Artificial Intervertebral Disc – Cervical

I. Policy

University Health Alliance (UHA) will reimburse for artificial disc replacement when it is determined to be medically necessary and when it meets the medical criteria guidelines (subject to limitations and exclusions) indicated below.

Artificial cervical disc replacement surgery or cervical disc arthroplasty (CDA) is a developing technique for the treatment of cervical radiculopathy that has been used in situations when an anterior cervical disectomy and fusion (ACDF) would otherwise be appropriate. Mounting evidence suggests that CDA is equal or superior to ACDF in terms of clinical outcomes. In a 2016 systematic review and meta-analysis of eight randomized controlled trials and over 2,300 subjects comparing CDA with ACDF with at least four years of follow-up, pooled analysis found that CDA led to significantly higher rates of success on most clinical outcome measures (e.g., overall success, neurologic success, improvement of disability scores) and lower rates of implant or surgically-related serious adverse events.

II. Criteria/Guidelines

A. Cervical intervertebral disc replacement or spinal arthroplasty is covered (subject to Limitations/Exclusions and Administrative Guidelines) when performed at one level (22856, 22861, 22884) in individuals with cervical degenerative disc disease when all of the following criteria are met:

1. An FDA-approved device (e.g., Prestige ST Cervical Disc, Bryan Cervical Disc, and ProDisc-C Total Disc Replacement; Mobi-C and Prestige LP are the only FDA-approved device for 2 levels) is used; and

2. Degeneration is confirmed by radiologic studies (e.g., CT, MRI, x-rays); and

3. The operative level is C3 to C7; and

4. The procedure is performed in a skeletally mature individual; and

5. The patient has intractable cervical radicular pain or myelopathy and has:

   a. Failed at least six weeks of physician-directed, conservative, non-operative management, which includes all of the following components:

      i. Exercise, including core stabilization exercises; and

      ii. Nonsteroidal and/or medication (unless contraindicated); and

      iii. Physical therapy, including passive and active treatment modalities; and

      iv. Activity/lifestyle modification; or

   b. Severe or rapidly progressive symptoms of nerve root or spinal cord compression requiring hospitalization or immediate surgical treatment.

B. Subsequent cervical artificial intervertebral disc implantation at an adjacent level is covered (subject to Limitations and Administrative Guidelines) when all of the following are met:

1. Criteria above are met; and

2. The device is FDA-approved for 2 levels; and

3. The planned subsequent procedure is at a different cervical level than the initial cervical artificial disc replacement; and
4. Clinical documentation that the initial cervical artificial intervertebral disc implantation is fully healed.

**NOTE:**

This UHA payment policy is a guide to coverage, the need for prior authorization and other administrative directives. It is not meant to provide instruction in the practice of medicine and it should not deter a provider from expressing his/her judgment.

Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or members’ individual benefit plans may apply, and this policy is not a guarantee of payment. UHA reserves the right to apply this payment policy to all UHA companies and subsidiaries.

UHA understands that opinions about and approaches to clinical problems may vary. Questions concerning medical necessity (see Hawaii Revised Statutes §432E-1.4) are welcome. A provider may request that UHA reconsider the application of the medical necessity criteria in light of any supporting documentation.

### III. Limitations/Exclusions

A. Artificial intervertebral disc replacement is not covered for any other indication (e.g., lumbar) as there is insufficient evidence regarding long-term benefits and harms to support recommendation (UTD 2018).

B. Cervical artificial disc replacement at one level combined with cervical spinal fusion at another level (adjacent or non-adjacent) is not covered as it has not been shown in the scientific literature to improve health care outcomes.

C. Cervical artificial intervertebral disc implantation is not covered for any other indication including those listed below as it has not been shown in the scientific literature to improve health care outcomes:
   1. Disc implantation at more than 2 levels
   2. Combined use of an artificial cervical disc and fusion
   3. Prior surgery at the treated level
   4. Previous fusion at another cervical level
   5. Translational instability
   6. Anatomical deformity (e.g., ankylosing spondylitis)
   7. Rheumatoid arthritis or other autoimmune disease
   8. Presence of facet arthritis
   9. Active infection
   10. Metabolic bone disease (e.g., osteoporosis, osteopenia, osteomalacia)
   11. Malignancy

### IV. Administrative Guidelines

A. Prior authorization is required.

B. To request prior authorization, please submit via UHA’s online portal.

C. All of the following documentation must be submitted:
   1. Imaging studies;
   2. Clinical notes describing symptoms and physical findings; and
3. Documentation of failure of conservative management for six weeks or more.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>22856</td>
<td>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</td>
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<tr>
<td>22861</td>
<td>Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical</td>
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<tr>
<td>22864</td>
<td>Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical</td>
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</tbody>
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V. Policy History

**Policy Number:** MPP-0041-120301

**Current Effective Date:** 09/19/2018

**Original Document Effective Date:** 03/01/2012

**Previous Revision Dates:** 07/01/2013, 01/01/2017

**PAC Approved Date:** 03/01/2013

**Previous Policy Title:** Artificial Disc Replacement – Cervical

References:


