

Pain does not prevent me walking any distance.
Pain prevents me walking more than one mile.
Pain prevents me walking more than a quarter of a mile.
Pain prevents me walking more than 100 yards.
I can only walk using a stick or crutches.
I am in bed most of the time and have to crawl to the toilet.

Section 5 - Sitting

I can sit in any chair as long as I like.
I can sit in my favourite chair as long as I like.
Pain prevents me from sitting for more than 1 hour.
Pain prevents me from sitting for more than half an hour.
Pain prevents me from sitting for more than 10 minutes.
Pain prevents me from sitting at all.

Section 6 - Standing

I can stand as long as I want without extra pain.
I can stand as long as I want but it gives me extra pain.
Pain prevents me from standing for more than 1 hour.
Pain prevents me from standing for more than half an hour.
Pain prevents me from standing for more than 10 minutes.
Pain prevents me from standing at all.

Section 7 - Sleeping

My sleep is never disturbed by pain.
My sleep is occasionally disturbed by pain.
Because of pain I have less than 6 hours sleep.
Because of pain I have less than 4 hours sleep.
Because of pain I have less than 2 hours sleep.  
Pain prevents me from sleeping at all.

**Section 8 - Sex life (if applicable)**
- My sex life is normal and causes no extra pain.
- My sex life is normal but causes some extra pain.
- My sex life is nearly normal but is very painful.
- My sex life is severely restricted by pain.
- My sex life is nearly absent because of pain.
- Pain prevents any sex life at all.

**Section 9 - Social life**
- My social life is normal and causes me no extra pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. sport, etc.
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted social life to my home.
- I have no social life because of pain.

**Section 10 - Travelling**
- I can travel anywhere without pain.
- I can travel anywhere but it gives extra pain.
- Pain is bad but I manage journeys over two hours.
- Pain restricts me to journeys of less than one hour.
- Pain restricts me to short necessary journeys under 30 minutes.
- Pain prevents me from travelling except to receive treatment

**Scoring & Interpretation:**
The 6 statements are scored from 0 to 5 with the first statement scoring 0 through to the last at 5. If more than one box is marked in each section, take the highest score.

The ODI score (index) is calculated as 

\[
\text{total score}/(5 \times \text{number of questions answered}) \times 100
\]

The disability scores are interpreted as follows: 0 to 20%, minimal disability; 20 to 40%, moderate disability; 40 to 60%, severe disability; 60 to 80%, crippled; and 80 to 100%, total incapacitation.

**References**