TOTAL ARTIFICIAL DISC REPLACEMENT FOR THE SPINE

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INSTRUCTIONS FOR USE

This Medical Policy provides assistance in interpreting UnitedHealthcare benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced. The terms of the federal, state or contractual requirements for benefit plan coverage may differ greatly from the standard benefit plan upon which this Medical Policy is based. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage supersedes this Medical Policy. All reviewers must first identify member eligibility, any federal or state regulatory requirements, and the contractual requirements for benefit plan coverage prior to use of this Medical Policy. Other Policies and Coverage Determination Guidelines may apply. UnitedHealthcare reserves the right, in its sole discretion, 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 MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines 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.

BENEFIT CONSIDERATIONS

Before using this policy, please check the federal, state or contractual requirements for benefit coverage.

COVERAGE RATIONALE

Cervical artificial total disc replacement of FDA-approved prosthesis for degenerative cervical disc disease with symptomatic intractable radiculopathy and/or myelopathy is proven and medically necessary in a skeletally mature individual when at least ONE of the following criteria is met:
- Herniated disc
- Osteophyte formation

AND both of the following:
- Documented patient history of neck and/or arm pain and/or a functional/neurological deficit associated with the cervical level to be treated
- Failed at least six weeks of non-operative treatment prior to implantation (only applicable for elective surgery; emergent surgery or does not require prior non-operative treatment)

Cervical artificial disc replacement is proven and medically necessary for treating symptoms of degenerative disc disease at one level even if they have radiological evidence of degenerative disc disease at multiple levels.
Radiologic evidence of degenerative disc disease is common in persons who are middle aged and older and does not necessarily correlate with clinical symptoms.
Cervical artificial total disc replacement is proven and medically necessary for treating symptomatic contiguous two level degenerative disc disease in skeletally mature patients when used according to U.S. Food and Drug Administration (FDA) labeled indications.

Note: Not all cervical artificial discs have FDA labeling for contiguous two level degenerative disc disease. Only cervical artificial discs FDA labeled for contiguous two level disease are proven and medically necessary for this indication. Refer to the FDA section below.

Cervical artificial disc replacement at one level combined with cervical spinal fusion surgery at another level (adjacent or non-adjacent) performed at the same surgical setting is unproven and not medically necessary.

This is commonly referred to as a hybrid surgery. There is insufficient published clinical evidence in peer-reviewed medical literature demonstrating the safety and efficacy of combination cervical spine surgery at multiple adjacent or non-adjacent levels.

Lumbar artificial total disc replacement is unproven and not medically necessary for treating single or multiple level degenerative disc disease in skeletally mature patients.

The long-term clinical outcome of lumbar disc replacement is unclear. The evidence from uncontrolled long-term studies suggests that potential degeneration of adjacent discs and facets and wear of the polyethylene part of the disc may occur and that, in some cases, revision surgery may be needed.

**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 the member specific benefit plan document 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 Coverage Determination Guidelines may apply.

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<td>Removal of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, cervical (List separately in addition to code for primary procedure)</td>
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Artificial total disc replacement refers to the replacement of a degenerating intervertebral disc with an artificial disc in adults with degenerative disc disease (DDD) in either the lumbar or cervical region of the spine. An artificial disc is intended to preserve range of motion (ROM) and reduce pain (ECRI, 2009). These prostheses replace the degenerated disc and have been proposed as a means of improving flexibility, maintaining spinal curvature and providing an equalized weight-bearing surface, while reducing or possibly eliminating pain.

Artificial discs may consist of two cobalt-chromium endplates that are attached to the vertebrae and a polyethylene disk that is inserted between the metal endplates may be metal on metal, metal on plastic, ceramic on ceramic or titanium on polyurethane. Discs are implanted through an anterior approach and are attached to vertebrae with screws, teeth, ridges, or pins.

### Cervical Artificial Disc (Single Level)

Cervical intervertebral disc prostheses that have been approved by the FDA for surgical implantation within the spine, for single-level cervical disc replacement include but are not limited to The Prestige® ST Cervical Disc (Medtronic Sofamor Danek, Memphis, TN), the PRODISC-C® Total Disc Replacement (Synthes, Inc., New York, NY) and the BRYAN® Cervical Disc (Medtronic Sofamor Danek, Memphis, TN), SECURE®-C Artificial Cervical Disc (Globus Medical Inc., Audubon, PA), and Mobi-C® Cervical Disc (LDS Spine USA, Inc. Austin, TX).

Hu et al. (2016) conducted a systematic review and meta-analysis to investigate the mid- to long-term outcomes of cervical disc arthroplasty (CDA) versus anterior cervical disectomy and fusion (ACDF) for the treatment of 1-level or 2-level symptomatic cervical disc disease. Eight prospective randomized controlled trials (RCTs) were included with 1317 and 1051 patients in CDA and ACDF groups, respectively. Overall success was considered achieved if a patient met all of the following items: NDI success, neurological success, absences of implant/surgery-related serious adverse events and secondary procedure. Pooled analysis showed patients in CDA group achieved significantly higher rates of overall success, Neck Disability Index (NDI) success, neurological success and significantly lower rates of implant/surgery-related serious adverse events and secondary procedure compared with that in ACDF group. The long-term functional outcomes (NDI, Visual Analog Scale (VAS) neck and arm pain scores, the Short Form 36 Health Survey physical component score (SF-36 PCS)), patient satisfaction and recommendation, and the incidence of superior adjacent segment degeneration also favored patients in CDA group with statistical difference. Patients in CDA group had a lower rate of inferior adjacent segment degeneration without statistical significance. The authors concluded that this meta-analysis showed that cervical disc arthroplasty was superior over anterior disectomy and fusion for the treatment of symptomatic cervical disc disease.

A meta-analysis was performed by Wu et al. (2016) which included randomized controlled trials that reported a minimum of 4 years of follow-up with regard to the rates of subsequent surgeries after artificial cervical disc replacement (ACDR) compared with anterior cervical disectomy and fusion (ACDF). The overall rate of subsequent surgery at the operated level and adjacent levels was lower in the ACDR group (7.4%) than in the ACDF group (16.8%). For subsequent surgery at the operated level or adjacent level, patients who received ACDR had a lower rate of subsequent surgery than patients who received ACDF. The authors concluded that ACDR had significantly fewer subsequent surgical interventions compared with ACDF, however, a review of the literature showed that there were an insufficient number of studies with respect to subsequent surgery with a minimum of 4 years of follow-up. Longer-term, multicenter studies are needed for better evaluation of the rate of subsequent surgery after ACDR.

Yao et al. (2016) performed a meta-analysis to compare the efficacy and safety of total disc arthroplasty (TDA) and anterior cervical discectomy and fusion (ACDF). Clinical indices included Neck Disability Index (NDI), Neurological Success (NS), Overall Success (OS), Return-to-Work Status (RWS), Reoperation (RO) and Implant/Surgical Procedure-Related Adverse Events (ISPRAE). A total of nine articles reporting on six trials with 2121 patients were included, in which 1082 underwent TDA and 1039 underwent ACDF. NDI scores were reported in five studies and did not differ significantly between the two groups. Neurological success was documented in 5 studies and the TDA group had significantly better neurological success compared with the ACDF group. Five studies provided data on overall success. The TDA group had significantly better overall success compared with the ACDF group. Return-to-work status after operation was reported in 3 studies and there was no significant difference between the two groups. Six trials
reported data on secondary surgical procedures. The results showed that TDA is associated with significantly lower incidence of secondary surgical procedures than ACDF. Six trials reported on secondary surgical procedures at the adjacent level. There was no significant difference between the two groups. The authors summarized that based on the current literature review and meta-analysis; the clinical outcomes of TDA are equivalent or superior to ACDF. In addition, more long-term RCTs will be needed to corroborate the current conclusions.

