

Policy Name and Number	Lumbar Artificial Disc Replacement L-005
Effective Date	September 1, 2018
Medical Necessity Criteria Checklist	<p><u>Patient:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Skeletally mature patient. <input type="checkbox"/> Advanced degenerative disc disease in one vertebral level between L3 and S1 characterized by moderate to severe degenerative disease with Modic changes. <input type="checkbox"/> Symptoms must correlate with imaging findings. <input type="checkbox"/> No more than Grade 1 Spondylolisthesis at the involved level or any listhesis at two or more lumbar segments. <input type="checkbox"/> Presence of symptoms for at least one year. <input type="checkbox"/> Failed at least 6 months of conservative treatment (including physical therapy, anti-inflammatory medications, analgesics, muscle relaxants and epidural steroid injections). <input type="checkbox"/> Favorable face to face psychological evaluation. <p><u>Device:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Must be FDA approved prosthetic intervertebral disc. <input type="checkbox"/> Single-level use only.
Contraindications Checklist	<p><u>Not Medically Necessary:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Moderate or severe facet arthropathy or pars defect at the operative level demonstrated by MRI scan, CT or plain radiograph. <input type="checkbox"/> Lumbosacral spinal fracture. <input type="checkbox"/> Scoliosis of the lumbosacral spine. <input type="checkbox"/> Active systemic infection or infection localized to site. <input type="checkbox"/> Tumor in the peritoneum, retroperitoneum or site of implantation. <input type="checkbox"/> Osteoporosis or osteopenia as defined by recent (within one year) DEXA scan. <input type="checkbox"/> 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. <input type="checkbox"/> Vascular, urological, or other peritoneal or retroperitoneal pathology that preclude safe and adequate anterior spine exposure. <input type="checkbox"/> Replacement at multiple adjacent or non-adjacent levels. <input type="checkbox"/> Cannot be combined with lumbar fusion.

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