Medical Management & Policy
Fax Number: 412-544-2921

Certificate of Medical Necessity (CMN) for Osteogenic Stimulators

Date: ____/_____/_____ **Requesting Provider: _____**

Ultrasonic – Non-spinal (E0760)			
1. Does the patient have a nonunion of a long-bone fracture?	Y	N	D
2. Date of fracture: _____			
3. Date of recent X-ray _____			
4. Has there been evidence of fracture healing?	Y	N	
5. If a FRESH fracture – what treatment has been provided, and why is an Ultrasonic stimulator being requested?			
6. Are any other stimulators currently in use for the same problem?			
Electrical – Non-spinal (20974/20975/E0747)			
1. Does the patient have a nonunion of a long-bone fracture? 2.	Y	N	D
2. Does the patient have failed fusion of a joint other than the spine?	Y	N	D
3. Does the patient have a congenital pseudoarthrosis?	Y	N	D
4. Date of fracture/fusion _____			
5. Date of recent X-ray _____			
6. Has there been any evidence of fracture healing?	Y	N	
Electrical – Spinal (E0748/20975)			
1. Date of spinal fusion _____			
2. How many levels were fused: _____			
3. Has recent fusion failed to heal (pseudoarthrosis) by objective radiological criteria?	Y	N	D
4. Has patient had a prior failed spinal fusion at same site?	Y	N	D

Contact Name: _____ **Phone :_____**

_____ _____

Physician Signature (Stamps are not acceptable) **Date**

Key - **(Y)**es, **(N)**o, **(D)**oes not apply

Requested Information:
1. Typed office note with pertinent information.