Artificial Disc Replacement, 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.

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, 22864) in individuals with cervical degenerative disc disease (722.4) 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 is the only FDA-approved device for 2 levels,) is used; and
2. 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. At least six weeks of conservative management has been tried and failed which includes all of the following components:
   a. Exercise, including core stabilization exercises; and
   b. Nonsteroidal and/or medication (unless contraindicated); and
   c. Physical therapy, including passive and active treatment modalities; and
   d. Activity/lifestyle modification

B. 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).
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.

### IV. Administrative Guidelines

A. Prior authorization is required.

B. To request prior authorization, please go to UHA’s website: [https://uhahealth.com/page/prior-authorization-forms](https://uhahealth.com/page/prior-authorization-forms) and submit via online.

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 disc-ectomy 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: M.SUR.06.120301  
Current Effective Date: 01/01/2017  
Original Document Effective Date: 03/01/2012  
Previous Revision Dates: 07/01/2013, 01/01/2017  
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