

**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? Y      N      D  
2.

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.