In a prospective, multi-center, randomized, un-blinded clinical trial, Jackson et al. (2016) evaluated subsequent surgery rates up to 5 years in patients treated with total disc replacement (TDR) or anterior cervical disectomy and fusion (ACDF) at 1 or 2 contiguous levels between C-3 and C-7. Patients with symptomatic degenerative disc disease were enrolled to receive 1- or 2-level treatment with either TDR (Mobi-C® Cervical Disc Prosthesis) as the investigational device or ACDF as the control treatment. There were 260 patients in the 1-level study (179 TDR and 81 ACDF patients) and 339 patients in the 2-level study (234 TDR and 105 ACDF patients). At 5 years, the occurrence of subsequent surgical intervention was significantly higher among ACDF patients for 1-level (TDR, 4.5%; ACDF, 17.3%) and 2-level (TDR, 7.3%; ACDF, 21.0%) treatment. The TDR group demonstrated significantly fewer index- and adjacent-level subsequent. The authors concluded that results from this study suggest that TDR may provide a substantial benefit over ACDF in providing a lower risk for subsequent surgical intervention. They further suggested that a lower rate of subsequent adjacent-level surgical procedures in patients who received TDR devices provides indirect evidence that motion preservation may lead to a lower rate of adjacent-level disease than an anterior fusion approach.

Bakar et al (2014) concluded that “Given the long-term outcomes that have been studied for anterior cervical disectomy and fusion, it is difficult to assess the future potential of anterior cervical disc arthroplasty as an alternative to anterior cervical disectomy and fusion. It is important to note that current studies with follow-up to 4 years have shown promising outcomes. The ability of anterior cervical disc arthroplasty to decrease the potential for common and well-known late complications of anterior cervical disectomy and fusion (such as adjacent segment disease) is an important and interesting possibility. Future long-term randomized controlled trials and cost effectiveness studies are needed to properly assess the continued use of artificial cervical disc arthroplasty and to determine the relative cost effectiveness compared with anterior cervical disectomy and fusion.”

A 2014 Hayes Medical Technology Directory report concludes that the evidence suggests that single level total artificial disc replacement (TDR) is either comparable or superior to ACDF for both clinical (overall success, NDI, neurologic success) and safety outcomes. There is growing evidence that bi-level TDR is generally consistent with ACDF for clinical and safety outcomes in the short term (Updated December 11, 2015).

In September 2012, ECRI Institute published an evidence based report evaluating cervical disc replacement that included evidence published until April 2012. Eleven publications met the inclusion criteria, six were randomized controlled trials and five consisted of case series. The evidence reviewed by ECRI did not permit conclusions regarding rate of occurrence of adverse events.

Jawahar et al. (2010) compared the incidence of adjacent segment disease in 93 patients who were randomized to receive artificial disc (n=59) or anterior cervical disectomy and fusion (n=34). The study was part of 3 different United States Food and Drug Administration (FDA) prospective randomized controlled Investigational Device Exemption (IDE) trials involving 3 different artificial discs (Kineflex-C®, Mobi-C® and AdventCervical®) at their institution. Visual analog pain score (VAS), Neck Disability Index (NDI), and cervical spine radiographs were collected at 6 weeks and at 3 and 6 months, and then annually up to 4 years after their surgery. At median follow-up of 36.4 months (range, 24-49 months), 65 patients were free from symptoms. In the remaining 28 patients, surgery was not successful. The success rates for artificial disc (71%) were not statistically different from those of fusion (73.5%). The actuarial median symptom-free survival period was not significantly different. The final scores for VAS and NDI were similar for both groups. Eighteen percent of artificial disc patients and 15% fusion patients developed adjacent segment degeneration. Concurrent lumbar DDD significantly increased the risk of adjacent segment degeneration. The authors only reported positive outcomes and did not report the incidence or rate of revision or account for those patients in whom surgery was not successful. Although artificial disc affords a significantly quicker symptomatic relief, the longer-term outcomes do not prove results superior to those with fusion. The authors concluded that artificial disc is equivalent to fusion for providing relief from symptoms in the treatment of one- and two-level DDD of cervical spine. Additionally, the risk of developing adjacent segment degeneration is equivalent after both procedures but is significantly higher in patients with concurrent DDD in lumbar spine. The authors only reported positive outcomes and did not report the incidence or rate of revision. Artificial disc appears to be equivalent to anterior cervical disectomy and fusion.

Huppert et al. (2011) conducted a prospective multicenter study to compare the clinical and radiological outcomes of cervical disc replacement between single- (n=175) and multilevel (n=56) patients receiving the Mobi-C® device. Follow-up (FU) evaluation was performed at 1, 3, 6, 12, and 24 months after surgery. Comparison between both groups was based on Neck Disability Index (NDI), Visual Analog Scale (VAS), and Range of Motion. At 24 months,
mean NDI and VAS scores for neck and arm pain were improved in both groups similarly. Improvement in range of motion was also similar with the single level group having an increase of 2.8 degrees compared to 2.2 degrees in the multilevel group. Post-operative analgesic use was higher in the multilevel group at 53% compared to 32% for the single level group. Complications occurred in 19 of the 175 (10.9%) single level patients compared to 11 in the 56 (19.6%) multilevel patients. The rate of dysphagia/dysphonia was significantly higher in the multi-level group (9/56 or 16%) versus (6/175 or 3.4%) in the single-level group. Four patients in the single level group underwent a secondary surgery (2 fusions; 2 disc replacement) versus 2 patients in the multilevel group that had a third device implanted. There were no significant differences between the groups however additional studies are needed to evaluate the impact on safety and efficacy for multilevel disc replacement.

A prospective study by Phillips et al. (2009) evaluated outcomes of cervical disc replacement performed in patients with and without previous anterior cervical decompression and fusion (ACDF) receiving the porous coated motion (PCM) artificial cervical disc in a United States Federal Drug Administration Investigational Device Exemption trial. One hundred fifty two patients were enrolled in the study; 126 patients without previous ACDF and 26 patients with a previous "adjacent level" fusion surgery. Postoperative follow-up occurred at 6-weeks, 3-month, 6-month, 1-year, and 2-years. At 1 year, 93 of the 126 patients with no prior surgery and 21 of 26 prior surgery patients completed follow-up. Outcomes were measured using the Neck Disability Index and Visual Analog Scores which showed improvement after surgery and were similar between groups at all time points. Revision surgery occurred in 2 of 126 primary patients, and in 2 of 26 patients in the adjacent-to-fusion group. The authors found that while both groups had similar outcomes, additional long-term studies are needed to evaluate complication rates as well as whether outcomes are maintained over time.

**Pro-Disc-C®**

The ProDisc-C® Total Disc Replacement is composed of three components: a cobalt chromium molybdenum alloy plate that is anchored into the inferior vertebral body, an ultra-high molecular weight polyethylene insert that is attached to the alloy plate providing an inferior convex bearing surface, and a second cobalt chromium molybdenum alloy plate that anchors to the superior vertebral body and has a concave bearing surface.

Kelly et al. (2011) compared adjacent segment motion following disc arthroplasty using the ProDisc-C® device versus anterior cervical discectomy and fusion (ACDF) in 209 patients in a prospective randomized controlled trial at 13 sites. The authors reported no significant difference in adjacent segment range of motion (ROM) was observed between ACDF and TDA. Only time was a significant predictor of postoperative ROM at both the cranial and caudal adjacent segments. The ROM decreased over time with fusion whereas disc replacement results in immediate motion sustained throughout the follow-up period.

Delamarter et al. (2010) presented the preliminary 4 year follow-up results of the Murrey IDE study. The follow-up rates at 48 months for ProDisc-C® TDR and ACDF were 63.0% and 46.2%, respectively, at the time of publication. After closure of randomized enrollment an additional group of 136 continued access (CA) patients had ProDisc-C® TDR surgery. At 24 months, there was no significant difference in neurologic improvement among the 3 groups. At 48 months, the overall neurologic improvement trended toward significance for ProDisc-C® TDR patients compared with ACDF patients. VAS scores decreased at 24 months in all 3 groups. At 48 months the ACDF group showed only a 38.7 mm reduction in mean VAS score from preoperative levels compared with 49.3 mm in the ProDisc-C® TDR group, although this difference was not statistically significant. On radiographic exam at 24 months, flexion-extension range of motion (ROM) at the index level was similar between the Pro-Disc-C® TDR and the CA group (9.38° and 9.50°). ROM was <2° in 91.2% of the ACDF patients at 24 months. At 48 months, flexion-extension ROM was maintained in Pro-Disc-C® TDR group (9.12°), and 95.5% of the ACDF group had <2°ROM. Of the original study participants, (103 Pro-Disc® and 106 ACDF), 11 patients (2 Pro-Disc-C® and 9 ACDF) required secondary surgical procedures by 24 months. The 3 Pro-Disc® patients converted to fusion. In the ACDF group, 6 underwent additional fusion at both the index and adjacent levels, 1 had a revision due to dysphagia associated with plate lift off, and 1 had posterior decompression with supplemental fixation. By 48 months, 3 of Pro-Disc-C® TDR patients and 12 of ACDF patients had required a secondary surgical procedure. The authors conclude that preliminary data at 4 years shows that both total disc replacement and ACDF are viable surgical options for patients with symptomatic cervical disk disease.

