WYOMING WORKERS’ SAFETY AND COMPENSATION
PREAUTHORIZATION CHECK SHEET
PRESTIGE ARTIFICIAL DISC
Cervical

Claimant: ____________________  Case Number: ____________  DOI: ____________
Surgeon: ____________________  Phone Number: ____________  Contact: ____________
Date of Review: ____________  Reviewer: _________________

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

***This procedure REQUIRES individual peer review by a spine surgeon.***

***The form must be completed in its entirety prior to submitting the record for peer review. Specific restrictions are listed below.***

Indication for use: Use of the Prestige cervical disc prosthesis is approved following single level anterior discectomy from C3-C4 to C7-T1 for intractable radiculopathy and/or myelopathy in skeletally mature patients (minimal age 18).

Date of Training by requesting Surgeon:

I. Pre-operative work up documented in the medical record to include ALL of the following criteria. DATES FOR ALL DIAGNOSTICS MUST BE LISTED.

A. Intractable radiculopathy and/or myelopathy, documented by:
   1. Patient history. Shoulder/arm and neck pain.  [Yes] [No] [Not Documented]
   2. Reported functional deficit.  [Yes] [No] [Not Documented]

B. Physical Examination:
   1. Neck ROM limited by pain.  [Yes] [No] [Not Documented]
   2. Neurological deficit/Pathological findings.  [Yes] [No] [Not Documented]

C. MRI. Date: ________________  [Yes] [No] [Not Documented]

D. Plain X-rays including lateral - flexion extension views.
   Date: ________________  [Yes] [No] [Not Documented]

E. CT scan for facet evaluation, dependent upon patient age.
   Date: ________________  [Yes] [No] [Not Documented]

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II. Patient selection criteria:

A. Radiculopathy and/or Myelopathy.  
   - Yes  
   - No

B. Single level symptomatic.  
   - Yes  
   - No

C. Preserved motion and disc space height at symptomatic level.  
   - Yes  
   - No

D. Unresponsive to non-operative treatment.
   1. Physical therapy.  
      - Yes  
      - No
   2. Oral anti-inflammatory medications.  
      - Yes  
      - No
   3. Injection therapy.  
      - Yes  
      - No
   4. Chiropractic manipulation.  
      - Yes  
      - No

***Note:  1. Use of all of these treatment modalities is not required.
         2. The patient may continue to work during conservative care.

III. Patient Contraindications (which also will result in denial of reimbursement):

A. All patient selection criteria are not met.  
   - Yes  
   - No

B. Significant degeneration/herniation at other levels.  
   - Yes  
   - No

C. Prior anterior cervical surgery.  
   - Yes  
   - No

D. Significant facet arthritis at operative level.  
   - Yes  
   - No

E. Cervical instability:
   1. Sagittal plane translation >3.5mm.  
      - Yes  
      - No
   2. Sagittal plane angulation >20 degrees.  
      - Yes  
      - No

F. Significant kyphosis.  
   - Yes  
   - No

G. Osteoporosis.  
   - Yes  
   - No

H. Cancer.  
   - Yes  
   - No

I. Infection.  
   - Yes  
   - No

J. Allergy to stainless steel.  
   - Yes  
   - No

IV. Contingency Treatment Plan:
   This is a new procedure and its long-term efficacy has not been established. The Division would like to know your follow up treatment plan if the patient remains symptomatic or develops adjacent segment disease.  
   Please explain.

Sent for physician review:
Doctor: _______________
Date: _______________

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