Medica Coverage Policy

Policy Name: Artificial Intervertebral Disc Replacement
Current Policy Effective Date: 11/26/2013

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, Medicaid and MinnesotaCare members, this policy will apply unless these 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 coverage policy may call the Medica Provider Service Center toll-free at 1-800-458-5512.

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

Coverage Policy

Artificial Cervical Disc Replacement:
Artificial intervertebral cervical disc replacement is not investigative when using an FDA-approved prosthetic cervical disc for the treatment of skeletally mature persons with symptomatic cervical degenerative disc disease or herniated disc at one level from C3 to C7.

Artificial intervertebral cervical disc replacement is investigative for all other indications including, but not limited to, treatment of degenerative disc disease at more than one level or treatment in combination with concurrent cervical spinal fusion. Reliable evidence does not permit conclusions concerning its effectiveness.

Artificial Lumbar Disc Replacement:
Artificial intervertebral lumbar disc replacement is investigative. Reliable evidence does not permit conclusions concerning its effectiveness.

Note: See Medica utilization management policy, Cervical Spine Surgeries III-SUR.37, for specific medical necessity criteria.

Description

Artificial intervertebral disc replacement 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. Artificial discs have been developed to replace a disc in either the lumbar spine (lower back) or cervical spine (neck). 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.

FDA Approval

Lumbar Artificial Discs:
The FDA has approved the following two artificial intervertebral lumbar discs through the Premarket Approval (PMA) process:
1. The Inmotion® Lumbar Artificial Disc (formerly Charité™ Artificial Disc) (DePuy Spine, Inc.) was approved in October 2004 for spinal arthroplasty in skeletally mature patients with degenerative disc disease (DDD) at one level from L4-S1. DDD is defined as discogenic back pain with degeneration of the disc confirmed by patient history and radiographic studies. Patients receiving the disc should have no more than 3 mm of spondylolisthesis at the involved level and should have failed at least six months of conservative treatment prior to implantation of the disc.
2. The PRODISC-L® Total Disc Replacement, (Synthes Spine, Inc.) was approved in August 2006 for spinal arthroplasty in patients who are skeletally mature and who have DDD at one level in the lumbar spine from L3-S1. Patients receiving this device should have no more than Grade 1 spondylolisthesis at the involved level and have had no relief from pain after at least six months of non-surgical treatment prior to disc implantation.

