



CLINICAL GUIDELINES

CMM-610: Lumbar Total Disc Arthroplasty Guidelines

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eviCore healthcare Clinical Decision Support Tool Diagnostic Strategies: This tool addresses common symptoms and symptom complexes. Requests for individuals with atypical symptoms or clinical presentations that are not specifically addressed will require physician review. Consultation with the referring physician, specialist and/or individual's Primary Care Physician (PCP) may provide additional insight.

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Clinical guidelines for medical necessity review of Comprehensive Musculoskeletal Management Services.

CMM-610: Lumbar Total Disc Arthroplasty

CMM-610.1: General Guidelines

CMM-610.2: Initial Primary Lumbar Total Disc Arthroplasty

CMM-610.3: Non-Indications

CMM-610.4: Procedure (CPT®) Codes

CMM-610.5: References

CMM-610.1: General Guidelines

Application of Guideline

- The determination of medical necessity for the performance of lumbar total disc arthroplasty is always made on a case-by-case basis.
- For prior authorization requirements, see **CMM-600.1: Prior Authorization Requirements**.

CMM-610.2: Initial Primary Lumbar Total Disc Arthroplasty

Initial primary lumbar total disc arthroplasty is considered **medically necessary** when **ALL** of the following are met:

- Age 18 to 60 years old
- Lumbar disc prosthesis approved by the FDA or for an FDA approved indication and in accordance with FDA labeling
- Absence of facet ankylosis or severe facet degeneration at the operative level
- Moderate to severe single-level disc degeneration at L3-4, L4-L5, or L5-S1 has been confirmed on recent (within 6 months) plain X-rays and advanced diagnostic imaging studies (i.e., CT, MRI)
- Subjective symptoms (secondary to single-level degenerative lumbar disc disease [DDD] including **BOTH** of the following:
 - ◆ Significant level of pain on a daily basis defined as **EITHER** of the following:
 - Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
 - Severe, disabling, crippling, or incapacitating discogenic axial lower back pain for at least one year
 - ◆ Clinically significant functional impairment (e.g. inability to perform household chores, prolonged standing or essential job functions)
- Structured physician-supervised, multi-modal, nonoperative management of medical care with licensed healthcare professionals which includes **ALL** of the following:
 - ◆ Regularly scheduled appointments
 - ◆ Follow-up evaluation
 - ◆ Less than clinically meaningful improvement with **BOTH** of the following for at least 6 consecutive months (unless contraindicated):
 - Prescription strength analgesics, steroids, and/or NSAIDs
 - Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician
- Absence of unmanaged significant mental and/or behavioral health disorders (e.g. major depressive disorder, chronic pain syndrome, secondary gain, opioid and alcohol use disorders)

CMM-610.3: Non-Indications

Not Medically Necessary

- Lumbar total disc arthroplasty performed without meeting the requirements listed in the General Guidelines and the procedure specific section is considered **not medically necessary**.
- Lumbar total disc arthroplasty is considered **not medically necessary** for **ANY** of the following:
 - ◆ The revision of a failed lumbar artificial total disc arthroplasty
 - ◆ The planned procedure includes the combined use of a prosthesis and spinal fusion (hybrid)
 - ◆ Lumbar partial disc prosthetics
 - ◆ Simultaneous multi-level implantation
 - ◆ The implant will be inserted outside of the spinal motion segments approved by the FDA
 - ◆ The patient has osteopenia or osteoporosis (T-score < -1.0)
 - ◆ Above or below or in combination with a spinal fusion or other stabilizing type surgical procedure
 - ◆ Lumbar disc prosthesis not approved by the FDA and not for an FDA approved indication and not in accordance with FDA labeling
 - ◆ Degenerative disc disease above L3-L4
 - ◆ Presence of unmanaged significant mental and/or behavioral health disorders (e.g. major depressive disorder, chronic pain syndrome, secondary gain, opioid and alcohol use disorders)
 - ◆ Age less than 18 years or greater than 60
 - ◆ As an adjunct to the treatment of primary central or far-lateral disc herniation
 - ◆ There is evidence on imaging studies of **ANY** of the following:
 - Degenerative or lytic spondylolisthesis > 3mm
 - Lumbar spinal stenosis
 - Pars interarticularis defect with either spondylolysis or isthmic spondylolisthesis
 - Lumbar scoliosis (> 11 degrees of sagittal plane deformity)
 - Spinal fracture
 - Infection
 - Multi-level degenerative disc disease (2 or more levels) on a preoperative MRI and plain X-rays
 - Presence of facet ankylosis or severe facet degeneration at the operative level
 - Presence of tumor or active infection at the site of implantation
 - Lumbar nerve root compression or bony spinal stenosis
 - Preoperative remaining disc height < 3mm
 - Mid-sagittal stenosis of <8mm (by MRI)
 - ◆ History of ankylosing spondylitis, rheumatoid arthritis, lupus, or other autoimmune disorder.
 - ◆ Allergy or sensitivity to implant materials

- ◆ Isolated radicular compression syndromes especially due to lumbar disc herniation
- ◆ Involved vertebral endplate is dimensionally smaller than the approximate dimensions of the implant in anterior/posterior width and lateral width
- ◆ Clinically compromised vertebral bodies at the affected level due to current or past trauma

CMM-610.4: Procedure (CPT®) Codes

This guideline relates to the CPT® code set below. Codes are displayed for informational purposes only. Any given code's inclusion on this list does not necessarily indicate prior authorization is required.

CPT®	Code Description/Definitions
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, single interspace; lumbar
22865	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar
+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)

This list may not be all inclusive and is not intended to be used for coding/billing purposes. The final determination of reimbursement for services is the decision of the health plan and is based on the individual's policy or benefit entitlement structure as well as claims processing rules

CMM-610.5: References

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