**Prestige®**

Evidence in the peer-reviewed published scientific literature evaluating early models of the Prestige® cervical disc included case series with few randomized trials.

The Prestige® ST Cervical Disc consists of a two-piece articulating metal-on-metal device that is inserted into the intervertebral disc space at a single cervical level using an anterior approach. As part of approval, the FDA is requiring a seven-year post-approval study to evaluate long-term safety and effectiveness of the Prestige® ST Cervical Disc.

Gornet et al. (2016) conducted a study to assess the safety and efficacy of the Prestige® LP Disc at 84-months follow-up. Prospective data from 280 cervical disc arthroplasty (CDA) patients with single-level cervical disc disease with
radiculopathy or myelopathy were compared with 265 historical control anterior cervical disectomy and fusion (ACDF) patients. Clinical and radiographic follow up was completed pre-operatively, intraoperatively, and at intervals up to 84 months. Statistical improvements in Neck Disability Index (NDI), neck/arm pain, and SF-36 were achieved by 1.5 months in both groups and maintained through 84 months. At 84 months, 86.1% of CDA versus 80.1% of ACDF patients achieved NDI success, (≥15-point improvement over baseline). Mean NDI score improvements exceeded 30 points in both groups. SF-36 PCS/MCS mean improvements were 13.1±11.9/8.2±12.3 points for CDA and 10.7±11.8/8.3±13.6 points for ACDF. Neurological success was 92.8% for CDA and 79.7% for ACDF patients. The rate of Overall Success was 74.9% for CDA and 63.2% for ACDF. At 84 months, 17.5% of CDA and 16.6% of ACDF patients had a possibly implant- or implant-surgical procedure-related adverse event. Eighteen (6.4%) CDA and 29 (10.9%) ACDF patients had a second surgery at the index level. At 84 months, 90.9% of CDA and 85.6% of ACDF patients were satisfied with the results of their treatment. The authors concluded that Prestige® LP maintained significantly improved clinical outcomes and segmental motion; statistical superiority of CDA was concluded for overall success. Additional studies are needed to establish long term efficacy.

**Bryan®**

The Bryan® cervical disc is composed of a plastic (polyurethane) center with titanium endplates. It is designed as a one-piece device that allows unconstrained motion. According to the manufacturer, the Bryan® cervical disc is indicated for use in skeletally mature patients with cervical degenerative disc disease (DDD) at one level from C3–C7. The Bryan® cervical artificial disc has a flexible membrane that surrounds the nucleus (the inner portion of the disc) that is filled with a lubricant. This membrane is designed for two purposes: to contain any wear debris that forms and to prevent any soft tissue in-growth. The articulating surfaces of this device are polyurethane on titanium. It has beaded porous coated endplates intended for biological fixation instead of fixation using screws into the vertebrae or fixation by use of stabilizing keels.

A meta-analysis of randomized controlled trials (RCTs) was performed by Xie et al. (2016) to evaluate the efficacy and safety in cervical disc arthroplasty (CDA) and anterior cervical disectomy and fusion (ACDF) for treating cervical degenerative disc diseases (CDDDs). Twenty RCTs with a total 4004 patients (2212 in the CDA and 1792 in the ACDF) met inclusion criteria. Fifteen of the included studies were multi-center trials; five were single-center trials. Eight types of disc prostheses were used and patients were followed up for at least 2 years. The outcome measurements included neck disability index (NDI), neurological success, range of motion (ROM), Visual Analogue Score (VAS), adverse events, adjacent segment disease (ASD), and reoperation. The NDI score, VAS of neck and VAS of arm of the CDA group was significantly lower than that of the ACDF group. The rate of neurological success and ROM were significantly higher than that of the ACDF group. The authors concluded that the results of this meta-analysis indicated that CDA was superior to ACDF regarding fewer severe advents, fewer ASDs, fewer reoperations, better neurological success, greater ROM, lower NDI scores and greater neck and arm pain functional recovery. They recommended additional large, definitive RCTs.

Dejaegher et al. (2016) presented the 10-year follow-up results after implantation of the Bryan® Cervical Disc Prosthesis in a single center. Eighty-nine patients underwent implantation of a single-level Bryan® Cervical Disc Prosthesis to treat radiculopathy and/or myelopathy. Clinical outcomes measured include Neurological Success, Neck Disability Index (NDI), Neck- and Arm-Pain, and Short Form-36 (SF-36). Adverse events and second surgeries were recorded and evaluated. Maintenance or improvement of the neurological state was seen in 89% of patients after 10-year follow-up. SF-36 Physical Component Summary (PCS) scores improved significantly at all follow-up points. Significant improvement for NDI, and Neck- and Arm-Pain scores was found. Mean angular motion of the prosthesis at 10-year follow-up was 8.6°. Mobility of the device, defined as >2° of angular motion, was reached in 81% of patients. During the study period, 21 patients (24%) developed new or recurrent radiculopathy or myelopathy, the majority of these being treated conservatively. Seven patients (8%) required 8 additional spine surgeries to treat persistent or recurrent symptoms. In this study, favorable long-term clinical outcome after implantation of the Bryan® Cervical Disc Prosthesis was seen, with the majority of prostheses remaining mobile after 10-year follow-up. However, still 6% of patients required adjacent level surgery.

Quan et al (2011) evaluated the long-term outcome of cervical disc arthroplasty. Clinical and radiological data were obtained from the 8-year post-operative review. The authors concluded that at 8-year follow-up, the Bryan® Cervical Disc arthroplasty maintains favorable clinical and radiological results, with preservation of movement and satisfactory clinical outcome in the majority of cases. However, the incidence of heterotopic ossification causing restricted range of movement of the prosthesis appears to increase with time, especially in bi-level procedures.

Coric et al. (2006) reported on the safety and efficacy of the Bryan® cervical artificial disc compared to fusion in 33 patients with single-level DDD based on data obtained at a single investigational site of the FDA IDE trial (Heller et al., 2009). At 24 month follow-up, no device-related complications had occurred and patients with the Bryan® disc had clinical outcomes similar to the patients who had undergone spinal fusion.
In a prospective, randomized study by Sasso et al. (2007), 115 patients were enrolled to compare the Bryan® artificial disc replacement to anterior cervical fusion. This study is a pooled data set from 3 centers involved in the FDA IDE trial (Heller et al., 2009) evaluating the Bryan® artificial cervical disc. There were 56 patients in the Bryan® group and 59 patients in the fusion group. Patients were followed for 24 months with 99 patients completing the study. Disability and pain were assessed using the Neck Disability Index (NDI) and the Visual Analog Scale (VAS) of the neck and of the arm pain. Range of motion was determined by independent radiologic assessment of flexion-extension radiographs. At 2 year follow-up, NDI for the Bryan® group is 11 and the control group is 20 and the average arm pain VAS for the Bryan® group was 14 and control 28. The disc replacement group retained an average of 7.9 degrees of flexion-extension at 24 months. There were 6 additional operations in this series: 4 in the cervical fusion and 2 in the artificial disc group. Based on these results, the authors concluded the Bryan® artificial disc replacement compares favorably to anterior cervical discectomy and fusion for the treatment of patients with 1-level cervical disc disease. The study is limited by short-term follow-up and subjective outcomes. Additional studies are needed to establish long-term efficacy.

