



State of Wyoming

Department of Workforce Services



Matthew H. Mead
Governor

DIVISION OF WORKERS' COMPENSATION
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Cheyenne, Wyoming 82002
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John Cox
Director
John Ysebaert
Deputy Director

PREAUTHORIZATION CHECK SHEET LUMBAR ARTIFICIAL DISC

Claimant: _____ Claim Number: _____ DOI: _____
Surgeon: _____ Phone Number: _____ Contact: _____

PRODISC-L

FDA GUIDELINES INDICATE SURGERY FOR ONE LEVEL ONLY.

Compensability should NOT be in question at the time of preauthorization for this procedure.

This procedure **REQUIRES** peer review by spine surgeons.

1. Pre-operative work up should be documented in the medical notes. **ALL CRITERIA ARE REQUIRED**
2. Dates should be documented for all diagnostic tests performed.
3. If medical data is lacking, the surgeon will be required to provide the missing information.

Surgeon meets training qualifications YES NO
COPY OF TRAINING CERTIFICATE MUST BE INCLUDED

Oswestry Low Back Disability Questionnaire YES NO

Indications: Degenerative disc disease at **ONE** level, level L3-S1 (Prodisc), causing discogenic low back pain, confirmed by patient history, physical examination, radiographic studies and procedure(s) to isolate the causative disc. Patients must have no more than a grade 1 spondylolisthesis, have failed at least 6 months of verified conservative therapy, and be skeletally mature (18 to 60 years of age).

1. MRI (Within last 12 months, must show degenerative disc disease L3-S1 for Prodisc)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date: _____
2. Discogram (Preferred but not required, must indicate concordant pain at L3-S1 for Prodisc)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date: _____
3. Plain x-rays obtained (within last 12 months):			
a. Standing AP	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date: _____
b. Standing Lateral Flexion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date: _____
c. Standing Lateral Extension	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date: _____
d. Any evidence of mechanical instability or alignment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date: _____
e. Documentation the x-rays were taken in the <u>upright</u> position.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date: _____



q. Autoimmune disorder.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
r. Calcification of abdominal vasculature per plain x-rays or CT scan.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
s. History of previous major anterior vessel surgery.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
t. Obesity. (Body mass index > 40 or 100 lbs. over ideal body weight)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
u. Vertebral endplate dimensionally smaller than 34.5 mm in the lateral and/or 27 mm in the anterior-posterior directions.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
v. Rheumatoid arthritis.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
w. Clinically compromised vertebral bodies at the affected level due to current or past trauma.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
x. Isolated radicular compression syndromes, especially due to disc herniation.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
y. Pars defect.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
z. Bony lumbar stenosis.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
aa. Evidence of inability to understand the procedure.	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Requesting Surgeon Signature

Date

Workers' Comp NCM Name

Date

Sent for Peer Review

Date

Notes:

Date: _____

References

US Food and Drug Administration. Page last updated 9/5/13. Prodisc-L Total Disc Replacement-P050010. Retrieved 2/6/14 from:
<http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/DeviceApprovalsandClearances/Recently-ApprovedDevices/ucm077620.htm>

