Summary of Medical Policy for Lumbar Total Disc Replacement: UnitedHealthCare

AESCULAP Implant Systems

Policy Name and Number	Lumbar Artificial Disc Replacement L-005
Effective Date	September 1, 2018
Medical Necessity Criteria Checklist	**Patient:** ❑ Skeletally mature patient. ❑ Advanced degenerative disc disease in one vertebral level between L3 and S1 characterized by moderate to severe degenerative disease with **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 one year.** ❑ Failed at least 6 months of conservative treatment (including physical therapy, anti-inflammatory medications, analgesics, muscle relaxants and epidural steroid injections). ❑ **Favorable face to face psychological evaluation.** **Device:** ❑ Must be FDA approved prosthetic intervertebral disc. ❑ Single-level use only.
Contraindications Checklist	**Not Medically Necessary:** ❑ 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. ❑ Replacement at multiple adjacent or non-adjacent levels. ❑ Cannot be combined with lumbar fusion.

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