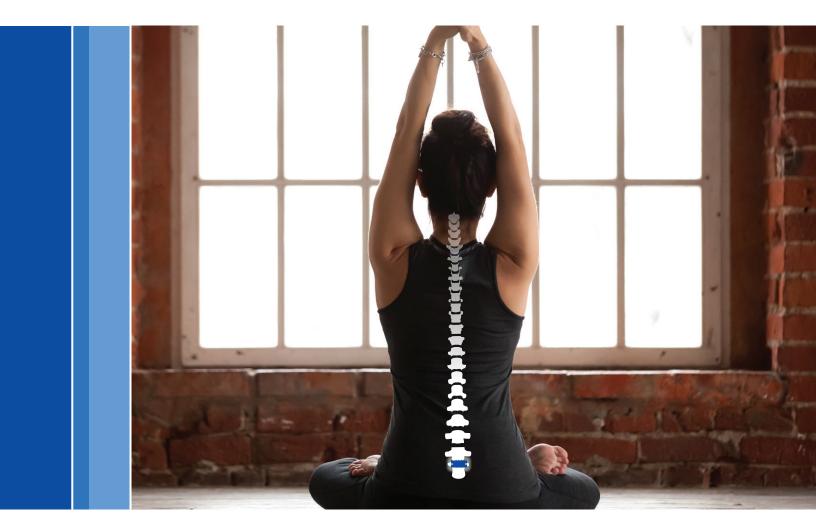
Certificates of Medical Necessity

for Lumbar Total Disc Replacement by Medical Policy



Aesculap Spine



Certificates of Medical Necessity Overview

This interactive document contains the Certificates of Medical Necessity specific to insurers with positive coverage of Lumbar Total Disc Replacement (LTDR) as well as a Nonspecific Certificate of Medical Necessity for all insurers not listed. The necessary Certificate of Medical Necessity can be sent directly to the commercial payer once all requirements are captured in the patient's chart. Please be aware that the Certificate of Medical Necessity may also be duplicated into your Electronic Medical Record (EMR) system from this document for ease of use.

For Commercial Insurers with Positive Coverage for LTDR:

If the patient's insurer has positive coverage of LTDR, the surgeon should use the Certificate of Medical Necessity specific to that patient's insurance during the appointment to ensure all requirements are captured in the patient's chart prior to the office's submission for prior authorization. If an insurer-specific Certificate of Medical Necessity is not available in this document, please use the Nonspecific Certificate of Medical Necessity.

Written Prior Authorization

It is critical that, after the appointment for a patient with positive coverage for LTDR, the office seek written prior authorization. If all conservative care records and other records as required by the Medical Policy as noted in the Certificate of Medical Necessity are not provided, even a covering payer will deny the procedure. Exhaustive records submitted upon initial prior authorization are critical to the success of the patient's access to this procedure.

Denial of Written Prior Authorization

If the office receives a denial for a written prior authorization for a payer covering LTDR and the patient meets the Certificate of Medical Necessity requirements, call the Patient Assistance Line (PAL), (contact information found below).

For Commercial Insurers without Positive Coverage for LTDR:

If the patient's insurer does not cover LTDR, the surgeon should still complete the Certificate of Medical Necessity, regardless of payer coverage status, as a back-up to surgeon charting. The Patient Assistance Line can assist in advocating for patients that are candidates for LTDR without positive coverage. Please find the PAL contact information below.

The activL Artificial Disc Patient Assistance Line (PAL)
Telephone: 844-245-1140
Fax: 844-285-1330
Cynthia@patientassistanceline.com

Disclaimer: This information is provided for informational purposes only. Healthcare providers are responsible for all decisions related to reimbursement. Providers are advised to contact payers to confirm benefits and coverage for each individual patient. The content above is subject to change without notice, as may be determined by the payer. Aesculap Implant Systems, LLC makes no representation or warranty regarding this information, its completeness or accuracy, and bears no responsibility for the results or consequences of the use of this information. It is intended to be a general overview of medical necessity criteria for this health plan. The criteria and contraindications checklist above may not be the same as the Indications/ Contraindications approved by FDA. The above information represents acceptance criteria of the Healthcare Provider.

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(Please click on the below commercial payer for a Certificate of Medical Necessity specific to their medical policy.)

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Surgeon Certification

I certify that this patient meets the criteria for medical necessity as outlined in your medical policy based on the following:

Age 18 to 60 years old; and

Primary complaint of axial pain to be of discogenic origin; and Symptoms for at least one year, which have not responded to a multifaceted program of conservative treatment over that period of time. Conservative management to include a combination of strategies; and

Presence of single level, advanced disc disease at L4–5 or L5–S1, as documented by magnetic resonance imaging (MRI) and plain radiographs demonstrating moderate to severe degeneration of the disc with Modic changes (peridiscal bone signal above and below the disc space in question). All imaging must be performed and read by an independent radiologist. Imaging studies should correlate with the clinical findings; and

Absence of disease at all other lumbar levels as documented by normal radiographs and MRI showing no abnormalities or mild degenerative changes; and

Significant pain and functional impairment refer to pain that is at least 3 out of 10 in intensity and is associated with inability to perform at least (2) ADLs and/or IADLs

Adherence to tobacco-cessation program resulting in abstinence from tobacco for at least 6 weeks prior to spinal surgery is recommended

Does not have any of the following contraindications:

Significant facet arthropathy at the operated level Disease above L4-L5

Bony lumbar spinal stenosis

Pars defect

Clinically compromised vertebral bodies at affected level due to current or past trauma

Lytic spondylolisthesis or degenerative spondylolisthesis of grade greater than 1

Allergy or sensitivity to implant materials (cobalt, chromium, molybdenum, polyethylene, titanium)

Presence of infection or tumor

Osteopenia or osteoporosis (defined as dual-energy x-ray absorptiometry (DEXA) bone

The procedure is not comprised of any of the following deemed not medically necessary per your medical policy:

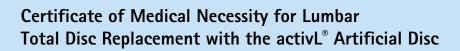
Disc replacement at more than one spinal level

Arthroplasty below, or in combination with, spinal fusion or other stabilizing-type procedure

Isolated radicular compression syndromes, especially due to disc herniation

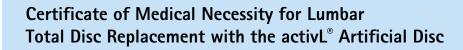
Hybrid lumbar TDA/Lumbar Fusion (lumbar total disc arthroplasty at one level at the same time as lumbar fusion at a different level)

Arthroplasty using devices other than those which are FDA approved, or use of an FDA-approved device in a manner which does not meet FDA requirements



Other:	
Notes:	
Device Requirements:	
Must be FDA approved and used per FDA labeling	
Single-level use only	
Enclosures	
Enclosed is the following documentation as required by your policy:	
Medical records with evidence of at least one year of failed conservative treatment	
Radiographs with evidence of degenerative disc disease with one confirmed symptomatic level	
Certification and Signature	
I certify that I am the surgeon identified on this certificate and that I have completed this form bas patient's case and on my examination of this patient.	ed on my thorough review of the
Surgeon Signature:	Date:

BCBS of Arkansas		
Policy Name: Artificial Inte	ervertebral Disc, Lumbar Spine	
Policy Number: 2004002		
Effective Da	nte: March 2015	
Patient Name:	Surgeon Name:	
Surgeon NPI:		
Facility Name:	Facility Tax ID:	
Facility Address:		
Facility Type: Inpatient Outpatient ASC		
-	nosis Code (Please Check One)	
M51.36 Other intervertebral degeneration, lumbar		
M51.37 Other intervertebral degeneration, lumbosacral		
M51.26 Other intervertebral disc displacement, lumbar		
M51.27 Other intervertebral disc displacement, lumbosacral		
Other		
Primary ICD-10-PCS Procedure C	Code (if Inpatient) (Please Check One)	
0SR20JZ Replacement of lumbar vertebral disc with synthetic s	ubstitute, open	
OSR40JZ Replacement of lumbosacral vertebral disc with synth	etic substitute, open	
Primary CPT®	Procedure Code	
22857 Total disc arthroplasty (artificial disc), anterior approach	including discectomy to prepare interspace, single interspace, lumbar	
Surgeon Certification		
I certify that this patient meets the criteria for medical necessity as	outlined in your medical policy based on the following:	
18 to 60 years old; and	Absence of active significant psychiatric disorders, such as	
Advanced single-level disease noted on an MRI and	major depression requiring pharmaceutical treatment; and	
plain radiographs of the lumbar spine at L4-L5 or L5-S1,	Absence of significant facet arthropathy at the operative level	
characterized by moderate to severe degeneration of the disc;	Does not have any of the following contraindications:	
and Primary complaint of axial pain with a possible secondary	Lumbar artificial intervertebral disc replacement in all other situations does not meet member benefit certificate	
Primary complaint of axial pain with a possible secondary complaint of lower extremity pain; and	primary coverage criteria thus the procedure is considered	
Presence of symptoms for at least one year that are not	investigational.	
responsive to conservative treatment which should include a		
physical therapy/rehabilitation program; and		
Other:		
Notes:		
Device Requirements:		
Must be FDA approved and used per FDA labeling		
Single-level use only		



Enclosed is the following documentation as required by your policy: Medical records with evidence of at least one year of failed conservative treatment Radiographs with evidence of degenerative disc disease with one confirmed symptomatic level Behavioral health screening results Certification and Signature I certify that I am the surgeon identified on this certificate and that I have completed this form based on my thorough review of the patient's case and on my examination of this patient.

