



Utilization Management
Phone: 1-877-284-0102 Fax: 1-800-510-2162

Durable Medical Equipment – Bone Stimulator Precertification Review

Date: _____ Reference #: _____ (provided after initial review)
A Utilization Management representative will fax you a reference number by the next business day after receiving this completed form. This reference number does not indicate an approval or denial of benefits, but only proof that the Plan has been notified. This information will be forwarded to the Plan's Managed Care Department. If you have any questions, please call Healthlink at 1-877-284-0102.

Provider Information

Provider Name: _____
 Address: _____
 Phone: _____
 Fax: _____

Patient Information

Patient Name: _____
 ID Number: _____
 Patient DOB: _____
 Address: _____
 Phone: _____

Ordering Physician Information

Physician Name: _____
 Address: _____
 Phone: _____
 Fax: _____
 TIN: _____

Treatment Information

Pertinent Medical History: (submit history, physical and include previous treatments and dates) _____

Date of Injury and/or Surgery: _____

Is the stimulator for spinal fusion? YES NO

If yes:

- One or more previously failed spinal fusion(s) YES NO
- Grade III or worse spondylolisthesis YES NO
- Fusion to be performed at more than one level YES NO
- History of tobacco use YES NO
- History of alcoholism YES NO
- Metabolic diseases where bone healing is likely to be compromised or growth is poor YES NO
 - Diabetes YES NO
 - Renal disease YES NO

Benefits depend upon the eligibility of the patient at the time of admission, subject to all other Plan limitations, pre-admission review requirement and prior related claims. Verification of eligibility and description of benefits are based upon the information we have on file and does not guarantee payment.

Other, please specify: _____

Is patient's body mass index (BMI) greater than 30? YES NO

Is patient 50% over their ideal body weight? YES NO

Is the stimulator for a failed spinal fusion? YES NO

If **yes**, provide clinical regarding failed spinal fusion:

Date of fracture: _____

Date of prior surgery: _____

Is fracture gap less than one centimeter (1cm)? YES NO

Results of serial radiographs or imaging studies where there is no evidence or progression of healing: _____

Is the bone growth stimulator a treatment for fracture non-unions and congenital pseudoarthroses of all long and short bones of the appendicular system? YES NO

Note: The diagnosis of fracture nonunion must meet **all** of the following criteria:

At least 45 days have passed since the date of fracture or the date of surgical treatment of the fracture?

YES NO

Serial radiographs or appropriate imaging studies confirm that no progressive signs of healing have occurred?

YES NO

The fracture gap is less than 1 centimeter?

YES NO

Is the bone growth stimulator for the treatment of joint fusion secondary to failed arthrodesis of the ankle or knee?

YES NO

Please provide any additional clinical information

Provider Contact Information

Contact Person: _____

Title: _____

Phone: _____

Fax: _____