Cervical Artificial Discs:
The FDA has approved the following artificial intervertebral cervical discs through the PMA process:
1. The Prestige® Cervical Disc System (Medtronic Sofamor Danek) was approved in July 2007 for reconstruction of the disc from C3-C7 following single-level discectomy for intractable radiculopathy and/or myelopathy. Intractable radiculopathy and/or myelopathy should be present with a herniated disc and/or osteophyte formation producing symptomatic nerve root and/or spinal cord compression which is documented by patient history and radiographic studies. The device is implanted via an open anterior approach.
2. The FDA approved the ProDisc™ C (Synthes, Inc.) in December 2007. It was approved for use in skeletally mature patients for reconstruction of the disc from C3-C7 for intractable symptomatic cervical disc disease (SCDD). Symptomatic cervical disc disease is defined as neck or arm pain and/or a functional/neurological deficit with at least one of the following conditions confirmed by imaging: herniated nucleus pulposis, spondylolisthesis, and/or loss of disc height. The ProDisc-C is implanted via an open anterior approach. Patients should have failed at least six weeks of non-operative treatment prior to disc replacement.
3. The Bryan® Cervical Disc (Medtronic Sofamor Danek) was approved in May 2009 for reconstruction of the disc from C3-C7 in skeletally mature patients following single-level discectomy for intractable radiculopathy and/or myelopathy. Intractable radiculopathy and/or myelopathy is defined as any combination of the following: disc herniation with radiculopathy, spondylotic radiculopathy, disc herniation with myelopathy, or spondylotic myelopathy resulting in impaired function and at least one clinical neurological sign associated with the cervical level to be treated, and necessitating surgery as demonstrated using computed tomography (CT), myelography and CT, and/or magnetic resonance imaging (MRI). The BRYAN® device is implanted via an open anterior approach. Patients receiving the disc should have failed at least six weeks of non-operative treatment prior to implantation.
4. The Secure® C Artificial Disc System (Globus Medical) was approved in September 2012 for use in skeletally mature patients for reconstruction of the disc at 1 level from C3 to C7 following single level discectomy for intractable radiculopathy (arm pain and/or a neurological deficit) with or without neck pain, or myelopathy due to a single-level abnormality localized to the disc space and at least 1 of the following conditions confirmed by radiographic imaging (CT, MRI, X-rays): herniated nucleus pulposus, spondylisis (defined by the presence of osteophytes), and/or visible loss of disc height as compared to adjacent levels. The FDA-approved clinical trial has not yet been published.
5. The PCM® Cervical Disc System (NuVasive, Inc.) was approved in October 2013 for use in skeletally mature patients for reconstruction of a degenerated cervical disc at 1 level from C3-C4 to C6-C7 following single-level discectomy for intractable radiculopathy (arm pain and/or a neurological deficit) with or without neck pain, or myelopathy due to a singlelevel abnormality localized to the disc space, and manifested by at least one of the following conditions confirmed by radiographic imaging (CT, MRI, X-rays): herniated nucleus pulposus, spondylisis (defined by the presence of osteophytes), and/or visible loss of disc height as compared to adjacent levels.
6. The MOBI-C® Cervical Disc Prosthesis (One-Level Indication) (LDR Spine USA) was approved in August 2013 for skeletally mature patients for reconstruction of the disc at one level from C3-C7 following single-level discectomy for intractable radiculopathy with or without neck pain or myelopathy due to a single-level abnormality localized to the level of the disc space and at least one of the following conditions confirmed by imaging (CT, MRI, X-rays): herniated nucleus
The MOBI-C® Cervical Disc Prosthesis (Two-Level Indication) (LDR Spine USA) was approved in August 2013 for skeletally mature patients for reconstruction of the disc from c3-c7 following discectomy at two contiguous levels for intractable radiculopathy with or without neck pain, or myelopathy due to abnormality localized to the level of the disc space and at least one of the following conditions confirmed by imaging (CT, MRI, X-rays): herniated nucleus pulposus, spondylosis (i.e., presence of osteophytes), and/or visible loss of disc height compared to adjacent levels. The MOBI-C is implanted using an anterior approach. Patients should have failed at least 6 weeks of conservative treatment or demonstrated progressive signs or symptoms despite nonoperative treatment prior to implantation.

The FDA has required post-market approval studies of each of the approved devices to evaluate longer-term safety and effectiveness of the device, and to more fully characterize adverse events when the device is used in a broader patient population.

Prior Authorization

Prior authorization is required for artificial cervical disc replacement. See Medica utilization management policy, Cervical Spine Surgeries III-SUR.37, for specific medical necessity criteria.

Prior authorization for artificial lumbar disc replacement is not applicable. However, claims for this service are subject to retrospective review and denial of coverage as investigative services are not eligible for reimbursement.

Coding Considerations

Use the current applicable CPT/HCPCS code(s). The following codes are included below for informational purposes only, and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement.

Cervical CPT:

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

22861 - Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical

22864 - Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical

0092T - Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection), each additional interspace, cervical

0095T - Removal of total disc arthroplasty (artificial disc), each additional interspace, cervical

0098T - Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, cervical

Cervical ICD-9 Procedure:

84.61 - Insertion of partial spinal disc prosthesis, cervical

84.62 - Insertion of total spinal disc prosthesis, cervical

84.66 - Revision or replacement of artificial spinal disc prosthesis, cervical

Lumbar CPT:

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,
Medica Coverage Policy

22865 - Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar

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)

Lumbar ICD-9 Procedure:
84.60 - Insertion of spinal disc prosthesis, not otherwise specified
84.63 - Insertion of spinal disc prosthesis, thoracic
84.64 - Insertion of partial spinal disc prosthesis, lumbosacral
84.65 - Insertion of total spinal disc prosthesis, lumbosacral
84.67 - Revision or replacement of artificial spinal disc prosthesis, thoracic
84.68 - Revision or replacement of artificial spinal disc prosthesis, lumbosacral
84.69 - Revision or replacement of artificial spinal disc prosthesis, not otherwise specified

Original Policy Effective Date: 4/1/2005
Re-Review Date(s): 12/18/2007
12/21/2010
10/22/2013

© 2013 Medica. Medica® is a registered service mark of Medica Health Plans. "Medica" refers to the family of health plan businesses that includes Medica Health Plans, Medica Health Plans of Wisconsin, Medica Insurance Company, and Medica Self-Insured, and Medica Health Management, LLC.