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Governor

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PREAUTHORIZATION CHECK SHEET
CERVICAL ARTIFICIAL DISC

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

☐ Mobi-C ☐ Secure-C ☐ Bryan-C

☐ Prestige-C ☐ ProDisc-C ☐ PCM-C

FDA Guidelines indicate surgery for one level only, with the exception of the Mobi-C which has been approved for replacement of two (2) adjacent cervical discs/levels

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 REQURED.**
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 Neck Pain Questionnaire ☐ YES ☐ NO

Indications: Use of the cervical artificial disc following SINGLE level discectomy from C3-C7 for skeletally mature patients (18-60 years of age) with conditions that result in diseased or bulging disc (intractable radiculopathy and/or myelopathy). The Mobi-C can be used to replace two adjacent cervical discs from C3-C7 for the same pathology. (No previous fusion at the same levels or adjacent levels.)

1. MRI (Within last 12 months, must show degenerative disc disease at C3-C7).	☐ Yes	☐ No	Date:
2. Discogram (preferred but not required, must indicate concordant pain at C3-C7).	☐ Yes	☐ No	Date:
3. Plain x-rays obtained (within last 12 months): a. Standing AP. b. Standing Lateral Flexion.	 ☐ Yes ☐ Yes	 ☐ No ☐ No	 Date: _____ Date: _____

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c. Standing Lateral Extension. d. Any evidence of mechanical instability or alignment. e. Documentation the x-rays were taken in the *upright* position.	☐ Yes ☐ Yes ☐ Yes	☐ No ☐ No ☐ No	Date: _____
4. Complete history and physical documenting the need for surgery and any contraindications.	☐ Yes	☐ No	Date:

5. One of the following conditions must be confirmed by imaging: a. Herniated nucleus pulposus. b. Spondylosis defined by the presence of osteophytes. c. Loss of disc height.	 ☐ Yes ☐ Yes ☐ Yes	 ☐ No ☐ No ☐ No
6. Previous spine surgeries, including locations and dates. (List below): **SURGERY WILL BE DENIED IF PREVIOUS SPINAL FUSION AT THE SAME LEVEL OR ADJACENT LEVEL.**	☐ Yes	☐ No
7. Conservative therapy been tried FOR AT LEAST 6 MONTHS. If yes, specify the therapy and the dates initiated on (List below):	☐ Yes	☐ No
8. Active smoker (smoking)	☐ Yes	☐ No
9. Substance abuse (drugs or alcohol)	☐ Yes	☐ No
10. Patient Contraindications: a. Osteopenia or osteoporosis with a measured T-score<1 b. Significant degeneration/herniation at other levels. c. Prior anterior cervical surgery. d. Significant facet arthritis at the operative level or at a level not treated by the replacement of disc e. Symptomatic or congenital stenosis. (*Some radiology reports may mention, "Central narrowing" but the surgeon may think it is insignificant or unrelated to the patient's symptoms.)* f. Marked cervical instability on radiographs (radiographic signs of subluxation >3.5mm or angulation of the disc space more than 11 degrees greater than adjacent segments g. Significant kyphotic deformity or significant reversal of lordosis. h. Severe spondylosis characterized by bridging osteophytes or a loss of disc height >50% or an absence of motion <2 degrees.	 ☐ Yes ☐ Yes ☐ Yes ☐ Yes ☐ Yes ☐ Yes ☐ Yes ☐ Yes	 ☐ No ☐ No ☐ No ☐ No ☐ No ☐ No ☐ No ☐ No

i. History of chronic steroid use. (*If a history of long term steroid use, may still have disc if now off of steroids, bone density scan with factor > or equal 1.0, and not expected to require chronic steroid therapy in the future.)*	☐ Yes	☐ No
j. Allergy to titanium, polyethylene, cobalt, chromium, or molybdenum.	☐ Yes	☐ No
k. Pregnancy.	☐ Yes	☐ No
l. Active infection, systemic (AIDS, HIV, Hepatitis) or localized spinal.	☐ Yes	☐ No
m. Autoimmune disorder.	☐ Yes	☐ No
n. Calcification of abdominal vasculature per plain x-rays or CT scan.	☐ Yes	☐ No
o. History of previous major anterior vessel surgery.	☐ Yes	☐ No
p. Obesity. (*Body mass index >40 or 100 lbs. over ideal body weight)*	☐ Yes	☐ No
q. Vertebral endplate dimensionally smaller than 34.5mm in the lateral and/or 27mm in the anterior-posterior directions	☐ Yes	☐ No
r. Rheumatoid arthritis.	☐ Yes	☐ No
s. Clinically compromised vertebral bodies at the affected level due to current or past trauma.	☐ Yes	☐ No
t. Significant cervical anatomical deformity or compromised vertebral bodies at the index level (ankylosing spondylitis, rheumatoid arthritis)	☐ Yes	☐ No
u. Symptoms necessitating surgical treatment at more than one cervical level.	☐ Yes	☐ No
v. Evidence of inability to understand the procedure.	☐ Yes	☐ No

Requesting Surgeon Signature _____ Date _____

Sent for Peer Review _____ Date _____

Notes: Date: _____

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