



Utilization Management
Phone No.: 1-877-284-0102 Fax No.: 1-800-510-2162

HealthLink Durable Medical Equipment—Bone Growth Stimulators Pre-Review

Date: _____ Notification # _____ (provided after initial review)
A Utilization Management representative will fax you a notification number by the next business day after receiving this completed form. This notification 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's Name: _____
Address _____
Phone No. _____ Fax No. _____

Patient Information

Patient's Name _____
ID Number _____ Patient's DOB: _____
Address _____
Height: _____ Weight: _____ Daytime Phone No. _____

Ordering Physician Information

Physician's Name _____
Address _____
Phone No. _____ Fax No. (Required) _____
TIN: _____

Treatment Information

Diagnosis & Past Medical History (please include previous treatments and dates): _____

Date of injury and/or surgery: _____

Is the stimulator for Spinal fusion: YES NO

If YES:

- | | | |
|--|------------------------------|-----------------------------|
| 1. One or more previously failed spinal fusion(s) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 2. Grade III or worse spondylolisthesis | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 3. Fusion to be performed at more than one level | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 4. History of tobacco use | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 5. History of alcoholism | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 6. Diabetes, renal disease, or other metabolic diseases where bone healing is likely to be compromised or growth is poor | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 7. Obese patients who are at greater than 50% over their ideal body weight (IBW) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

Is the stimulator for a failed fusion YES NO

Is the bone growth stimulator for individuals with failed spinal fusion YES NO

If YES, provide clinical regarding failed spinal fusion.

Date of prior surgery _____

Serial x-rays results over a 3 month period. _____

Is the bone growth stimulator a treatment for fracture nonunions 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:

1. At least 45 days have passed since the date of fracture or the date of surgical treatment of the fracture. YES NO
2. Serial radiographs or appropriate imaging studies confirm that no progressive signs of healing have occurred. YES NO
3. 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 YOU MAY HAVE.

* Type(s) of Medical Equipment with HCPC code and prices:

TYPE _____ HCPCs _____

Contact Information

Contact Person _____
Phone No. _____ Fax No. _____

Staff Signature/Title: _____ Date: _____

**Preferred provider available for DME and HI services*

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.