Authorization criteria:
Cervical spine surgery for adults with artificial disc replacement

For Blue Care Network HMO<sup>SM</sup> (commercial) and BCN Advantage<sup>SM</sup> members only

Clinical review is required for adult members (age ≥18). The medical necessity criteria are outlined below.

CPT code: *22856, *22858 and *22861

**Cervical disc herniation, degenerative cervical disc disease or myelopathy**

ALL of the following:

1. BOTH of the following:
   a. Radiculopathy with either a motor deficit** or a sensory deficit***
   b. AT LEAST ONE of the following:
      i. Bilateral upper or lower extremity weakness (less than 2 out of 5 muscle strength), numbness or pain
      ii. Bowel or bladder dysfunction and other etiologies excluded
      iii. Spasticity by physical exam
      iv. Bilateral loss of dexterity (decreased fine motor control in the hands)
      v. Gait disturbance and other etiologies excluded

2. Continued symptoms or findings after treatment with ALL:
   a. Appropriate non-steroidal anti-inflammatory drugs or acetaminophen for at least 3 weeks (unless contraindicated/not tolerated)
   b. Physician-directed home exercise program OR physical therapy for at least 6 weeks
   c. Activity modification for at least 6 weeks

3. Imaging that correlates with symptoms and findings

4. ONE of the following:
   a. The implantation is planned at a single level AND the device is FDA approved.
   b. The implantation is planned simultaneously for two levels AND ALL of the following:
      i. The device is FDA approved for two levels.
      ii. The above criteria are met for EACH disc level.
   c. The procedure is subsequent to a previously implanted disc at an adjacent level AND ALL of the following:
      i. The device is FDA approved for two levels.
      ii. The above criteria are met for EACH disc level.
      iii. There is clinical documentation that the previous implanted disc is fully healed.

5. NONE of the following contraindications to this procedure applies:
   a. Infection or malignancy at the level of disc replacement
   b. Significant facet arthritis at the level of disc replacement
   c. Metabolic bone disease (for example, osteoporosis, osteomalacia or osteopenia)
   d. Spine instability
   e. Anatomical deformity (for example, severe spondylosis or ankylosing spondylitis)
   f. Rheumatoid arthritis or other autoimmune disease
   g. Ossification of the posterior longitudinal ligament
   h. Prior disc surgery at the treated level
      i. Previous fusion at any cervical level
   j. Disc implant at more than two levels
   k. Combined use of an artificial disc and fusion

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Current authorization criteria effective date: March 2018
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Cervical disc herniation, degenerative cervical disc disease or myelopathy (continued)

6. All significant psychosocial and substance abuse issues have been adequately addressed.
7. Education has been provided to the patient that:
   a. Cigarette smoking has been shown to adversely affect cervical spinal fusion outcome AND
   b. Smoking cessation prior to and after surgery is strongly recommended, with both pharmacologic and nonpharmacologic assistance offered.

**Radiculopathy with a motor deficit refers to depressed or asymmetrical reflexes or weakness in affected muscles in a SPECIFIC NERVE ROOT DISTRIBUTION — for example, deltoids and biceps (C5), biceps and brachioradialis (C6), triceps and wrist extensors (C7), intrinsic hand muscles (C8).**

***Radiculopathy with a sensory deficit refers to numbness or pain is present in a SPECIFIC NERVE ROOT DISTRIBUTION — for example: neck, shoulder and upper arm pain (C5); neck, shoulder and radial forearm pain (C6); neck shoulder and dorsal forearm pain (C7); neck, shoulder and ulnar forearm pain (C8).***

References

McKesson’s InterQual® 2017 Procedures Adult Criteria, Artificial Disc Replacement, Cervical Spine.

Blue Cross/BCN Medical Policy Artificial Intervertebral Disc: Cervical Spine - effective date Jan. 1, 2018