A prospective randomized controlled trial by Garrido et al. (2010) reported 4 year follow-up results 47 patients from the Sasso (2007) study randomly assigned to undergo cervical arthroplasty with the Bryan® disc (n=21) or spinal fusion (n=26). Outcomes were measured by neck disability index (NDI) score, visual analog score (VAS) for both neck and arm pain, short form (SF-36) physical and mental scores. At the 4 year follow-up, NDI scores changed from 50 preoperatively in both groups to 10 in the cervical disc group and 16.7 in the fusion group. Preoperative neck pain scores on a visual analog scale (VAS) were 76.2 in the disc group and 80.6 in the fusion group. After four years, neck VAS scores were 13.6 in the disc group and 28.1 in the fusion group. Arm pain VAS scores were 78.8 in the disc group and 77.1 in the fusion group preoperatively. After four years, arm pain VAS scores were 10.8 in the disc group and 21.7 in the fusion group. Results were similar between the 2 groups for the SF-36 physical scores; however, for the SF-36 mental scores, there was a 24% improvement in the disc group compared with 13% in the fusion group at 4 years. A total of 6 patients in the control group and 1 patient in the disc group (total of 7 procedures) required reoperation from the initial procedures. In the control group this included 3 procedures for adjacent-level degenerative disc disease (DDD) and 1 procedure for remote-level DDD which were revised to a fusion, and 2 procedures in 1 patient for pseudarthrosis (failed spinal fusion) that required a facet neurotomy and supplemental fixation. There was 1 procedure for adjacent-level DDD in the disc group that was converted to a fusion. These results appear to show a clinical favorable outcome regarding functional outcomes and adjacent segment disease for cervical disc replacement. Longer term, multicenter studies will be required to definitively prove that cervical arthroplasty does statistically correlate with a lower incidence of adjacent level degeneration and overall better outcomes.

Heidecke et al. (2008) conducted a prospective study of 54 consecutive patients with degenerative cervical disease who underwent ventral discectomy and disc replacement with the Bryan® Cervical Disc prosthesis. A total of 59 prosthetic discs were implanted, in 49 patients at a single level and in 5 at two adjacent levels. Neurological status was evaluated pre-operatively and at one and two years thereafter. Plain X-rays, CT, and MRI were used for preoperative diagnostics. Post-operative follow-up was done by X-rays. Clinical results and functional outcome at 2 years showed that all patients reported excellent or good neurological outcome. Seven patients experienced loss of mobility, mainly due to the development of heterotopic ossification. Further investigations with longer follow-up periods and with a control group (e.g. fusion with intervertebral cage) will be necessary for a definitive assessment of the long-term functionality and benefits of artificial cervical discs.

Goffin et al. (2010) reported on 4- and 6-year follow-up results after cervical disc replacement surgery using the Bryan® Cervical Disc Prosthesis. A total of 98 patients (89 with 1-level and 9 with 2-level implantations) participated in the follow-up studies for up to 10 years postoperatively. Outcomes were measured utilizing the 36-Item Short Form Health Survey, Neck Disability Index, numerical ratings of neck and arm pain, neurological outcomes, Odom classification and angular motion findings from lateral flexion-extension radiographs. The mean angular motion results at 4 and 6 years postoperatively for 1-level patients were 7.3 and 7.7°, respectively. Two-level patients had slightly less motion at 4 and 6 years postoperatively with mean caudal values of 5.7 and 6.0°, respectively, and cephalad values of 4.2 and 6.2°, respectively. A total of 65 patients (61 1-level and 4 2-level patients) had at least 1 adverse event recorded however only 6 of these were judged to be related to the device. These events included device migration, device removal, hoarseness and vocal cord paralysis, as well as 3 cases involving pain and neurological symptoms. In addition, 8 patients underwent further neck surgery to treat symptoms. The authors conclude that favorable outcomes persist after 4-6 years of follow-up. The study was manufacturer sponsored and is limited by small sample size and subjective outcomes.

A study by Walraevens et al. (2010) of the same 89 patients in the Goffin study above assessed the intermediate and long-term radiographic characteristics of disk replacement surgery with the Bryan® Cervical Disc. There were no cases of anteroposterior migration or subsidence. Mobility at the treated level was preserved in > or = 85% of cases. The authors concluded that the device maintains preoperative motion at the index and adjacent levels, seems to protect against acceleration of adjacent-level degeneration as seen after anterior cervical discectomy and fusion, and remains securely anchored in the adjacent bone mass in the long run.
**Professional Societies**

**American Academy of Orthopaedic Surgeons (AAOS)**

Although it is not an official position statement, in 2010 the AAOS published a technology overview of cervical disc arthroplasty. The committee addressed four key questions regarding the technology, comparing the outcomes of patients treated with cervical intervertebral disc (IVD) replacement to patients treated with anterior cervical disc fusion (ACDF). The key questions addressed what patient characteristics predicted successful outcomes in patients who underwent cervical IVD replacement compared to ACDF; do patients with herniated disc and arm pain, with or without neck pain, have equal or better outcomes when compared to ACDF, are the revision rates and/or complication rates equal or better in those who receive disc replacement compared to ACDF, and for patients which is more economical, according to hospital length of stay and return to work. Regarding patient characteristics, the data was inconclusive, most studies did not report a statistical analysis, and only one level II study reported no statistically significant difference. For clinical outcomes, five level II studies were included. There was a trend for better NDI scores and NDI success rate at early follow-up, data for long term follow-up was inconclusive. While one study reported arthroplasty had significantly higher neurologic success rates, two level II studies reported no statistically significant differences. A majority of the studies reported no statistically significant difference in either neck or arm pain scores at short term follow-up (six months to 24 months), long term data was inconclusive. The result reported by three level II studies was inconclusive regarding SF-36 scores and there were no differences in the number of patients who returned to work at 24 months. The results of four level II studies were included, three did not report secondary surgery results similarly, and therefore the results could not be compared. The results for adverse events were also inconclusive in these same studies. Patients who underwent arthroplasty returned to work in significantly fewer days although the length of hospital stay did not vary between groups.

**International Society for the Advancement of Spine Surgery (ISASS)**

The ISASS published a policy statement (ISASS, 2014) supporting the safety and efficacy of cervical disc arthroplasty as an alternative to anterior cervical discectomy and fusion for individuals with one or two level cervical radiculopathy or myelopathy.

**North American Spine Society (NASS)**

The NASS has revised its formal coverage recommendation for Cervical Artificial Disc Replacement (CADR). The evidence-based coverage policy recommendation now includes support for both one and two-level CADR when clinically indicated (radiculopathy or myelopathy from disc degeneration following appropriate non-operative care). The Coverage Committee states that the "rationale for coverage of CADR is based on the indications and results of many randomized controlled trials (RCTs) that have compared the procedure to what most would consider the gold standard surgical treatment, anterior cervical discectomy and fusion (ACDF)" (Orthopreneur, December 2015).

**National Institute for Health and Care Excellence (NICE)**

In 2010, NICE issued a guidance statement on the use of prosthetic intervertebral disc replacement in the cervical spine. NICE concluded that the current evidence on the efficacy of prosthetic intervertebral disc replacement in the cervical spine shows that this procedure is as least as efficacious as fusion in the short term and may result in a reduced need for revision surgery in the long term. They further state that the evidence raises no particular safety issues that are not already known in relation to fusion procedures.

**Cervical Artificial Disc (Two Level)**

Zou et al. (2016) conducted a meta-analysis of randomized controlled trials to evaluate the clinical effects requiring surgical intervention between anterior cervical discectomy and fusion (ACDF) and cervical disc arthroplasty (CDA) at two contiguous levels cervical disc degeneration. The overall sample size at baseline was 650 patients (317 in the TDR group and 333 in the ACDF group). The results of the meta-analysis indicated that the CDA patients had significant superiorities in mean blood loss, reoperation, adjacent segment degeneration and Neck Disability Index. No significant difference was identified between the two groups regarding mean surgical time, neck and arm pain scores reported on a visual analog scale and rate of postoperative complications. The CDA group of sagittal range of motion (ROM) of the operated and adjacent levels, functional segment units (FSU) and C2-7 is superior to ACDF group by radiographic data of preoperation, postoperation and follow-up. The authors concluded that the cervical disc arthroplasty (CDA) group is equivalent and in some aspects has more significant clinical outcomes than the ACDF group at two contiguous levels cervical disc degeneration.