Surgeon Signature: Date:

BCBS of Louisiana		
Policy Name: Artificial Intervertebral Disc: Lumbar Spine		
Policy Number: #00145		
Effective Date: September 4,	2018	
Patient Name: Surgeon N	ame:	
Surgeon NPI:		
Facility Name: Facility Tax	x ID:	
Facility Address:		
Facility Type: Inpatient Outpatient ASC		
Primary ICD-10-CM Diagnosis Code (Please Check One)		
M51.36 Other intervertebral degeneration, lumbar		
M51.37 Other intervertebral degeneration, lumbosacral		
M51.26 Other intervertebral disc displacement, lumbar		
M51.27 Other intervertebral disc displacement, lumbosacral		
Other		
Primary ICD-10-PCS Procedure Code (if Inpat	ti ent) (Please Check One)	
OSR20JZ Replacement of lumbar vertebral disc with synthetic substitute, open		
OSR40JZ Replacement of lumbosacral vertebral disc with synthetic substitute, open		
Primary CPT® Procedure Code		
22857 Total disc arthroplasty (artificial disc), anterior approach including dis	cectomy to prepare interspace, single interspace, lumbar	

Surgeon Certification

I certify that this patient meets the criteria for medical necessity as outlined in your medical policy based on the following:

Age 18 to 60 years old; and

Primary complaint of axial pain to be of discogenic origin; and Symptoms for at least one year, which have not responded to a multifaceted program of conservative treatment over that period of time. Conservative management to include a combination of strategies; and

Presence of single level, advanced disc disease at L4-L5 or L5-S1, as documented by magnetic resonance imaging (MRI) and plain radiographs demonstrating moderate to severe degeneration of the disc with Modic changes (peridiscal bone signal above and below the disc space in question). All imaging must be performed and read by an independent radiologist. Imaging studies should correlate with the clinical findings; and Absence of disease at all other lumbar levels as documented by normal radiographs and MRI showing no abnormalities or mild degenerative changes; and

Documented significant pain and impairment: Pain that is at least 3 out of 10 in intensity and is associated with inability to perform at least two (2) ADL's

Absence of contraindications listed below

Does not have any of the following contraindications:

Significant facet arthropathy at the operated level Disease above L4-L5
Bony lumbar spinal stenosis
Pars defect

Clinically compromised vertebral bodies at affected level due to current or past trauma

Lytic spondylolisthesis or degenerative spondylolisthesis of grade greater than 1

Allergy or sensitivity to implant materials (cobalt, chromium, molybdenum, polyethylene, titanium)

Presence of infection or tumor

Osteopenia or osteoporosis (defined as dual-energy x-ray absorptiometry [DEXA] bone density measured T-score less than -1.0)

The procedure is not comprised of any of the following deemed not medically necessary per your medical policy:

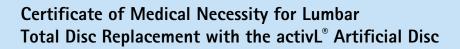
Disc replacement at more than one spinal level; OR Arthroplasty below, or in combination with, spinal fusion or other stabilizing-type procedure

Isolated radicular compression syndromes, especially due to disc herniation

Hybrid lumbar total disc arthroplasty (TDA)/Lumbar Fusion (lumbar TDA at one level at the same time as lumbar fusion at a different level)

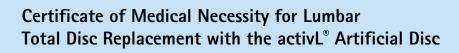
Arthroplasty using devices other than those which are U.S. Food and Drug Administration (FDA) approved, or use of an FDA-approved device in a manner which does not meet FDA requirements.

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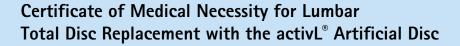
Other:	
Notes:	
Device Requirements:	
Must be FDA approved and used per FDA labeling	
Single-level use only	
Enclosures	
Enclosed is the following documentation as required by your policy:	
Medical records with evidence of at least one year of failed conservative	treatment and DEXA scan results
Radiographs with evidence of degenerative disc disease with one confirm	ned symptomatic level
Certification and Sig	nature
I certify that I am the surgeon identified on this certificate and that I have contained a patient's case and on my examination of this patient.	ompleted this form based on my thorough review of the
Surgeon Signature:	Date:

BCBS of No	orth Dakota
Policy Name: Artificial Inter	rvertebral Disc Replacement
Policy Num	ber: #00145
Effective Date	e: July 1, 2018
Patient Name:	Surgeon Name:
Surgeon NPI:	[
Facility Name:	Facility Tax ID:
Facility Address:	
Facility Type: Inpatient Outpatient ASC	
-	osis Code (Please Check One)
M51.36 Other intervertebral degeneration, lumbar	
M51.37 Other intervertebral degeneration, lumbosacral	
M51.26 Other intervertebral disc displacement, lumbar	
M51.27 Other intervertebral disc displacement, lumbosacral	
Other	
Primary ICD-10-PCS Procedure Co	de (if Inpatient) (Please Check One)
OSR20JZ Replacement of lumbar vertebral disc with synthetic sub	ostitute, open
OSR40JZ Replacement of lumbosacral vertebral disc with synthet	ic substitute, open
Primary CPT° P	Procedure Code
22857 Total disc arthroplasty (artificial disc), anterior approach in	ncluding discectomy to prepare interspace, single interspace, lumbar
Surgeon Certification	
I certify that this patient meets the criteria for medical necessity as ou	tlined in your medical policy based on the following:
One-level degenerative disc disease (DDD) from L4-S1 as shown on CT or MRI; and Failure of 3 months of conservative therapy including BOTH of the following: A trial of non-steroidal anti-inflammatories (NSAIDs); and A documented trial of up to six-weeks of physical therapy; and	The individual is between 18-65 years old; and Symptoms are localizable to one-level in the L4-S1 area; and Absence of moderate or severe facet joint arthropathy confirmed by CT or MRI. Lumbar artificial intervertebral disc replacement is considered experimental/investigational and therefore non-covered when ALL of the above criteria are not met.
Other:	
Notes:	
	sures
Enclosed is the following documentation as required by your policy:	
Medical records with evidence of 3+ months of failed conservation	ve treatment
Radiographs with evidence of degenerative disc disease with one	confirmed symptomatic level



Certification and Signature	
I certify that I am the surgeon identified on this certificate and that I have completed this form based on my thorough review of the	
patient's case and on my examination of this patient.	
Surgeon Signature	Date:

Blue Shield o	f California
	roplasty (artificial disc replacement)
·	SSC_NIA_CG_304
·	e: July 1, 2019
Patient Name:	Surgeon Name:
Surgeon NPI:	Jungeon Name.
Facility Name:	Facility Tax ID:
Facility Address:	Tucinity Tux 12.
Facility Type: Inpatient Outpatient ASC	
	osis Code (Please Check One)
M51.36 Other intervertebral degeneration, lumbar	and could (i reade direct one)
M51.37 Other intervertebral degeneration, lumbosacral	
M51.26 Other intervertebral disc displacement, lumbar	
M51.27 Other intervertebral disc displacement, lumbosacral	
Other	
	de (if Inpatient) (Please Check One)
OSR20JZ Replacement of lumbar vertebral disc with synthetic su	
·	·
OSR40JZ Replacement of lumbosacral vertebral disc with synthet	Procedure Code
·	
	ncluding discectomy to prepare interspace, single interspace, lumbar
Surgeon Certification	
I certify that this patient meets the criteria for medical necessity as ou	, , ,
Between ages of 18 and 60	Osteoporosis or osteopenia or vertebral bodies compromised
Degenerative disc disease or significant discogenic back pain	by disease or prior trauma
with disc degeneration confirmed by documented patient	Allergy or sensitivity to implant materials
history, physical exam, and radiographic studies	Isolated lumbar radiculopathy (especially due to herniated
No more than Grade 1 (low level) spondylolisthesis based on	disc) or chronic radiculopathy (unremitting especially leg
x-ray at operative level	symptoms lasting over 1 year)
DDD is limited to the single spinal level at which the lumbar	Spinal stenosis or scoliosis
TDA is planned	Spondylolisthesis greater than Grade 1
No significant facet arthropathy at operative level	Disc degeneration requiring treatment of more than one
At least six months of non-operative treatment noted in	level
medical records, including physical therapy/rehabilitation	Severe facet arthrosis or joint degeneration
program with cognitive behavioral components, pain	Presence of free disc fragment
management injections and active exercise program	Myelopathy
Does not have any of the following contraindications:	Morbid obesity
Disease above L4-L5 (for activL® Artificial Disc)	Psychosocial risk factors
Active systemic or local infection	
Other:	
Notes:	



Device Requirements:

Must be FDA approved and used per FDA labeling

Single-level use only

Enclosures

Enclosed is the following documentation as required by your policy:

Medical records with evidence of 6+ months of failed conservative treatment

Radiographs with evidence of degenerative disc disease with one confirmed symptomatic level

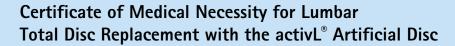
Certification and Signature

I certify that I am the surgeon identified on this certificate and that I have completed this form based on my thorough review of the patient's case and on my examination of this patient.

Surgeon Signature: Date:

_Care	eFirst
	acement: Lumbar Disc Prostheses
	ber: 7.01.088
Effective Date	: April 16, 2018
Patient Name:	Surgeon Name:
Surgeon NPI:	
Facility Name:	Facility Tax ID:
Facility Address:	
Facility Type: Inpatient Outpatient ASC	
Primary ICD-10-CM Diagno	osis Code (Please Check One)
M51.36 Other intervertebral degeneration, lumbar	
M51.37 Other intervertebral degeneration, lumbosacral	
M51.26 Other intervertebral disc displacement, lumbar	
M51.27 Other intervertebral disc displacement, lumbosacral	
Other	
Primary ICD-10-PCS Procedure Co	ode (if Inpatient) (Please Check One)
OSR20JZ Replacement of lumbar vertebral disc with synthetic su	bstitute, open
OSR40JZ Replacement of lumbosacral vertebral disc with synthet	tic substitute, open
Primary CPT° F	Procedure Code
22857 Total disc arthroplasty (artificial disc), anterior approach i	ncluding discectomy to prepare interspace, single interspace, lumbar
Surgeon Certification	
I certify that this patient meets the criteria for medical necessity as ou	utlined in your medical policy based on the following:
Skeletally mature	Pars defect;
DDD at only one (1) level in the lumbar spine from L4-S1	Involved vertebral endplate that is dimensionally smaller than
Have had no relief from pain after at least 6 months of	34.5 mm in the medial-lateral and / or 27 mm in the
non-surgical treatment	anterior-posterior directions;
No more than 3 mm spondylolisthesis at the involved level	Clinically compromised vertebral bodies at the affected level
Does not have any of the following contraindications:	due to current or past trauma;
Active systemic infection or infection localized to the site of	Lytic spondylolisthesis or degenerative spondylolisthesis of
implantation; Osteopenia or osteoporosis defined as DEXA bone density	grade > 1; Prior spinal fusion;
measured T-score < -1.0;	Moderate to severe degenerative facet joint disease
Bony lumbar spinal stenosis;	The procedure is not comprised of any of the following deemed
Allergy or sensitivity to implant materials (cobalt, chromium,	not medically necessary per your medical policy:
molybdenum, polyethylene, titanium);	Vertebral Disc Replacement at more than one level
Isolated radicular compression syndromes, especially due to disc	Patients who do not meet the above criteria.
herniation;	
Other:	

Notes:



Device Requirements: Must be FDA approved and used per FDA labeling Single-level use only Certification and Signature I certify that I am the surgeon identified on this certificate and that I have completed this form based on my thorough review of the patient's case and on my examination of this patient. Surgeon Signature: Date:

CIGNA		
Policy Name: Intervertebral Disc (IVD) Prostheses		
Policy Number: 0104		
Effective Date: 10/15/2019		
Patient Name:	Surgeon Name:	
Surgeon NPI:		
Facility Name:	Facility Tax ID:	
Facility Address:		
Facility Type: Inpatient Outpatient ASC		
Primary ICD-10-CM Diagn	osis Code (Please Check One)	
M51.36 Other intervertebral degeneration, lumbar		
M51.37 Other intervertebral degeneration, lumbosacral		
M51.26 Other intervertebral disc displacement, lumbar		
M51.27 Other intervertebral disc displacement, lumbosacral		
Other		
Primary ICD-10-PCS Procedure Co	ode (if Inpatient) (Please Check One)	
OSR20JZ Replacement of lumbar vertebral disc with synthetic substitute, open		
OSR40JZ Replacement of lumbosacral vertebral disc with synthetic substitute, open		
Primary CPT° [Procedure Code	
22857 Total disc arthroplasty (artificial disc), anterior approach i	including discectomy to prepare interspace, single interspace, lumbar	

Surgeon Certification

I certify that this patient meets the criteria for medical necessity as outlined in your medical policy based on the following:

Chronic, unremitting, discogenic low back pain and disability secondary to single-level DDD

The implant will be inserted at an FDA approved lumbar sacral level specific to the implant being used Unremitting low back pain and significant functional impairment is refractory to at least six consecutive months of structured, physician supervised conservative medical management which includes ALL of the following components:

Exercise, including core stabilization exercises; Nonsteroidal and/or steroidal medication (unless contraindicated);

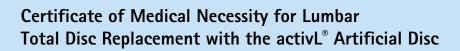
Physical therapy, including passive and active treatment modalities;

Activity/lifestyle modification

The procedure is not comprised of any of the following deemed not medically necessary per your medical policy:

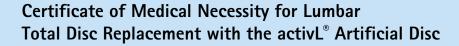
Hybrid

Simultaneous multilevel implantation is planned
The individual has osteopenia or osteoporosis (T-score <-1.0)
The individual has a history of prior lumbar fusion
The implant will be inserted outside of the recommended
lumbar/sacral level for the specific implant being used
There is evidence on imaging studies of ANY of the
following: degenerative spondylolisthesis of Grade 2 or
greater; infection; multilevel DDD: Nerve root compression
or spinal stenosis; pars interarticularis defect with either
spondylolysis or isthmic spondylolisthesis; scoliosis; severe
facet joint arthrosis; spinal fracture; tumor.



Other:		
Notes:		
Device Requirements:		
Must be FDA approved and used per FDA labeling		
Single-level use only		
Enclosures		
Enclosed is the following documentation as required by your policy:		
Medical records with evidence of 6+ months of failed conservative treatment		
Radiographs with evidence of degenerative disc disease with one confirmed sys	mptomatic level	
Certification and Signature	e	
I certify that I am the surgeon identified on this certificate and that I have complete patient's case and on my examination of this patient.	ed this form based on my thorough review of the	
Surgeon Signature:	Date:	

Total bise Replacement with the active Alterrelai bise		
Emblem Health		
Policy Name: Artificial Intervertebral Disc Policy		
·	Policy Number: MG.MM.SU.46e	
·	October 12, 2018	
Patient Name: Surgeon Name:		
Surgeon NPI:		
Facility Name:	Facility Tax ID:	
Facility Address:		
Facility Type: Inpatient Outpatient ASC		
Primary ICD-10-CM Diagno	osis Code (Please Check One)	
M51.36 Other intervertebral degeneration, lumbar		
M51.37 Other intervertebral degeneration, lumbosacral		
M51.26 Other intervertebral disc displacement, lumbar		
M51.27 Other intervertebral disc displacement, lumbosacral		
Other		
Primary ICD-10-PCS Procedure Co	ode (if Inpatient) (Please Check One)	
OSR20JZ Replacement of lumbar vertebral disc with synthetic su	bstitute, open	
OSR40JZ Replacement of lumbosacral vertebral disc with synthet	tic substitute, open	
Primary CPT° F	Procedure Code	
22857 Total disc arthroplasty (artificial disc), anterior approach i	ncluding discectomy to prepare interspace, single interspace, lumbar	
Surgeon Certification		
I certify that this patient meets the criteria for medical necessity as ou	utlined in your medical policy based on the following:	
Skeletally mature Disease confirmed by radiographic imaging (e.g. CT or MRI followed by a discogram) Pain confined to operative level (by discogram) No nerve root compression or narrowing of lateral recesses Grade/millimeter measurement of spondylolisthesis commensurate with the FDA- indication specific to the disc (as variance exists between the devices) Pain score greater than or equal to 40 on Visual Analog Scale (VAS)	At least six months of consistent, conservative treatment as noted in physician office progress notes, which demonstrate at least two have been tried: physical therapy, chiropractic care, ice/heat therapy, pharmacotherapy (e.g. oral/injectable analgesia such as NSAIDS, muscle relaxants, epidural/facet injections) The procedure is not comprised of any of the following deemed not medically necessary per your medical policy: Off label-use Insertion despite presence of contraindications identified	
Disability score greater than or equal to 30 on the Oswestry Low Back Pain Disability Questionnaire or Neck Disability Index	within specific product labeling Previous spinal fusion/other spinal surgery at affected level Current or previous fracture at affected level.	



Device Requirements:

Must be FDA approved and used per FDA labeling

Single-level use only

Enclosures

Enclosed is the following documentation as required by your policy:

Medical records with evidence of 6+ months of failed conservative treatment

Radiographs with evidence of degenerative disc disease with one confirmed symptomatic level

Certification and Signature

I certify that I am the surgeon identified on this certificate and that I have completed this form based on my thorough review of the patient's case and on my examination of this patient.

Surgeon Signature: Date:

eviCore		
Policy Name: Clinical Guidelines Spine Surgery: Lumbar Total Disc Arthroplasty		
Effective Date: August 1, 2019		
Patient Name: Surgeon Name:		
Surgeon NPI:		
Facility Name: Facility Tax ID:		
Facility Address:		
Facility Type: Inpatient Outpatient ASC		
Primary ICD-10-CM Diagnosis Code (Please Check One)		
M51.36 Other intervertebral degeneration, lumbar		
M51.37 Other intervertebral degeneration, lumbosacral		
M51.26 Other intervertebral disc displacement, lumbar		
M51.27 Other intervertebral disc displacement, lumbosacral		
Other		
Primary ICD-10-PCS Procedure Code (if Inpatient) (Please Check One)		
OSR20JZ Replacement of lumbar vertebral disc with synthetic substitute, open		
OSR40JZ Replacement of lumbosacral vertebral disc with synthetic substitute, open		
Primary CPT° Procedure Code		
22857 Total disc arthroplasty (artificial disc), anterior approach including discectomy to prepare interspace, single interspace, lumbar		

Surgeon Certification

I certify that this patient meets the criteria for medical necessity as outlined in your medical policy based on the following:

An FDA approved implant is used in accordance with FDA requirements

Presence of chronic, unremitting, discogenic lower back pain and associated disability secondary to single-level degenerative disc disease (DDD) for at least one year. Age 18 to 60 years old

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 pain Clinically significant functional impairment (e.g., inability to perform household chores, prolonged standing or essential job functions)

Absence of unmanaged significant behavioral health disorders (e.g., major depressive disorder, chronic pain syndrome, secondary gain, drug and alcohol abuse)

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

Moderate to severe single-level disc degeneration at L4–L5, or L5–S1 has been confirmed or recent (with 6 months) plain radiographs and advanced diagnostic imaging studies (i.e., CT, MRI)

Absence of significant facet arthropathy at the operative level Lumbar artificial total disc arthroplasty is considered not medically necessary for ANY of the following:

The revision of a failed lumber total disc arthroplasty
The planned procedure includes the combined use of a
prosthesis and spinal fusion (hybrid)

Lumbar partial disc prosthetics

Simultaneous multilevel implantation

The implant will be inserted outside of the spinal motion segments approved by the FDA

The individual has osteopenia or osteoporosis (T-score <-1.0)

Above or below or in combination with a spinal fusion or other stabilizing type surgical procedure

A lumbar disc prosthesis not approved by the FDA or for an FDA approved indication

Degenerative disc disease above L4-L5

Presence of unmanaged significant behavioral health disorders (e.g., major depressive disorder, chronic pain syndrome, secondary gain, drug and alcohol abuse)

Age less than 18 or greater than 60

As an adjunct to the treatment of primary central or far-lateral disc herniation

There is evidence on imaging studies or ANY of the following:

Lytic or degenerative spondylolisthesis of Grade 2 or greater. Lumbar bony spinal stenosis or Lumbar nerve root compression

Pars interarticularis defect with either spondylolysis or isthmic spondylolisthesis

Scoliosis

Spine fracture

Active systemic infection, presence of tumor or active infection at the site or implantation.

Multi-level degenerative disc disease (2 or more levels) on a preoperative MRI and plain radiographs

Significant facet arthropathy at the operated level Presence of tumor or active infection at the site of implantation

Lumbar nerve root compression or bony spinal stenosis Allergy or sensitivity to implant materials

Isolated radicular compression syndromes especially due to lumbar disc herniation

Involved vertebral endplate that is dimensionally smaller that the approximate dimensions of the implant in anterior/posterior width

Clinically compromised vertebral bodies at the affected level due to current or past trauma

Other:	
Notes:	
Enclosures	
Enclosed is the following documentation as required by your policy:	
Medical records with evidence of 6+ months of failed conservative treatment	
Radiographs with evidence of degenerative disc disease with one confirmed symptomatic level	
Behavioral health screening	
Certification and Signature	
I certify that I am the surgeon identified on this certificate and that I have completed this form based on my thorough review of the patient's case and on my examination of this patient.	
Surgeon Signature:	Date:

Excellus BCBS (Includes Univera Healthcare)		
Policy Name: Artificial Lumbar Intervertebral Disc		
Policy Number: 7.01.63		
Effective Date: June 18, 2019		
Patient Name: Su	urgeon Name:	
Surgeon NPI:		
Facility Name: Fa	acility Tax ID:	
Facility Address:		
Facility Type: Inpatient Outpatient ASC		
Primary ICD-10-CM Diagnosis Code (Please Check One)		
M51.36 Other intervertebral degeneration, lumbar		
M51.37 Other intervertebral degeneration, lumbosacral		
M51.26 Other intervertebral disc displacement, lumbar		
M51.27 Other intervertebral disc displacement, lumbosacral		
Other		
Primary ICD-10-PCS Procedure Code (if Inpatient) (Please Check One)		
OSR20JZ Replacement of lumbar vertebral disc with synthetic substitute, open		
OSR40JZ Replacement of lumbosacral vertebral disc with synthetic substitute, open		
Primary CPT° Procedure Code		
22857 Total disc arthroplasty (artificial disc), anterior approach including discectomy to prepare interspace, single interspace, lumbar		

Surgeon Certification

I certify that this patient meets the criteria for medical necessity as outlined in your medical policy based on the following:

Use of an FDA Approved Implant

Presence of chronic, unremitting, discogenic lower back pain and associated disability secondary to single-level degenerative disc disease (DDD) in a skeletally mature individual Age 18-60 years old;

Significant level of pain on a daily basis defined as either of the following:

- 1. Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as greater than or equal to 7;
- 2. Severe, disabling, crippling, or incapacitating pain; Clinically significant functional impairment such as the inability to perform household chores, prolonged standing or essential job functions); and

Absence of unmanaged significant behavioral health disorders (e.g., major depressive disorder, chronic pain syndrome, secondary gain, drug and alcohol abuse);

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; and

Provider directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician.

Moderate to severe single-level disc degeneration at 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); Absence of significant facet arthropathy at the operative level. Documentation of Nicotine Free Status:

Patient is a non-tobacco user, or

Patient must have abstained from tobacco use for at least 6 weeks prior to the planned spinal fusion surgery as evidenced by lab results (cotinine level) documenting nicotine-free status (NOTE: in order to complete the prior authorization process for spinal fusion surgery, planning should allow for enough time to submit lab results performed after the 6-week tobacco abstinence period.

Does not have any of the following contraindications:

The revision of a failed lumber total disc arthroplasty
The planned procedure includes the combined use of a
prosthesis and spinal fusion (hybrid)
Lumbar partial disc prosthetics

Simultaneous multilevel implantation

2 Continued on next page

The implant will be inserted outside of the spinal motion segments approved by the FDA

The individual has osteopenia or osteoporosis (T-score <-1.0)

Above or below or in combination with a spinal fusion or other stabilizing type surgical procedure

A lumbar disc prosthesis not approved by the FDA or for an FDA approved indication

Degenerative disc disease above L4-L5

Presence of unmanaged significant behavioral health disorders (e.g., major depressive disorder, chronic pain syndrome, secondary gain, drug and alcohol abuse)
Age less than 18 or greater than 60

As an adjunct to the treatment of primary central or farlateral disc herniation

There is evidence on imaging studies or ANY of the following: Lytic or degenerative spondylolisthesis of Grade 2 or greater. Lumbar bony spinal stenosis or Lumbar nerve root compression Pars interarticularis defect with either spondylolysis or isthmic spondylolisthesis

Scoliosis

Spine fracture

Active systemic infection, presence of tumor or active infection at the site or implantation.

Multi-level degenerative disc disease (2 or more levels) on a preoperative MRI and plain radiographs

Significant facet arthropathy at the operated level

Allergy or sensitivity to implant materials

Isolated radicular compression syndromes especially due to lumbar disc herniation

Involved vertebral endplate that is dimensionally smaller that the approximate dimensions of the implant in anterior/posterior width

Clinically compromised vertebral bodies at the affected level due to current or past trauma

Other:	
Notes:	
Device Requirements:	
Must be FDA approved and used per FDA labeling	
Single-level use only	
Enclos	ures
Enclosed is the following documentation as required by your policy:	
Medical records with evidence of 6+ months of failed conservative	treatment
Documentation of Nicotine Free Status	
Radiographs with evidence of degenerative disc disease with one confirmed symptomatic level	
Behavioral health screening results	
Certification ar	nd Signature
I certify that I am the surgeon identified on this certificate and that I have patient's case and on my examination of this patient.	ave completed this form based on my thorough review of the
Surgeon Signature:	Date:

Geisinger Health Plan		
Policy Name: Artificial I	ntervertebral Disc	
Policy Number	: MP 147	
Effective Date: Jan	uary 1, 2017	
Patient Name: Su	urgeon Name:	
Surgeon NPI:		
	acility Tax ID:	
Facility Address:		
Facility Type: Inpatient Outpatient ASC		
Primary ICD-10-CM Diagnosis	Code (Please Check One)	
M51.36 Other intervertebral degeneration, lumbar		
M51.37 Other intervertebral degeneration, lumbosacral		
M51.26 Other intervertebral disc displacement, lumbar		
M51.27 Other intervertebral disc displacement, lumbosacral		
Other		
Primary ICD-10-PCS Procedure Code	(if Inpatient) (Please Check One)	
OSR20JZ Replacement of lumbar vertebral disc with synthetic substi	tute, open	
OSR40JZ Replacement of lumbosacral vertebral disc with synthetic s	substitute, open	
Primary CPT° Proc	cedure Code	
22857 Total disc arthroplasty (artificial disc), anterior approach inclu	uding discectomy to prepare interspace, single interspace, lumbar	
Surgeon Certification		
I certify that this patient meets the criteria for medical necessity as outlined in your medical policy based on the following:		
Skeletally mature	Osteoporosis	
Single level DDD from L3-S1	Mid-sagittal stenosis less than 8 mm	
No relief from low back pain after a minimum of 6 months	Positive straight leg raise radiculopathy	
of failed conservative therapy (e.g. physical therapy, bracing, Other surgery at affected level		
injections)	Significant facet arthritis	
Does not have any of the following complicating conditions	Spinal tumor	
such as:	Morbid obesity	
Multi-level disease	Metal allergy	
Non-contained disc	Scoliosis	
Previous spinal fusion	More than 3 mm spondylolisthesis at the involved level	
Other:		
Notes:		
Device Requirements:		
Must be FDA approved and used per FDA labeling		
Single-level use only		



Enclosures

Enclosed is the following documentation as required by your policy:

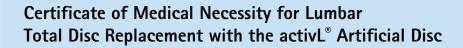
Medical records with evidence of 6+ months of failed conservative treatment

Certification and Signature

I certify that I am the surgeon identified on this certificate and that I have completed this form based on my thorough review of the patient's case and on my examination of this patient.

Surgeon Signature:	Date:
Juiquoi Jiquature.	Date.

HCSC (BCBS TX,	IL, OK, NM & MT)
Policy Name and Number: In	tervertebral Disc Prostheses
Policy Numb	er: 712.028
	: November 15, 2017
	Surgeon Name:
Surgeon NPI:	- W 15
·	Facility Tax ID:
Facility Address:	
Facility Type: Inpatient Outpatient ASC	-:- C-d- (Dlama Charle One)
Primary ICD-10-CM Diagno	sis Code (Please Check Une)
M51.36 Other intervertebral degeneration, lumbar	
M51.37 Other intervertebral degeneration, lumbosacral	
M51.26 Other intervertebral disc displacement, lumbar	
M51.27 Other intervertebral disc displacement, lumbosacral	
Other	
Primary ICD-10-PCS Procedure Cod	de (if Inpatient) (Please Check One)
OSR20JZ Replacement of lumbar vertebral disc with synthetic sub	stitute, open
OSR40JZ Replacement of lumbosacral vertebral disc with synthetic	c substitute, open
Primary CPT° Pr	rocedure Code
22857 Total disc arthroplasty (artificial disc), anterior approach in	cluding discectomy to prepare interspace, single interspace, lumbar
Surgeon Certification	
I certify that this patient meets the criteria for medical necessity as out	tlined in your medical policy based on the following:
Skeletally mature	Disc will be used for single-level reconstruction following
DDD at only one (1) level in the lumbar spine from L3-S1,	lumbar discectomy within the L3-S1 region
confirmed by radiographic studies (CT, MRI, x-rays, etc)	Minimum Oswestry Disability Index (ODI) score equal to or > 40
Radicular back/leg pain that has failed a minimum of six (6)	The procedure is not comprised of any of the following
months of conservative treatment	deemed not medically necessary per your medical policy:
No more than Grade 1 (0-25%) spondylolisthesis at the involved level	For all other indications, including but not limited to, multilevel use whether done simultaneously or at different
	times
Other:	
other.	
Notes:	
Davies Demains manter	
Device Requirements:	
Must be FDA approved and used per FDA labeling	
Single-level use only	



Enclosures

Enclosed is the following documentation as required by your policy:

Medical records with evidence of 6+ months of failed conservative treatment

Radiographs with evidence of degenerative disc disease with one confirmed symptomatic level

Certification and Signature

I certify that I am the surgeon identified on this certificate and that I have completed this form based on my thorough review of the patient's case and on my examination of this patient.

