

# Total Artificial Disc Replacement for the Cervical Spine (for North Carolina Only)

**Policy Number:** CSNCT0437.06  
**Effective Date:** March 1, 2024

[Instructions for Use](#)

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Related Policies
<ul style="list-style-type: none"> <li><a href="#">Interspinous Fusion and Decompression Devices (for North Carolina Only)</a></li> <li><a href="#">Spinal Fusion and Bone Healing Enhancement Products</a></li> <li><a href="#">Spinal Fusion and Decompression (for North Carolina Only)</a></li> </ul>

## Application

This Medical Policy only applies to the state of North Carolina.

## Coverage Rationale

For medical necessity clinical coverage criteria for Total Artificial Disc Replacement for the Cervical Spine, refer to the [North Carolina Medicaid \(Division of Health Benefits\) Clinical Coverage Policy, Physician: 1A-30, Spinal Surgeries](#).

## Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
0098T	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, cervical (List separately in addition to code for primary procedure)
22856	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophylectomy for nerve root or spinal cord decompression and microdissection); single interspace, cervical
22858	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophylectomy for nerve root or spinal cord decompression and microdissection); second level, cervical (List separately in addition to code for primary procedure)
22861	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical
22864	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical
22899	Unlisted procedure, spine

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# U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

Artificial discs are regulated by the FDA, but products are too numerous to list. Refer to the following website for more information (use product code MJO). Refer to: <https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMA/pma.cfm>. (Accessed November 14, 2023)

## References

North Carolina Medicaid, Division of Health Benefits, Physician Clinical Coverage Policies, No: 1A-30. Available at: <https://medicaid.ncdhhs.gov/1a-30-spinal-surgeries/download?attachment>. Accessed November 14, 2023.

## Policy History/Revision Information

Date	Summary of Changes
11/01/2024	<b>Template Update</b> <ul style="list-style-type: none"><li>Modified font style; no change to policy content</li></ul>
03/01/2024	<b>Related Policies</b> <ul style="list-style-type: none"><li>Removed reference link to the Medical Policy titled <i>Minimally Invasive Spine Surgery Procedures (for North Carolina Only)</i></li></ul> <b>Supporting Information</b> <ul style="list-style-type: none"><li>Updated <i>References</i> section to reflect the most current information</li><li>Archived previous policy version CSNCT0437.05</li></ul>

## Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state, or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state, or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state, or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state, or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.