The purpose of a study by Radcliff et al. (2016) was to report the outcome of a study of 2-level cervical total disc replacement (Mobi-C®) versus anterior cervical discectomy and fusion (ACDF). This study reports the 5-year results of a prospective, randomized US FDA investigational device exemption (IDE) study conducted at 24 centers in patients with 2-level, contiguous, cervical spondylisis. Clinical outcomes at up to 60 months were evaluated, including validated outcome measures, incidence of reoperation, and adverse events. A total of 225 patients received the Mobi-C® cervical total disc replacement device and 105 patients received ACDF. The Mobi-C® and ACDF follow-up rates
were 90.7% and 86.7%, respectively, at 60 months. There was significant improvement in all outcome scores relative to baseline at all time points. The Mobi-C® patients had significantly more improvement than ACDF patients in terms of Neck Disability Index score, SF-12 Physical Component Summary, and overall satisfaction with treatment at 60 months. The reoperation rate was significantly lower with Mobi-C® (4%) versus ACDF (16%). There were no significant differences in the adverse event rate between groups. The authors concluded that there was significantly greater improvement in general in disease-specific outcome measures and a lower rate of reoperation in the 2-level disc replacement patients versus ACDF control patients.

In September 2016, ECRI Institute published a Health Technology Assessment Information Service Product Brief evaluating Mobi-C® Artificial Cervical Disc (Zimmer Biomet) for Treating Two-level Degenerative Cervical Disc Disease. They searched and selected web-based resources for documents relevant to the topic and published between January 1, 2011, and August 11, 2016. The report concluded that evidence from the review suggests that, compared with results of patients undergoing ACDF, patients with symptomatic cervical disc disease who underwent two-level Mobi-C® TDR had greater improvement in general and disease-specific outcomes, a lower reoperation rate, and less radiographic adjacent segment pathology. Results would need confirmation in another RCT to provide more definitive conclusions. It further states that evidence from the review suggests that two-level Mobi-C® was as safe and effective as one-level Mobi-C® TDR at two- to four-year follow-up. No differences between groups were found in clinical outcomes, overall complication rates, and subsequent surgery rates. Post-hoc analyses have certain limitations, however, so these findings would need to be confirmed in another prospective comparative study for definitive conclusions.

Subsequent to the 2013 publication, Davis and colleagues (2014) reported 48 month outcomes for this same cohort of subjects. The 48 month follow-up rate was 89% for the disc group and 81.2% for the fusion group. Statistical significance for two level disc replacement reported at 24 months was maintained at 48 months for NDI scores, SF-12 PCS scores, patient satisfaction, and overall success. The authors reported the overall success at 48 months for the disc group was statistically superior compared with the fusion group. The fusion group demonstrated a higher rate of adjacent segment degeneration, while the disc group maintained segmental range of motion with no device failure.

Hybrid Surgery
Artificial disc replacement at one level combined with spinal fusion surgery at another level (adjacent or non-adjacent) is referred to as hybrid surgery. There are few clinical trials to support improved health outcomes and patient selection criteria has not been firmly established.

Chen et al. (2016) retrospectively analyzed data from 108 patients with three-level cervical myelopathy who underwent hybrid surgery. Implantation of Bryan® artificial discs into two contiguous segments and cage fusion of adjacent segments was performed for all patients. Based on the Japanese Orthopedic Association (JOA) score, Neck Disability Index (NDI), and Odom’s criteria, the clinical symptoms and neurological function before and after surgery were evaluated. Mean follow-up duration was 36 months. At the final follow-up, the mean JOA scores were higher compared with preoperative values (15.08 ± 1.47 versus 9.18 ± 1.22) and the NDI values were decreased (12.32 ± 1.03 versus 42.68 ± 1.83). The clinical outcomes were rated as excellent (76 patients), good (22 patients), fair (six patients), and poor (four patients) based on Odom’s criteria. For patients with predominant nerve root symptoms, radicular pain of the upper limbs showed remission; in those with dominant symptoms of spinal cord compression, both muscle strength and sensation improved. Mean range of motion of segments with replaced artificial discs was not significantly different from the value obtained before surgery; the overall ROM of the cervical vertebrae was similar to the pre-surgery value. The main complications include postoperative infection, prosthesis movement, dysphagia, dysphonia, and heterotopic ossification. The authors concluded that these findings suggested a satisfactory clinical effectiveness for hybrid surgery but additional multicenter, long-term follow-up studies with large populations are needed to validate these findings.

Shi and colleagues (2015) performed a retrospective review of 36 patients with adjacent three-level cervical spondylorhesis who were treated with anterior cervical discectomy and fusion (ACDF) combined with cervical disc arthroplasty (CDA) (hybrid surgery) between October 2008 and October 2012. Clinical evaluation was based on the Neck Disability Index (NDI), Japanese Orthopaedic Association (JOA) score, and postoperative JOA score improvement rate (IR). Radiographic parameters, angular range of motion (ROM) for C2-C7, and ROM for the superior and inferior adjacent segments were measured before the operation, at 1, 3, 6, and 12 months post operation, and at the final follow-up evaluation. All cases were followed for at least 28 months. There was a significant postoperative improvement in NDI and JOA scores compared to preoperative levels. The JOA score improvement rate was 70.83 % at the final follow-up evaluation. One patient required a second surgery for symptomatic adjacent segment degeneration. The mean C2-C7 ROM, which was 46.39 ± 2.41° before the operation, was recovered after 12 months (46.03 ± 4.64°) and was maintained at the last follow-up evaluation (47.50 ± 4.59°). The ROM of the superior and inferior adjacent segments, which was 14.25 ± 1.81° and 10.89 ± 1.65° before the operation, respectively, was recovered after 6 months (14.03 ± 1.46° and 10.75 ± 2.37°, respectively) and increased at the last follow-up evaluation (15.00 ± 1.15° and 11.47 ± 1.84°, respectively). During the follow-up period, heterotopic ossification

Total Artificial Disc Replacement for the Spine
UnitedHealthcare Community Plan Medical Policy

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occurred in three patients. Adjacent segment degeneration was encountered in two cases, and one of these required a second surgical treatment. The authors concluded that the results indicate that hybrid surgery seems to be a promising, acceptable, and alternative surgical approach for the treatment of multi-level cervical disc disease. Some authors have investigated this method of treatment but the evidence in the published peer-reviewed literature is limited by lack of controls, small sample size and short term outcomes. Additional research is needed to clearly establish a role for hybrid technologies.

**Lumbar Artificial Disc**

Total disc replacement for multisegmental DDD in the lumbar spine is currently considered an off-label indication for disc replacement. Studies comparing the clinical outcomes of single-level disc replacement with disc replacement performed at more than one level remain limited.

ProDisc®-L: The second IVD device that has been proposed for use in the lumbar spine for the treatment of DDD is the ProDisc®-L. The ProDisc®-L Total Disc Replacement (Synthes Spine, Inc., West Chester, PA) is a weight-bearing modular implant consisting of two endplates and one polyethylene inlay. The endplates (i.e., one inferior and one superior) are manufactured from cobalt-chromium alloy, with the superior endplate available in two sizes (i.e., medium and large) and two lordotic angles (i.e., 6 and 11 degrees). The polyethylene inlay snap-locks into the inferior endplate of the inferior convex-bearing surface that articulates with the concave-bearing surface of the superior endplate. According to the manufacturer, the ProDisc®-L (previously known as the ProDisc® II) allows a range of 13 degrees of flexion and 7 degrees of extension, with lateral bending of ± 10 and axial rotation of ± 3.

ActivL® Artificial Disc is an implant that replaces the function of a damaged or diseased spinal disc. The ActivL® consists of two metal (cobalt-chromium with a titanium coating) endplates surrounding a plastic (polyethylene) insert. The endplates attach to the patient’s vertebrae, and the plastic insert fits between them. The insert is designed to move during daily activities. The device replaces a disc in the lumbar spine and is intended to relieve pain and allow forward and backward motion at the spinal level.

A systematic review of overlapping meta-analyses comparing total disc replacement (TDR) with fusion for treating lumbar degenerative disc disease (LDDD) was conducted by Ding et al. (2017). Five meta-analyses only comprising randomized controlled trials (RCTs) were included. This systematic review showed that there are conflicting results among these overlapping meta-analyses. Based on this systematic review, the best available evidence indicated that TDR compared with fusion for LDDD had statistically, but not clinically, significant superiority regarding disability, pain relief, and quality of life in a selected group of patients in the short term. The prevention of adjacent segment and facet joint degeneration, as the primary reason for adopting TDR noted by the manufactures, was not appropriately evaluated. This study could not assess the long-term results, because almost all of the primary studies only have data for 2 years. The authors concluded the current best available evidence suggests that TDR may be an effective technique for the treatment of selected patients with LDDD, and is at least equal to lumbar fusion in the short term. However, considering that disadvantages may appear after years, spine surgeons should be cautious about performing TDR on a large scale.