Surgeon Signature: Date:

HealthPartners		
Policy Name: Artificial intervertebral disc replacement – Lumbar		
Effective Date: April 1, 2017		
Patient Name: Surgeon Name:		
Surgeon NPI:		
Facility Name: Fac	cility Tax ID:	
Facility Address:		
Facility Type: Inpatient Outpatient ASC		
Primary ICD-10-CM Diagnosis Code (Please Check One)		
M51.36 Other intervertebral degeneration, lumbar		
M51.37 Other intervertebral degeneration, lumbosacral		
M51.26 Other intervertebral disc displacement, lumbar		
M51.27 Other intervertebral disc displacement, lumbosacral		
Other		
Primary ICD-10-PCS Procedure Code (if Inpatient) (Please Check One)		
OSR20JZ Replacement of lumbar vertebral disc with synthetic substitute, open		
OSR40JZ Replacement of lumbosacral vertebral disc with synthetic substitute, open		
Primary CPT° Procedure Code		
22857 Total disc arthroplasty (artificial disc), anterior approach including discectomy to prepare interspace, single interspace, lumbar		

Surgeon Certification

I certify that this patient meets the criteria for medical necessity as outlined in your medical policy based on the following:

Surgical implantation of an FDA-approved lumbar artificial intervertebral disc in a skeletally mature member is eligible for coverage when ALL of the following criteria are met:

Documentation indicates chronic, unremitting discogenic low back pain and functional impairment due to single-level degenerative disc disease (DDD)

Single-level disc degeneration has been confirmed on complex imaging studies (i.e. computerized tomography [CT] scan, magnetic resonance imaging [MRI])

Imaging studies confirm either 3 mm or less of spondylolisthesis at the involved level or Grade 1 spondylolisthesis

The implant will be inserted at an FDA-approved lumbar/sacral level specific to the implant being used

Documentation indicates that the member has failed (failed is defined as unremitting low back pain and significant functional impairment refractory to conservative treatments) ≥ 6 months of structured, physician supervised conservative medical treatment which includes ALL of the following components:

Exercise, including core stabilization exercises

Non-steroidal and/or steroidal medication (unless contraindicated)

Physical therapy

The procedure is not comprised of any of the following deemed not medically necessary per your medical policy:

The planned procedure includes the combined use of an artificial disc prosthesis and spinal fusion (i.e., hybrid surgery)

The planned procedure includes simultaneous multilevel implantation

The member has osteopenia or osteoporosis (T-score < -1.0) The member has a history of previous fusion surgery at any lumbar vertebral level

There is evidence on imaging studies of ANY of the following:

Degenerative spondylolisthesis of Grade 2 or greater at the involved level

Infection

Multilevel degenerative disc disease

Nerve root compression or spinal stenosis

Pars interarticularis defect with either spondylolysis or isthmic spondylolisthesis

Scoliosis

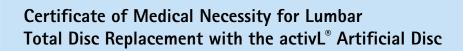
Severe facet joint arthrosis

Spinal fracture

Tumor

The requested device is a non FDA-approved lumbar artificial intervertebral disc.

Continued on next page



Other:	
Notes:	
Device Requirements:	
Must be FDA approved and used per FDA labeling	
Single-level use only	
Enclosures	
Enclosed is the following documentation as required by your policy:	
Medical records with evidence of 6+ months of failed conservative treatment	
Radiographs with evidence of degenerative disc disease with one confirmed symptomatic leve	el
Certification and Signature	
I certify that I am the surgeon identified on this certificate and that I have completed this form based on my thorough review of the patient's case and on my examination of this patient.	
Surgeon Signature:	Date:

Horizon BCBSNJ		
Policy Name: Artificial Intervertebral Disc: Lumbar Spine		
Effective Date: Februar	ry 24, 2017	
Patient Name: Surgeon Name:		
Surgeon NPI:		
Facility Name: Facility Tax ID:		
Facility Address:		
Facility Type: Inpatient Outpatient ASC		
Primary ICD-10-CM Diagnosis Code (Please Check One)		
M51.36 Other intervertebral degeneration, lumbar		
M51.37 Other intervertebral degeneration, lumbosacral		
M51.26 Other intervertebral disc displacement, lumbar		
M51.27 Other intervertebral disc displacement, lumbosacral		
Other		
Primary ICD-10-PCS Procedure Code (if Inpatient) (Please Check One)		
OSR20JZ Replacement of lumbar vertebral disc with synthetic substitute, open		
OSR40JZ Replacement of lumbosacral vertebral disc with synthetic substitute, open		
Primary CPT° Procedure Code		
22857 Total disc arthroplasty (artificial disc), anterior approach including discectomy to prepare interspace, single interspace, lumbar		

Surgeon Certification

I certify that this patient meets the criteria for medical necessity as outlined in your medical policy based on the following:

Are skeletally mature;

Have degenerative disc disease (DDD) at one level in the lumbar spine at L4-L5 or L5-S1

Have degenerative disc disease (DDD) confirmed by member history and radiographic studies (i.e., MR imaging and provocative discography);

Have no more than Grade I spondylolisthesis

Have had no relief from pain after at least six months of conservative/non-operative treatment (e.g., physical therapy, facet joint injections, epidural steroids, ultrasound, manipulation, anti-inflammatory medications, analgesic medications, muscle relaxants, lumbosacral stabilization therapy)

Does not have any of the following contraindications:

Active systemic infection or infection localized to the site of implantation,

Osteoporosis,

Osteopenia,

Bony lumbar stenosis,

Allergy or sensitivity to implant materials (e.g., cobalt, chromium, titanium, polyethylene)

solated radicular compression syndromes, especially to disc herniation, or pars defect

Involved vertebral endplate that is dimensionally smaller than 31 mm in the medial-lateral and/or 26 mm in the anterior/posterior directions

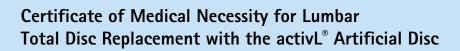
Clinically compromised vertebral bodies at the affected level due to current or past trauma

The procedure is not comprised of any of the following deemed not medically necessary per your medical policy:

Use at more than one level

Use at a spinal level(s) other than L4-L5 or L5-S1

Use in members with prior thoracic or lumbar spinal fusion



Other:	
Notes:	
Device Requirements:	
Must be FDA approved and used per FDA labeling	
Single-level use only	
Enclosures	
Enclosed is the following documentation as required by your policy:	
Medical records with evidence of 6+ months of failed conservative treatment	
Radiographs with evidence of degenerative disc disease with one confirmed symptomatic lev	rel
Certification and Signature	
I certify that I am the surgeon identified on this certificate and that I have completed this form be patient's case and on my examination of this patient.	ased on my thorough review of the
Surgeon Signature:	Date:

Humana		
Policy Name: Artificial Intervertebral Disc Replacement		
Policy Number: HCS-0442-014		
Effective Date: February 26, 2019		
Patient Name:	Surgeon Name:	
Surgeon NPI:		
Facility Name:	Facility Tax ID:	
Facility Address:		
Facility Type: Inpatient Outpatient ASC		
Primary ICD-10-CM Diagnosis Code (Please Check One)		
M51.36 Other intervertebral degeneration, lumbar		
M51.37 Other intervertebral degeneration, lumbosacral		
M51.26 Other intervertebral disc displacement, lumbar		
M51.27 Other intervertebral disc displacement, lumbosacral		
Other		
Primary ICD-10-PCS Procedure Code (if Inpatient) (Please Check One)		
OSR20JZ Replacement of lumbar vertebral disc with synthetic substitute, open		
OSR40JZ Replacement of lumbosacral vertebral disc with synthetic substitute, open		
Primary CPT° Procedure Code		
22857 Total disc arthroplasty (artificial disc), anterior approach including discectomy to prepare interspace, single interspace, lumbar		

Surgeon Certification

I certify that this patient meets the criteria for medical necessity as outlined in your medical policy based on the following:

DDD at ONE level, L4–5 or L5–S1, confirmed by a complex imaging study (e.g. CT, MRI, positive concordant discography) Failure of at least six months of conservative treatment (e.g. medications, physical therapy)

Unrelenting low back pain and significant functional impairment (Significant functional impairment is defined as direct and measurable reduction in performance of an organ or body part)

FDA approved lumbar/sacral level to be utilized in accordance with FDA labeling and implanted with an anterior retroperitoneal approach

No more than Grade 1 spondylolisthesis at the involved level (Grade 1 is 25% or less of vertebral body slipping forward) Documentation of Skeletal Maturity

Does not have any of the following contraindications:

Abdominal pathology precluding an anterior retroperitoneal approach

Active or chronic infection, systemic or infection localized to the operative site

Allergy or sensitivity to the implant

Bony lumbar stenosis

Chronic radiculopathy over a period of at least a year

Extruded disc material with sequestrum (i.e. free fragment)

Facet joint degeneration

Isolated lumbar radiculopathy, especially d/t herniated disc

Myelopathy, Pars defect, or Scoliosis

Preoperative remaining disc height < 3 mm

Spondylolisthesis degenerative or isthmic > than grade 1 segmental instability

Osteoporosis or osteopenia defined as DEXA bone mineral density T-score < or equal to -1.0

Clinically compromised vertebral bodies at the affected level due to current or past disease (e.g. ankylosing spondylitis) or trauma (fracture)

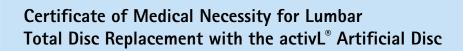
Involved vertebral endplate dimensionally smaller than 31 mm in the medial lateral and/or

The procedure is not comprised of any of the following deemed not medically necessary per your medical policy:

Hybrid

Multilevel lumbar disc replacement

Prior surgery at the treated level



Other:		
Notes:		
Device Requirements:		
Must be FDA approved and used per FDA labeling		
Enclosures		
Enclosed is the following documentation as required by your policy:		
Medical records with evidence of 6+ months of failed conservative treatment and DEXA scan results		
Documentation of Skeletal Maturity		
Radiographs with evidence of degenerative disc disease with one confirmed symptomatic level		
Certification and Signature		
I certify that I am the surgeon identified on this certificate and that I have completed this form be patient's case and on my examination of this patient.	ased on my thorough review of the	
Surgeon Signature:	Date:	

