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

Certificate of Medical Necessity (CMN) for Osteogenic Stimulators				
Date:// Requesting F	Provider:			
Ultrasonic – No	on-spinal (E0760)			
1. Does the patient have a nonunion of a long-bone fracture?		Y	Ν	D
2. Date of fracture:				
3. Date of recent X-ray				
4. Has there been evidence of fracture healing?		Y	Ν	
5. If a FRESH fracture – what treatment has been provided	l, and why is an Ultrasonic stim	ulator being	g requested	[?
6. Are any other stimulators currently in use for the same particular of the same particula	roblem?			
Electrical – Non-spinz	al (20974/20975/E0747)			
 Does the patient have a nonunion of a long-bone fractur 2. 	· · ·	Y	Ν	D
2. Does the patient have failed fusion of a joint other than t	he spine?	Y	Ν	D
3. Does the patient have a congenital pseudoarthrosis?		Y	Ν	D
4. Date of fracture/fusion				
5. Date of recent X-ray				
6. Has there been any evidence of fracture healing?		Y	Ν	
Electrical – Spin	nal (E0748/20975)			
1. Date of spinal fusion				
2. How many levels were fused:				
3. Has recent fusion failed to heal (pseudoarthrosis) by obje	ective radiological criteria?	Y	Ν	D
4. Has patient had a prior failed spinal fusion at same site?		Y	Ν	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 pe	rtinent info	ormation.	