A systematic review and meta-analysis was performed by Lackey et al. (2016) to assess the effect of hybrid constructs which involve a total disc arthroplasty (TDA) with stand-alone anterior lumbar interbody fusion (ALIF) versus non-hybrid constructs including posterior transpedicular fixation or multi-level stand-alone ALIF as a surgical intervention for degenerative disc disease (DDD) in the lumbar spine. Primary outcomes analyzed included the Oswestry Disability Index (ODI) and the Visual Analogue Scale (VAS) for back pain. Three studies met inclusion criteria. When comparing hybrid constructs to multi-level TDA or lumbar fusion (LF) improvements in back pain were found with a VAS back pain score reduction of 1.38 postoperatively and a VAS back pain score reduction of 0.99 points at 2-years follow-up. Current results slightly favor clinically significant improved VAS back pain score outcomes postoperatively and at 2-years follow-up for hybrid constructs in multi-level lumbar DDD of the spine when compared with non-hybrid multi-level LF or TDA. The authors stated that it cannot be concluded that a hybrid construct is superior to multi-level LF or TDA based on this meta-analysis and recommend further prospective studies to delineate best practice in the management of degenerative disc disease of the lumbar spine.

Pimenta et al. (2016) conducted a prospective nonrandomized single-center study to analyze results of XL-TDR for the treatment of symptomatic degenerative disc disease. Sixty cases were enrolled. Eleven of 60 patients (18%) had not completed at least a 5-year follow-up (FUP), and 49 were enrolled in the analysis. The mean FUP was 93 months. End points included visual analog scale (VAS) and Oswestry Disability Index (ODI) questionnaires, radiographic outcomes (radiographs and CT) such as heterotopic ossification (HO) and maintenance of disc motion, complications, reoperation, and heterotopic ossification grades. All but 3 patients stood up/walked at the same day. Five levels (10%; 5/53) required fusion. Two cases (4%; 2/49) evolved with adjacent level disease that required surgery. One case required sacroiliac fusion. One partial disc migration was identified. Flexion extension films from 38 levels were available at least at a 5-year FUP. HO grade 0 = 13%; grade I =18%; grade II = 32%; grade III = 16%; grade IV = 21% (8 cases). Most heterotopic ossification cases (85%) occurred in the lateral aspect of the disc space. Patient-
reported outcomes showed significant improvement maintained up to a minimum of 5 years. VAS back pain: preoperative 8.5, postoperative early 2.5, and last FUP 3.0. ODI: preoperative 54%, postoperative early 31%, and last FUP 21%. The authors concluded that the data show satisfactory sustained pain relief and improved physical function for the patients and lumbar artificial disc replacement done by the lateral approach seems to be a feasible effective treatment for mild degenerative disc disease. Further research with larger randomized controlled trials is needed to validate these findings.

An August 2015 Hayes Medical Technology assessment evaluated 7 randomized controlled trials (RCTs), 1 nonrandomized trial, and 6 controlled studies with long-term (7 to 17 years) results published between 2002 through July 2015. A total of 2882 patients who underwent one or two level disc replacement treatment were included. The findings suggest that 1-level lumbar disc replacement (LDR) is comparable in efficacy and safety to fusion for the treatment of symptomatic degenerative disc disease in selected patients who have failed conservative treatment. Questions remain regarding the long-term safety of lumbar disc replacement and there is insufficient evidence comparing LDR with continued treatment with more conservative nonsurgical treatment options.

A Cochrane review (Jacobs, et al., 2012) was conducted to determine how total disc replacement compared with other treatments for chronic low back pain. The review included seven randomized trials involving 1474 subjects in total, and involved the use of four discs: Charite®, Maverick®, Prodisc-L®, and Flexicore®. Six of the trials compared disc replacement to lumbar fusion and one compared disc replacement to nonsurgical treatment consisting of a rehabilitation protocol with cognitive treatment and physical therapy. Follow-up was 24 months in all studies with the exception of one which was five years. The subjects who had disc replacement surgery had slightly better back pain and function outcome scores compared to those who had fusion surgery; the differences did not appear clinically significant. The studies did not demonstrate any other benefit and did not provide any information regarding long-term risks. As a result, the review concluded the spine surgery community should be cautious with regards to adopting the technology on a large scale; long-term outcomes are lacking. Pain relief outcomes are short-term and studies evaluating adjacent segment degeneration and facet joint degeneration are lacking.

Berg et al. (2009) conducted a randomized controlled trial (RCT) comparing total disc replacement (TDR) and instrumented lumbar fusion in 152 patients. Patients in the TDR group were randomized to receive the Charite®, Prodisc® or the Maverick® artificial disc. Outcomes were measured utilizing global assessment (GA), visual analog scale (VAS) for back and leg pain, Oswestry Disability Index, SF36 and EQ5D at 1 and 2 years. There were no differences in outcomes between 1 or 2-level surgery, or between different TDR devices, nor the two different fusion techniques (PLF and PLIF). At 1 year post procedure, the TDR group showed greater improvement in all outcome measurements however by 2 years post procedure, the fusion group had results similar to the TDR group. This study showed that TDR had better outcomes initially however by 2 years, TDR and fusion had similar results. The study is limited by short-term follow-up and subjective outcomes. Additional studies are needed to establish long-term efficacy.

Pro-Disc®

Park et al. (2015) conducted a retrospective analysis to evaluate successful outcomes following lumbar total disc replacement (TDR) using ProDisc® II on 54 patients (81 segments) between March 2002 and February 2007. Data was reviewed at 1, 2, 5 and 7 year follow-up. Clinical outcomes were evaluated using Visual Analog Scale (VAS), Oswestry Disability Index (ODI), and subjective satisfaction (4-point scale). Radiographic results included segmental range of motion (ROM). Total VAS scores decreased significantly at postoperative 1 year and 2 year, compared with preoperative VAS score. Although total VAS scores increased until the last follow-up, they remained significantly lower than the preoperative value. All postoperative ODI scores at any follow-up time were significantly lower than the baseline value. There was significant increase in ODI scores between 2-year and last follow-up. The final range of motion (ROM) was shown to be lower than the preoperative ROM and lumbar lordosis was increased and well-maintained during all postoperative follow-up times. Five patients (9.3%) required revision fusion surgeries. A small sample size makes it difficult to decide whether these conclusions can be generalized to a larger population.

In 2011 Delamarter et al. published the results of a prospective randomized multicenter FDA IDE trial evaluating the ProDisc-L® compared to circumferential fusion for two-level DDD. Reported outcomes included patient self-assessments, physical, neurological and radiograph assessment pre-operatively and six weeks, three, six, twelve, eighteen and twenty-four months postoperatively. Although ODI scores significantly improved in both groups from preoperative to postoperative, results were significantly better in the total disc group. A significant reduction in narcotic usage was also reported for the disc group. In the authors opinion two-level lumbar disc replacement using the ProDisc-L® device was a viable alternative to lumbar arthrodesis for the treatment of two-level disc disease.

In a prospective, randomized, multicenter, Food and Drug Administration-regulated Investigational Device Exemption clinical trial by Zigler et al. (2007), 286 patients were enrolled to study the ProDisc-L® total disc replacement system versus circumferential fusion for the treatment of 1-level degenerative disc disease. Patients were evaluated before and after surgery, at 6 weeks, 3, 6, 12, 18, and 24 months. There were no complications reported for the ProDisc-L®. Follow-up at 6 weeks and 3 months showed the ProDisc-L® patients recorded SF-36 Health Survey scores significantly
higher than the control group (P = 0.018, P = 0.0036, respectively). Comparison of the 2 groups using the Oswestry Low Back Pain Disability Questionnaire (Oswestry Disability Index [ODI]) showed improvement in 91.8% of the investigational and 84.5% of the control patients at 24 months. Review of radiographic range of motion showed maintenance within normal functional range to be 93.7% in the investigational patients and averaged 7.7 degrees. It was concluded that in properly chosen patients, ProDisc-L® appears to be superior to circumferential fusion by multiple clinical criteria. The study is limited by short-term follow-up and subjective outcomes. Additional studies are needed to establish long-term efficacy.