Medica		
Policy Name: Clinical Guidelines Spine Surgery: Lumbar Total Disc Arthroplasty		
Policy Number: III-SUR.34		
Effective Date: Ja	anuary 21, 2019	
Patient Name:	Surgeon Name:	
Surgeon NPI:		
Facility Name:	Facility Tax ID:	
Facility Address:		
Facility Type: Inpatient Outpatient ASC		
Primary ICD-10-CM Diagnosis Code (Please Check One)		
M51.36 Other intervertebral degeneration, lumbar		
M51.37 Other intervertebral degeneration, lumbosacral		
M51.26 Other intervertebral disc displacement, lumbar		
M51.27 Other intervertebral disc displacement, lumbosacral		
Other		
Primary ICD-10-PCS Procedure Code (if Inpatient) (Please Check One)		
OSR20JZ Replacement of lumbar vertebral disc with synthetic substitute, open		
OSR40JZ Replacement of lumbosacral vertebral disc with synthetic substitute, open		
Primary CPT° Procedure Code		
22857 Total disc arthroplasty (artificial disc), anterior approach including discectomy to prepare interspace, single interspace, lumbar		

Surgeon Certification

I certify that this patient meets the criteria for medical necessity as outlined in your medical policy based on the following:

Use of an FDA Approved Implant

Skeletally mature

Individual has documented symptomatic DDD, with or without radicular pain, resulting in unremitting low back pain

Documentation of continued episodes of unremitting back pain demonstrating compromised ability to perform routine ADL's Imaging studies/radiological evidence documents a DDD lesion at a level correlating with impaired ADL's

 $\ensuremath{\mathsf{BMI}}$ is less than 40 at the time of prior auth request

Documentation of insertion at one level (L4-5 or L5-S1)

Documentation of failure of a minimum of six (6) months of conservative medical management related to current episode/symptoms

Documentation of an Oswestry Disability Index (ODI) score(S) at the conclusion of conservative treatment (e.g. physical therapy regimen, injection therapy) demonstrating one(1) of the following:

Less than 30% improvement in (ODI) score between first and last conservative treatment session

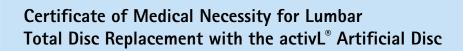
Continued ODI score of greater than or equal to 30% at the conclusion of conservative treatment and thereafter If the individual has not had conservative treatment and ODI score of greater than or equal to 30% within one month prior to the date of prior authorization request For an individual unable to complete a minimum of six (6) month of conservative treatment, documentation of one (1)

ODI score of greater than or equal to 30% at the time conservative management is discontinued Inability to perform routine activities of daily living

Does not have any of the following contraindications:

Moderate to severe facet joint arthritis Localized or systemic infection Spinal tumor or other active malignancy Osteoporosis Spondylolisthesis

of the following is required



Other:		
Notes:		
Enclosures		
Enclosed is the following documentation as required by your policy:		
Documentation of continued episodes of unremitting back pain demonstrating compromised ability to perform routine ADL's.		
Radiographs with evidence of degenerative disc disease with one confirmed symptomatic level		
Documentation of insertion at one level (L4-5 or L5-S1).		
Documentation of failure of a minimum of six (6) months of conservative medical management related to current episode/symptoms.		
Documentation of an Oswestry Disability Index (ODI) score(s) at the conclusion of conservative treatment		
Certification and S	ignature	
I certify that I am the surgeon identified on this certificate and that I have patient's case and on my examination of this patient.	completed this form based on my thorough review of the	
Surgeon Signature:	Date:	

Medical Mutual		
Policy Name: Artificial Intervertebral Disc Replacement: Cervical, Thoracic, and Lumbar		
Policy Number: #200813		
Effective Date: October 11, 2017		
Patient Name: Su	urgeon Name:	
Surgeon NPI:		
Facility Name: Fac	acility Tax ID:	
Facility Address:		
Facility Type: Inpatient Outpatient ASC		
Primary ICD-10-CM Diagnosis Code (Please Check One)		
M51.36 Other intervertebral degeneration, lumbar		
M51.37 Other intervertebral degeneration, lumbosacral		
M51.26 Other intervertebral disc displacement, lumbar		
M51.27 Other intervertebral disc displacement, lumbosacral		
Other		
Primary ICD-10-PCS Procedure Code (if Inpatient) (Please Check One)		
OSR20JZ Replacement of lumbar vertebral disc with synthetic substitute, open		
OSR40JZ Replacement of lumbosacral vertebral disc with synthetic substitute, open		
Primary CPT° Procedure Code		
22857 Total disc arthroplasty (artificial disc), anterior approach including discectomy to prepare interspace, single interspace, lumbar		

Surgeon Certification

I certify that this patient meets the criteria for medical necessity as outlined in your medical policy based on the following:

18 or older and skeletally mature;

Single level between L4-S1

FDA-approved artificial disc (vertebra-specific);

Symptomatic lumbar DDD (discogenic back pain with

degeneration of the disc confirmed by imaging

[CT, MRI, or x-rays)

Spondylolisthesis at the involved level per the FDA-approved

artificial disc specific limits

Candidate for lumbosacral spinal fusion

Failure of at least 6 months of conservative treatment, including

ALL of the following: Physical therapy, anti-inflammatory medication; analgesic medication; avoidance of exacerbating activities

Does not have any of the following contraindications:

Allergy or sensitivity to implant materials

Active systemic infection or infection at the operative site Osteopenia or osteoporosis (bone density T-score -2.5 or lower measured by dual energy x-ray absorptiometry

[DEXA]

Moderate to advanced spondylosis characterized by bridging osteophytes, marked reduction or absence of motion, or collapse of the intervertebral disc space of > 50% of its normal height

Marked lumbosacral instability on imaging (e.g., signs of subluxation >3.5 mm or angulation of the disc space >11 degrees greater than adjacent segments)

Significant kyphotic deformity, significant reversal of

lordosis, or significant spondylolisthesis

Significant lumbosacral anatomical deformity or

compromised vertebral bodies at the index level due to

systemic disease, previous surgery, or trauma

Severe facet joint arthropathy

Symptoms necessitating surgical treatment at > 1

lumbosacral level

Congenital stenosis

Previous surgery at the involved level

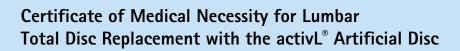
Spinal metastases

Current medical condition requires long-term use of medications affecting bone quality and fusion rates

(e.g., systemic corticosteroids)

Nerve root compression

Stenosis



Other:	
Notes:	
Device Requirements:	
Must be FDA approved and used per FDA labeling	
Medical records with evidence of 6+ months of failed conservative treatment	
Radiographs with evidence of DDD with one confirmed symptomatic level	
Certification and Signature	
I certify that I am the surgeon identified on this certificate and that I have completed this form bas	sed on my thorough review of the
patient's case and on my examination of this patient.	
Surgeon Signature:	Date:

Moda Health		
Policy Name: Intervertebral Disc Prosthesis		
Effective Date: July 1, 2019		
Patient Name: Surgeon Name:		
Surgeon NPI:		
Facility Name: Facility Tax ID:		
Facility Address:		
Facility Type: Inpatient Outpatient ASC		
Primary ICD-10-CM Diagnosis Code (Please Check One)		
M51.36 Other intervertebral degeneration, lumbar		
M51.37 Other intervertebral degeneration, lumbosacral		
M51.26 Other intervertebral disc displacement, lumbar		
M51.27 Other intervertebral disc displacement, lumbosacral		
Other		
Primary ICD-10-PCS Procedure Code (if Inpatient) (Please Check One)		
OSR20JZ Replacement of lumbar vertebral disc with synthetic substitute, open		
OSR40JZ Replacement of lumbosacral vertebral disc with synthetic substitute, open		
Primary CPT° Procedure Code		
22857 Total disc arthroplasty (artificial disc), anterior approach including discectomy to prepare interspace, single interspace, lumbar		

Surgeon Certification

I certify that this patient meets the criteria for medical necessity as outlined in your medical policy based on the following:

FDA-approved lumbar prosthetic intervertebral discs will be covered to plan limitations when ALL of the following criteria are met:

The patient is skeletally mature

Diagnosis of degenerative disc disease at only one level confirmed by patient history and advanced imaging studies (CT scan or MRI) within the last 6 months

Disc replacement is planned for one level

No more than Grade I spondylolisthesis at the involved level Patient suffers from low back pain that has not responded to at least 6 months of conservative treatment including all of the following:

NSAIDS, analgesics, steroids

Physical therapy

Epidural steroid injections/selective nerve root blocks Patient is a candidate for spine surgery (such as a fusion)

No prior lumbar spinal fusion

Patient meets 1 or more of the following:

Patient is a non-smoker

Patient is a documented smoker and has abstained from tobacco for at least 6 weeks prior to surgery as evidence by lab results documenting (cotinine level) nicotine-free status

Does not have any of the following contraindications:

Previous lumbar fusion

Simultaneous multilevel implantations is planned

Osteoporosis or osteopenia

Imaging studies confirm any of the following conditions:

Infection (active systemic or localized to the site of implantation)

Spinal tumor

Multiple levels of degenerative disc disease

Degenerative spondylolisthesis of Grade 2 or greater

Pars interarticularis defect with either spondylolysis or isthmic spondylolisthesis

Severe facet joint arthrosis

Nerve root compression or spinal stenosis

Scoliosis

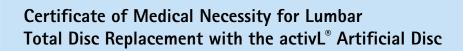
Spinal fracture

History of chronic steroid use

Pregnancy

Morbid obesity

Known allergy or sensitivity to implant materials (cobalt, chromium, molybdenum, polyethylene, titanium)



Other:	
Notes:	
Device Requirements:	
Must be FDA approved and used per FDA labeling (including any labeling	requirements regarding degree of spondylolisthesis)
Single-level use only	
Enclosures	
Enclosed is the following documentation as required by your policy:	
Medical records with evidence of 6+ months of failed conservative treatr	nent
Radiographs with evidence of degenerative disc disease with one confirm	ed symptomatic level
Tobacco cessation records	
Certification and Sign	nature
I certify that I am the surgeon identified on this certificate and that I have conpatient's case and on my examination of this patient.	mpleted this form based on my thorough review of the
Surgeon Signature:	Date:

Molina Healthcare		
Policy Name: Artificial Intervertebral Disc Replacement (ADR) Surgery		
Policy Number: MC	CP-011	
Effective Date: September 13, 2018		
Patient Name: Surgeon Name:		
Surgeon NPI:		
Facility Name: Facili	ity Tax ID:	
Facility Address:		
Facility Type: Inpatient Outpatient ASC		
Primary ICD-10-CM Diagnosis Code (Please Check One)		
M51.36 Other intervertebral degeneration, lumbar		
M51.37 Other intervertebral degeneration, lumbosacral		
M51.26 Other intervertebral disc displacement, lumbar		
M51.27 Other intervertebral disc displacement, lumbosacral		
Other		
Primary ICD-10-PCS Procedure Code (if Inpatient) (Please Check One)		
OSR20JZ Replacement of lumbar vertebral disc with synthetic substitute, open		
OSR40JZ Replacement of lumbosacral vertebral disc with synthetic substitute, open		
Primary CPT° Procedure Code		
22857 Total disc arthroplasty (artificial disc), anterior approach including discectomy to prepare interspace, single interspace, lumbar		

Surgeon Certification

I certify that this patient meets the criteria for medical necessity as outlined in your medical policy based on the following:

Age 18-60 years old

Device is FDA approved for lumbar disc replacement Diagnosis of single level degenerative lumbar disc disease with intractable radiculopathy and/or myelopathy confirmed with imaging studies

Symptoms of unremitting back and/or leg pain, resulting in disability and/or neurological deficit refractory to all of the following: Six months or more of standard medical management unless contraindicated:

Activity restrictions and/or;

Exercise; and Analgesics; and Physical therapy

The planned implant will be used in the reconstruction of a lumbar disc in only one vertebral level

Candidate for single-level lumbar decompression and interbody fusion

Does not have any of the following contraindications:

Active systemic infection or infection localized to the site of implantation

Allergy or sensitivity to implant materials

Bony lumbar stenosis

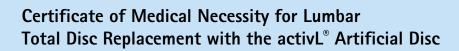
Isolated radicular compression syndromes, especially due to

disc herniation

Osteopenia

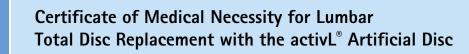
Osteoporosis

Pars defect



Other:	
Notes:	
Device Requirements:	
Must be FDA approved and used per FDA labeling (including any labeling requirements re	egarding degree of spondylolisthesis)
Single-level use only	
Enclosures	
Enclosed is the following documentation as required by your policy:	
Medical records with evidence of 6+ months of failed conservative treatment	
Certification and Signature	
I certify that I am the surgeon identified on this certificate and that I have completed this for patient's case and on my examination of this patient.	m based on my thorough review of the
Surgeon Signature:	Date:

Para	mount	
Policy Name: Artificial Intervertebral Disc Replace	cement: HMO, PPO, Individual Marketplace & Elite	
Policy Num	ber: PG-0027	
Effective Date.	: August 25, 2017	
Patient Name:	Surgeon Name:	
Surgeon NPI:		
Facility Name:	Facility Tax ID:	
Facility Address:		
Facility Type: Inpatient Outpatient ASC		
	nosis Code (Please Check One)	
M51.36 Other intervertebral degeneration, lumbar		
M51.37 Other intervertebral degeneration, lumbosacral		
M51.26 Other intervertebral disc displacement, lumbar		
M51.27 Other intervertebral disc displacement, lumbosacral		
Other		
Primary ICD-10-PCS Procedure C	ode (if Inpatient) (Please Check One)	
OSR20JZ Replacement of lumbar vertebral disc with synthetic substitute, open		
OSR40JZ Replacement of lumbosacral vertebral disc with synthe	etic substitute, open	
Primary CPT°	Procedure Code	
22857 Total disc arthroplasty (artificial disc), anterior approach	including discectomy to prepare interspace, single interspace, lumbar	
Surgeon Certification		
I certify that this patient meets the criteria for medical necessity as o	utlined in your medical policy based on the following:	
Skeletally mature Unremitting low back pain and significant functional impairment is refractory to at least six consecutive months of structured, physician supervised conservative medical management, which includes ALL of the following components: Exercise, including core stabilization exercises Nonsteroidal and/or steroidal medication (unless contraindicated) Physical therapy, including passive and active treatment modalities Other:	Activity/lifestyle modifications Single-level disc degeneration has been confirmed on complex imaging studies (i.e. CT, MRI) The implant will be inserted at an FDA approved lumbar/sacral level specific to the implant being used Elite members must be 60 years of age or younger The procedure is not comprised of any of the following deemed not medically necessary per your medical policy Lumbar artificial disc at more than one level	
Notes:		



Enclosures

Enclosed is the following documentation as required by your policy:

Medical records with evidence of 6+ months of failed conservative treatment

Certification and Signature

I certify that I am the surgeon identified on this certificate and that I have completed this form based on my thorough review of the patient's case and on my examination of this patient.

Surgeon Signature:	Date:

Preferred One		
Policy Name: Intervertebral Disc Prosthesis		
Policy Number: MC/F022		
Effective Date: September 16, 2019		
Patient Name:	Surgeon Name:	
Surgeon NPI:		
Facility Name:	Facility Tax ID:	
Facility Address:		
Facility Type: Inpatient Outpatient ASC		
Primary ICD-10-CM Diagnosis Code (Please Check One)		
M51.36 Other intervertebral degeneration, lumbar		
M51.37 Other intervertebral degeneration, lumbosacral		
M51.26 Other intervertebral disc displacement, lumbar		
M51.27 Other intervertebral disc displacement, lumbosacral		
Other		
Primary ICD-10-PCS Procedure Code (if Inpatient) (Please Check One)		
OSR20JZ Replacement of lumbar vertebral disc with synthetic substitute, open		
OSR40JZ Replacement of lumbosacral vertebral disc with synthetic substitute, open		
Primary CPT° Procedure Code		
22857 Total disc arthroplasty (artificial disc), anterior approach including discectomy to prepare interspace, single interspace, lumbar		

Surgeon Certification

I certify that this patient meets the criteria for medical necessity as outlined in your medical policy based on the following:

The member is skeletally mature.

The member has low back pain which has failed at least 6 months of conservative treatment within 1 year prior to the scheduled surgery date. The conservative treatment must have included physical therapy.

Findings on imaging show either 3mm or less of spondylolisthesis or no more than Grade I spondylolisthesis localized to the disc space being treated

Recent imaging has reasonably excluded alternate causes of pain.

Does not have any of the following contraindications:

Active systemic infection or infection at the operating site Allergy or sensitivity to any of the implant materials Any significant lumbar spine deformity at the involved level due to current or past trauma or disease (eg, Ankylosing spondylitis, rheumatoid arthritis); or

Marked lumbar instability on radiographs (eg, radiographic signs of subluxation greater than 3.5mm or angulation of the disc space more than 11 degrees greater than adjacent segments).

Osteopenia or osteoporosis

Severe lumbar facet joint arthropathy

Pars defect/spondylolysis

Stenosis

Leg pain caused by single nerve root compression (aka pinched nerve) [NOTE: Secondary leg pain may be present if it is not isolated]

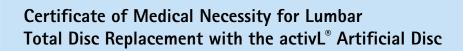
Nerve root damage (chronic radiculopathy, ie, greater than 1 year), disc fragment that has separated and moved from the disc space, or spinal deformity such as scoliosis

Isolated radicular compression syndromes, especially due to disc herniation

Involved vertebral endplate dimensionally smaller than 34.5 mm in the medial-lateral and/or 27mm in the anterior-posterior directions

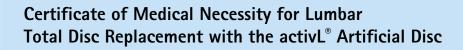
The following is considered investigative.

Intervertebral lumbar disc prosthesis, multi-level.



Other:	
Notes:	
Device Requirements:	
Must be used per FDA labeling (including any labeling requirements regarding degree of spon	dylolisthesis)
Enclosures	
Enclosed is the following documentation as required by your policy:	
Medical records with evidence of 6+ months of failed conservative treatment	
Radiographs with evidence of degenerative disc disease with one confirmed symptomatic level	
Certification and Signature	
I certify that I am the surgeon identified on this certificate and that I have completed this form bapatient's case and on my examination of this patient.	ised on my thorough review of the
Surgeon Signature:	Date:

QualChoice		
Policy Name and Number: I	ntervertebral Disc Prosthesis	
Policy Numb	er: Bl 182.00	
Effective Date: D	ecember 1, 2018	
Patient Name:	Surgeon Name:	
Surgeon NPI:		
Facility Name:	Facility Tax ID:	
Facility Address:		
Facility Type: Inpatient Outpatient ASC		
Primary ICD-10-CM Diagno	osis Code (Please Check One)	
M51.36 Other intervertebral degeneration, lumbar		
M51.37 Other intervertebral degeneration, lumbosacral		
M51.26 Other intervertebral disc displacement, lumbar		
M51.27 Other intervertebral disc displacement, lumbosacral		
Other		
Primary ICD-10-PCS Procedure Code (if Inpatient) (Please Check One)		
OSR20JZ Replacement of lumbar vertebral disc with synthetic su	ostitute, open	
OSR40JZ Replacement of lumbosacral vertebral disc with synthet	ic substitute, open	
Primary CPT° F	Procedure Code	
22857 Total disc arthroplasty (artificial disc), anterior approach including discectomy to prepare interspace, single interspace, lumbar		
Surgeon Certification		
I certify that this patient meets the criteria for medical necessity as ou	tlined in your medical policy based on the following:	
Skeletally mature, and	To optimize clinical outcomes for this major elective procedure,	
With DDD at one level from L3-S1 confirmed radiologically, and	it is also required:	
Are symptomatic with radicular pain, and	Patient is a non-smoker, OR	
Who have failed at least six months of conservative	Patient is a documented smoker and has abstained for at	
management	least 6 weeks prior to surgery as evidenced by lab results	
NSAIDS, analgesics, steroids	documenting nicotine-free status (cotinine level)	
Physical therapy	Does not have any of the following contraindications:	
Epidural steroid injection/selective nerve root block	Combined use of a prosthesis and spinal fusion (hybrid)	
Other:		
Notes:		



Enclosures

Enclosed is the following documentation as required by your policy:

Medical records with evidence of 6+ months of failed conservative treatment and DEXA scan results

Tobacco cessation records if applicable

Certification and Signature

I certify that I am the surgeon identified on this certificate and that I have completed this form based on my thorough review of the patient's case and on my examination of this patient.