Kim et al. (2007) completed a prospective controlled study of 32 patients who underwent lumbar total disc replacement using the ProDisc® II prosthesis. Patients were monitored for 24 months. Nineteen patients had single level total disc replacements (TDR), while 11 patients had TDR at two levels. Radiographic documentation of each patient's range of motion (ROM) was obtained prior to and every 6 months following TDR. Differences between these measures were compared and the outcomes were reported using degrees as a control measure. Visual analog and disability indexes improved significantly during the follow up period. ROM improved within the first 6 months at levels L3-4 and L4-5 being noted. ROM decreased following TDR at the L5-S1 level, with no significant improvement noted at any time. The level of the TDR was found to be a potential negative factor in the minimal gains that were achieved in ROM. Long-term patient follow-up is needed to determine the clinical outcomes of using this prosthesis in the lumbar spine.

Tropiano et al. (2005) reported on 64 patients who had single or multiple-level implantation with a Prodisc® total lumbar disc replacement. The follow-up period was 7 to 11 years with a mean of 8.7 years. There were significant improvements in back pain, radiculopathy, disability, and modified Stauffer-Coventry scores. Radiographs did not identify loosening, migration, or mechanical failure in any patient. A patient age of less than 45 years and a history of prior lumbar surgery had small but significant negative effects on outcome. Five patients had approach-related complications. The relatively small number of patients and lack of randomization and a control group are weaknesses of this study.

A retrospective study by Yaszay et al. (2008) of 42 patients enrolled in a prospective randomized FDA ProDisc®-L trial, were analyzed to determine factors that could influence motion and patient satisfaction following total disc replacement (TDR) at L4/5 or L5/S1. The patients selected received a TDR at L4/5 or L5-S1. Pre- and postoperative disc height and range of motion (ROM) were measured from standing lateral and flexion-extension radiographs. Anterior and posterior disc heights increased; however, the patients' ROM had decreased. Threshold factors (i.e., anterior and posterior disc heights) that were analyzed showed patients with <9 mm of anterior disc height had an increased ROM of 2.2°of disc height had a -2.2 decrease in their ROM. These findings were considered significant. While improvements were noted based on patient reported visual analog scale scores and Oswestry Disability Index measures, no significant difference between the groups could be found that would explain the average decrease in ROM from 7.0° to 5.7°patients following the use of TDR will determine if the ROM gains will be maintained.

In 3 case series (n=22, 25, 104 patients) of ProDisc® implants, Bertagnoli reported statistically significant improvements in pain and disability at 2 to 4 year follow-up (Bertagnoli, 2005a; Bertagnoli, 2005b; Bertagnoli, 2006). The relatively small number of patients, lack of control groups and short-term follow-up are weaknesses of these studies.

**activL® Artificial Disc**

Garcia et al. (2015) conducted a prospective, multicenter, randomized, controlled, investigational device exemption (IDE) trial to evaluate the comparative safety and effectiveness of lumbar total disc replacement (TDR) in the treatment of patients with symptomatic degenerative disc disease (DDD) who are unresponsive to nonsurgical therapy. The study consisted of patients presenting with symptomatic single-level lumbar DDD who failed at least 6 months of nonsurgical management. They were randomly assigned to treatment with an investigational TDR device (activL®, n=218) or FDA-approved control TDR devices (ProDisc-L® or Charité®, n=106). Patient satisfaction with treatment was over 90% in both groups at 2 years. Back pain severity improved 74% with activL® and 68% with controls. Oswestry Disability Index (ODI) improved 67% with activL® and 61% with controls and Physical Component Summary score (88%vs. 81%) favored the activL® group. The percentage of patients working full-time with no restrictions increased from 33% at pretreatment to 57% at 2 years with activL® and from 33% to 49% with control. Return to work was approximately 1 month shorter with activL® versus controls. The percentage of patients with disc height increase >3mm was 94% with activL® and 87% with controls. Change in range of motion in lateral flexion-extension radiographs was statistically greater with activL® compared with controls in segmental rotation and translation but not in lateral rotation on side-bending radiographs. The rate of device-related serious adverse events was lower in patients treated with activL® versus controls (12% vs. 19%). Surgical reintervention rates were comparable (activL® 2.3%, control 1.9%). The authors concluded that the single-level activL® TDR is safe and effective for the treatment of symptomatic lumbar DDD through 2 years. The long-term durability of the activL® TDR is unknown and requires further investigation.
**Professional Societies**

**American Pain Society**
Guidelines from the American Pain Society (Chou 2014) found insufficient evidence regarding long-term benefits and harms of disc replacement to support recommendations. Vertebral fusion is the most common surgery for chronic, nonspecific low back pain. Surgical instrumentation (use of pedicle screws or other hardware) increases fusion rates, but it is not known if instrumentation improves clinical outcomes. More research with longer follow-up is needed to determine the appropriate role of artificial disc replacement versus fusion. The authors suggest that vertebral fusion be performed for patients who undergo surgical intervention for chronic low back pain.

**National Institute for Health and Care Excellence (NICE)**
In 2009 NICE concluded that the current evidence on the safety and efficacy of prosthetic intervertebral disc replacement in the lumbar spine is adequate to support its use in the lumbar spine.

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**U.S. FOOD AND DRUG ADMINISTRATION (FDA)**

**Lumbar**
The following lumbar disc replacement products (product code MJO) have received FDA approval:

- The activL® Artificial Disc (Aesculap Implant Systems, LLC) received FDA Premarket Approval on June 11, 2015. It is indicated for people who have fully formed and fully grown bones (are skeletally mature), have low back pain due to a problem with one lumbar disc (as determined by a doctor), have been diagnosed as having degenerative disc disease (DDD) in only one lumbar disc at either level L4/L5 or L5/S1 (as determined by a doctor), and have gone through at least six months of nonsurgical treatment without relief. The device is designed to help stabilize the operated spinal level and allow motion at the level. Additional information is available at: [http://www.fda.gov/medicaldevices/productsandmedicalprocedures/deviceapprovalsandclearances/recently-approveddevices/ucm455656.htm](http://www.fda.gov/medicaldevices/productsandmedicalprocedures/deviceapprovalsandclearances/recently-approveddevices/ucm455656.htm). (Accessed February 26, 2017)

- The Charite® intervertebral disc (DePuy Spine, Inc., Raynham, MA) received FDA Premarket Approval on October 26, 2004. It is approved for use in patients who have single-level degenerative disc disease (L4-S1) of the lumbar spine and who have had no relief from low back pain after at least six months of nonsurgical treatment. Removed from the market in 2012. Additional information is available at: [http://www.accessdata.fda.gov/cdrh_docs/pdf4/p040006a.pdf](http://www.accessdata.fda.gov/cdrh_docs/pdf4/p040006a.pdf). (Accessed February 26, 2017)

- The ProDisc-L® Total Disc Replacement received FDA Premarket Approval on August 14, 2006 for use in patients who have single-level degenerative disc disease of the lumbar spine (L3-S1) and who have had no relief from low-back pain after at least 6 months of nonsurgical treatment. Additional information is available at: [http://www.accessdata.fda.gov/cdrh_docs/pdf5/P050010A.pdf](http://www.accessdata.fda.gov/cdrh_docs/pdf5/P050010A.pdf). (Accessed March 8, 2017)

**Cervical**
The following cervical disc replacement products (product code MJO) have received FDA approval:

- **Mobi-C® Cervical Disc Prosthesis** received premarket approval on August 7, 2013. (P110002). The Mobi-C® Cervical Disc Prosthesis consists of two metal (cobalt-chrome alloy2) endplates and a plastic (ultra-high molecular weight polyethylene) insert that fits between the endplates. The device is placed between two adjacent neck bones (cervical vertebrae) to replace a diseased cervical disc that is causing arm pain and/or weakness or numbness. The device is indicated for skeletally mature patients who have stopped growing to replace a cervical disc in the neck (from C3-C7) following removal of the disc for conditions that result from a diseased or bulging disc at only one spinal level. The device should help stabilize the operated spinal level and allow motion at the level. Unlike a fusion procedure, the Mobi-C® Cervical Disc Prosthesis is designed to allow motion at the operated spinal level. The effects of the diseased disc removal should include pain relief and improved function. Additional information is available at: [http://www.accessdata.fda.gov/cdrh_docs/pdf11/P110002a.pdf](http://www.accessdata.fda.gov/cdrh_docs/pdf11/P110002a.pdf). (Accessed February 26, 2017)

- **Mobi-C® Cervical Disc Prosthesis (two-level)** received premarket approval of August 23, 2013. (P110009). The Mobi-C® Cervical Disc Prosthesis consists of two metals (cobalt-chrome endplates and a plastic (ultra-high molecular weight polyethylene) implant that fits between the endplates. The device is placed between two adjacent neck bones (cervical vertebrae) to replace a diseased cervical disc at two adjacent levels that are causing arm pain and/or weakness or numbness. The Mobi-C® Cervical Disc Prosthesis is intended for skeletally mature patients (people who have stopped growing) to replace two adjacent cervical discs in the neck (from C3-C7) following removal of the discs for conditions that result from a diseased or bulging disc at two adjacent spinal levels. The two devices should help stabilize the operated spinal levels. Unlike a fusion procedure the Mobi-C® Cervical Disc Prosthesis is designed to allow motion at the operated spinal levels. The effects of removing the diseased discs should include pain relief and improved function. Additional information is available at: [http://www.accessdata.fda.gov/cdrh_docs/pdf11/P110009a.pdf](http://www.accessdata.fda.gov/cdrh_docs/pdf11/P110009a.pdf). (Accessed February 26, 2017)

- **ProDisc-c® Total Disc Replacement** received premarket approval on December 17, 2007 (P070001). The device is indicated for skeletally mature patients for reconstruction of the disc from C3-C7 following single-level discectomy for intractable symptomatic cervical disc disease (SCDD). Symptomatic cervical disc disease is defined
as neck or arm (radicular) pain and/or a functional/neurological deficit with at least one of the following conditions confirmed by imaging (CT, MRI, or x-rays): herniated nucleus pulposus, spondylosis (defined by the presence of osteophytes) and/or loss of disc height. The ProDisc-C® total disc replacement is implanted via an open anterior approach. Patients receiving the ProDisc-C® total disc replacement should have failed at least six weeks of non-operative treatment prior to implantation. Additional information is available at: http://www.accessdata.fda.gov/cdrh_docs/pdf7/p070001a.pdf. (Accessed February 26, 2017)

- **Prestige® LP Cervical Disc** received premarket approval on July 24, 2014. Indicated in skeletally mature patients for reconstruction of the disc at one level from C3-C7 following single-level discectomy for intractable radiculopathy (arm pain and/or a neurological deficit) with or without neck pain, or myelopathy due to a single-level abnormality localized to the level of the disc space and at least one of the following conditions confirmed by imaging (CT, MRI, x-ray): herniated nucleus pulposus, spondylosis (defined by the presence of osteophytes), and/or visible loss of disc height as compared to adjacent levels. In July 2016, the Prestige® LP received FDA approval for implantation at 2 levels. Additional information is available at: http://www.accessdata.fda.gov/cdrh_docs/pdf9/. (Accessed February 26, 2017)

- **Prestige® Cervical Disc System** received premarket approval on July 16, 2007 (P060018). The device is indicated in skeletally mature patients for reconstruction of the disc from C3-C7 following single-level discectomy for intractable radiculopathy and/or myelopathy. The PRESTIGE® device is implanted via an open anterior approach. Intractable radiculopathy and/or myelopathy should present with at least one of the following items producing symptomatic nerve root and/or spinal cord compression which is documented by patient history (e.g., pain [neck and/or arm pain], functional deficit, and/or neurological deficit), and radiographic studies (e.g., CT, MRI, x-rays, etc.): 1) herniated disc, and/or 2) osteophyte formation. The safety and effectiveness of the device has not been established in patients who have not undergone at least six weeks of conservative treatment or had signs of progression or spinal cord nerve root compression with continued non-operative care. Additional information is available at: http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfpma/pma.cfm?id=P060018. (Accessed March 8, 2017)

- **Bryan® Cervical Disc** received premarket approval on May 12, 2009 (P060023). The device is indicated in skeletally mature patients for reconstruction of the disc from C3-C7 following single-level discectomy for intractable radiculopathy and/or myelopathy. The Bryan® device is implanted via an open anterior approach. Intractable radiculopathy and/or myelopathy is defined as any combination of the following: disc herniation with radiculopathy, spondylotic radiculopathy, disc herniation with myelopathy or spondylotic myelopathy resulting in impaired function and at least one clinical neurological sign associated with the cervical level to be treated, and necessitating surgery as demonstrated using computed tomography (CT), myelography and CT and/or magnetic resonance imaging (MRI). Patients receiving the Bryan® Cervical Disc should have failed at least six weeks of non-operative treatment prior to implantation. Additional information is available at: http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfpma/pma.cfm?id=P060023. (Accessed March 8, 2017)

- **SECURE®-C Artificial Cervical Disc** received premarket approval on September 28, 2012 (P100003). The SECURE®-C Artificial Cervical Disc is intended to be used in skeletally mature patients (people who have stopped growing) to replace a cervical disc in the neck (from C3-C7) following removal of the disc for conditions that result from a diseased or bulging disc (intractable radiculopathy3 or myelopathy4) at only one level. The device should help stabilize the operated disc in the neck. Unlike a fusion procedure5, the SECURE®-C Artificial Cervical Disc is designed to allow motion at the operated disc. The effects of the diseased disc removal should include pain relief and improved function. Additional information is available at: http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfpma/pma.cfm?id=P100003. (Accessed March 8, 2017)

- **PCM® Cervical Disc System** received premarket approval on October 26, 2012 (P100012). The PCM Cervical Disc consists of two metal (cobalt-chrome alloy) endplates and a plastic (ultra-high molecular weight polyethylene) insert that fits between the endplates. The device is placed between two adjacent neck bones (vertebrae) to replace a diseased cervical disc2 that is causing arm pain and/or weakness or numbness. The PCM Cervical Disc is intended to be used in skeletally mature patients (people who have stopped growing) to replace a cervical disc from C3-C7 following removal of the disc for conditions that result from a diseased or bulging disc (intractable radiculopathy3 or myelopathy4) at only one level. The device should help stabilize the operated disc in the neck (spinal level). Unlike a fusion procedure5, the PCM Cervical Disc is designed to allow motion at the operated spinal level. The effects of the diseased disc removal should include pain relief and improved function. Additional information is available at: http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfpma/pma.cfm?id=P100012. (Accessed March 8, 2017)

**CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)**

Medicare does not have a National Coverage Determination (NCD) for cervical artificial disc replacement. Local Coverage Determinations (LCDs) exist, refer to the LCDs for [Category III CPT® Codes](http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfpma/pma.cfm?id=P100018), [Non-Covered Category III CPT Codes](http://www.accessdata.fda.gov/cdrh_docs/pdf7/p070001a.pdf), [Non-Covered Services](http://www.accessdata.fda.gov/cdrh_docs/pdf7/p070001a.pdf), [Services that are Not Reasonable and Necessary](http://www.accessdata.fda.gov/cdrh_docs/pdf7/p070001a.pdf) and [Surgery: Fusion for Degenerative Joint Disease of the Lumbar Spine](http://www.accessdata.fda.gov/cdrh_docs/pdf7/p070001a.pdf).
Medicare does not cover lumbar artificial disc replacement (LADR) for Medicare population over 60 years of age. For Medicare beneficiaries 60 years of age and younger, there is no national coverage determination for LADR, leaving such determinations to continue to be made by the local contractors. Refer to the NCD for Lumbar Artificial Disc Replacement (LADR) (150.10). LCDs exist; see the LCDs for Non-Covered Services and Services that are Not Reasonable and Necessary. (Accessed March 10, 2017)

REFERENCES


Chou R. Subacute and chronic low back pain: Surgical treatment. April 2014. UpToDate Inc., Waltham, MA.


### POLICY HISTORY/REVISION INFORMATION

<table>
<thead>
<tr>
<th>Date</th>
<th>Action/Description</th>
</tr>
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<tbody>
<tr>
<td>05/01/2017</td>
<td>• Updated list of related policies; added reference link to Medicare Advantage Coverage Summary titled <em>Artificial Disc Replacement, Cervical and Lumbar</em></td>
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<tr>
<td></td>
<td>• Updated supporting information to reflect the most current clinical evidence, FDA and CMS information, and references; no change to coverage rationale or lists of applicable codes</td>
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