Surgeon Signature: Date:

Quartz Health System (formerly known as Gunderson Health System)		
Policy Name and Number: Artificial Intervertebral Disc Replacement		
Effective Date: January 16, 2019		
Patient Name: Surgeon Name:		
Surgeon NPI:		
Facility Name:	acility Tax ID:	
Facility Address:		
Facility Type: Inpatient Outpatient ASC		
Primary ICD-10-CM Diagnosis Code (Please Check One)		
M51.36 Other intervertebral degeneration, lumbar		
M51.37 Other intervertebral degeneration, lumbosacral		
M51.26 Other intervertebral disc displacement, lumbar		
M51.27 Other intervertebral disc displacement, lumbosacral		
Other		
Primary ICD-10-PCS Procedure Code (if Inpatient) (Please Check One)		
OSR20JZ Replacement of lumbar vertebral disc with synthetic substitute, open		
OSR40JZ Replacement of lumbosacral vertebral disc with synthetic substitute, open		
Primary CPT° Procedure Code		
22857 Total disc arthroplasty (artificial disc), anterior approach including discectomy to prepare interspace, single interspace, lumbar		

Surgeon Certification

I certify that this patient meets the criteria for medical necessity as outlined in your medical policy based on the following:

Low back pain, resulting in disability and/or neurological deficit that are refractory to at least six (6) months of conservative management for pain relief including ALL the following:

Analgesics, nonsteroidal and/or steroidal medication (unless contraindicated); AND

Application of ice or heat; AND

Physical therapy, including passive and active treatment modalities; AND

Activity/lifestyle modification; AND

Single-level disc degeneration is documented and includes BOTH of the following criteria:

The implant procedure includes reconstruction of a single level at any single disc space from L3 to S1; AND Patient should have no more than a Grade 1 (no more than 3mm) spondylolisthesis at the involved single level.

Does not have any of the following contraindications:

Use of non- FDA approved lumbar disc prosthesis The planned procedure includes the combined use of a prosthesis and spinal fusion (i.e., hybrid surgery); The patient had prior fusion at an adjacent lumbar level;

The patient had prior surgery at the treated level;

Osteopenia, osteomalacia, or osteoporosis (T-score of -3.5, or -2.5, with vertebral crush fracture);

Rheumatoid arthritis or other autoimmune disease;

Paget's disease, osteomalacia or any other metabolic bone disease:

Radiological evidence of ANY of the following:

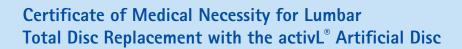
Significant lumbar anatomical deformity or compromised vertebral bodies at the index level (e.g., ankylosing spondylitis, rheumatoid arthritis, lumbar spinal stenosis or nerve root compression, or compromise due to current or past trauma);

Spinal metastases/tumor.

Skeletal immaturity.

Multi-level lumbar disc arthroplasty.

Use of lumbar prosthetic intervertebral discs (e.g., the activL Artificial Disc, the Charite Artificial Disc, and the ProDisc-L Total Disc Replacement) for lumbarsacral degenerative disc disease.



Other:	
Notes:	
Device Requirements:	
Must be FDA approved and used per FDA labeling (including any la	beling requirements regarding degree of spondylolisthesis)
Single-level use only	
Enclose	ıres
Enclosed is the following documentation as required by your policy:	
Medical records with evidence of 6+ months of failed conservative	treatment
Documented diagnosis and symptoms of radiculopathy or myelopathy including physical limitations related to the disease	
Radiographs with evidence of degenerative disc disease with one confirmed symptomatic level	
Certification ar	d Signature
I certify that I am the surgeon identified on this certificate and that I had patient's case and on my examination of this patient.	ave completed this form based on my thorough review of the
Surgeon Signature:	Date:

United HealthCare		
Policy Name: Lumbar Artificial Disc Replacement		
Policy Number: 2019T0437V		
Effective Date: July 1, 2019		
Patient Name: Surg	geon Name:	
Surgeon NPI:		
Facility Name: Facil	ility Tax ID:	
Facility Address:		
Facility Type: Inpatient Outpatient ASC		
Primary ICD-10-CM Diagnosis Code (Please Check One)		
M51.36 Other intervertebral degeneration, lumbar		
M51.37 Other intervertebral degeneration, lumbosacral		
M51.26 Other intervertebral disc displacement, lumbar		
M51.27 Other intervertebral disc displacement, lumbosacral		
Other		
Primary ICD-10-PCS Procedure Code (if Inpatient) (Please Check One)		
OSR20JZ Replacement of lumbar vertebral disc with synthetic substitute, open		
OSR40JZ Replacement of lumbosacral vertebral disc with synthetic substitute, open		
Primary CPT° Procedure Code		
22857 Total disc arthroplasty (artificial disc), anterior approach including discectomy to prepare interspace, single interspace, lumbar		

Surgeon Certification

I certify that this patient meets the criteria for medical necessity as outlined in your medical policy based on the following:

18 to 60 years old

Advanced degenerative disc disease in one vertebral level between L3 and S1 with either moderate to severe degenerative disease or Modic changes

Symptoms must correlate with imaging findings

No more than Grade 1 Spondylolisthesis at the involved level or any listhesis at two or more lumbar segments

Presence of symptoms for at least 6 months

Failed at least 6 months of conservative treatment immediately prior to implantation of artificial disc. (including physical therapy, anti-inflammatory medications, analgesics, muscle relaxants and epidural steroid injections)

Favorable face to face psychological evaluation

Does not have any of the following contraindications:

The procedure is not comprised of any of the following deemed not medically necessary per your medical policy:

Isolated radicular compression syndromes especially due to disc herniation

Spinal stenosis or radiculopathy

Moderate or severe facet arthropathy or pars defect at the operative level demonstrated by MRI scan, CT or plain radiograph Lumbosacral spinal fracture

Scoliosis of the lumbosacral spine

Active systemic infection or infection localized to site Tumor in the peritoneum, retroperitoneum or site of implantation

Osteoporosis or osteopenia as defined by recent (within one year) DEXA scan

Previous lumbar spine surgery where the previous surgery destabilized the spine or where the spine at the level of the previous surgery is an alternate source of pain

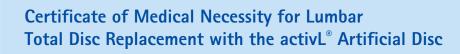
Vascular, urological, or other peritoneal or retroperitoneal pathology that preclude safe and adequate anterior spine exposure

The procedure is not comprised of any of the following deemed not medically necessary per your medical policy:

More than one spinal level

Prior history of lumbar fusion or when combined with a lumbar fusion at any level

Treating any other indications not listed above



Other:		
Notes:		
Device Requirements:		
Must be FDA approved and used per FDA labeling		
Single-level use only		
Enclosures		
Enclosed is the following documentation as required by your policy:		
Medical records with evidence of 6+ months of failed conservative treatment and DEXA scan results		
Radiographs with evidence of degenerative disc disease with one confirmed symptomatic level		
Behavioral health screening results		
Certification and Signature		
I certify that I am the surgeon identified on this certificate and that I have completed this form based on my thorough review of the		
patient's case and on my examination of this patient.		
Surgeon Signature:	Date:	



Certificate of Medical Necessity		
Patient Name:	Surgeon Name:	
Surgeon NPI:		
Facility Name:	Facility Tax ID:	
Facility Address:		
Facility Type: Inpatient Outpatient ASC		
Primary ICD-10-CM Diagnosis Code (Please Check One)		
M51.36 Other intervertebral degeneration, lumbar		
M51.37 Other intervertebral degeneration, lumbosacral		
M51.26 Other intervertebral disc displacement, lumbar		
M51.27 Other intervertebral disc displacement, lumbosacral		
Other		
Primary ICD-10-PCS Procedure Code (if Inpatient) (Please Check One)		
OSR20JZ Replacement of lumbar vertebral disc with synthetic substitute, open		
OSR40JZ Replacement of lumbosacral vertebral disc with synthetic substitute, open		
Primary CPT° Procedure Code		
22857 Total disc arthroplasty (artificial disc), anterior approach including discectomy to prepare interspace, single interspace, lumbar		

Surgeon Certification

I certify that this patient meets the criteria for medical necessity as outlined in your medical policy based on the following:

I certify that this patient meets the criteria for medical necessity as outlined in your medical policy based on the following:

Is skeletally mature (18-60)

Needs single-level disc replacement with activL (FDA approved artificial disc) as confirmed by imaging, at:

L4-L5 or L5-S1

Has failed at least six (6) months of nonoperative, physician-supervised, conservative treatment

Has no more than Grade 1 spondylolisthesis

May have some radiologic evidence of degeneration at adjacent levels but without symptoms/pain

Has passed a psychological screening for behavioral health disorders

Has clinically significant functional impairment (ODI) and pain (VAS)

Does not have any of the following contraindications:

Isolated radiculopathy, especially due to herniated disc

Chronic radiculopathy (unremitting pain with predominance of leg pain symptoms greater than back pain symptoms extending over a period of at least a year)

Spinal stenosis

Active systemic infection or localized infection near the surgical site

Osteoporosis or osteopenia determined by DEXA scan

Allergy or sensitivity to the implant materials

Extruded disc material with sequestrum

Myelopathy

Spinal deformity, such as scoliosis

Clinically compromised vertebral bodies at the affected level due to trauma or disease

Facet ankylosis or facet joint degeneration

Preoperative remaining disc height < 3 mm



Other:		
Notes:		
Enclosures		
Enclosed is the following documentation as required by your policy:		
Medical records with evidence of 6+ months of failed conservative treatment and DEXA scan results		
My clinical notes		
Radiographs with evidence of degenerative disc disease with one confirmed symptomatic level		
Behavioral health screening results		
Certification and Signature		
I certify that I am the surgeon identified on this certificate and that I have completed this form based on my thorough review of the		
patient's case and on my examination of this patient.		
Surgeon Signature:	Date:	