STATE OF OKLAHOMA
Oklahoma Health Care Authority
OHCA CERTIFICATE OF MEDICAL NECESSITY
OSTEOGENESIS STIMULATORS

SECTION A **Certification Type/Date: INITIAL ____ / _____ / _____ REVISED _____ / _____ / _____ RECERTIFICATION _____ / _____ / _____**

PATIENT NAME, ADDRESS, TELEPHONE and MEMBER NUMBER (_____) - _____ - _____ MEMBER # _____		SUPPLIER NAME, ADDRESS, TELEPHONE and NSC OR applicable NPI NUMBER/LEGACY NUMBER (_____) - _____ - _____ NSC OR NPI # _____
PLACE OF SERVICE _____	HCPCS CODE	PT DOB _____ / _____ / _____ Sex ____ (M/F) Ht. ____ (in) Wt. ____ (lbs.)
NAME and ADDRESS of FACILITY *If applicable*	_____ _____ _____ _____	PHYSICIAN NAME, ADDRESS, TELEPHONE and applicable NPI/LEGACY NUMBER (_____) - _____ - _____ NSC OR NPI # _____

SECTION B Information in this Section **May Not Be** Completed by the Supplier of the Items/Supplies.

EST. LENGTH OF NEED (# OF MONTHS); _____ 1-99 (99=LIFETIME) | DIAGNOSIS CODES (ICD-10): _____ _____ _____ _____

ANSWERS	ANSWER QUESTIONS 1- 3 FOR NONSPINAL ELECTRICAL OSTEOGENESIS STIMULATOR INVASIVE/NONINVASIVE. ANSWER QUESTION 4 - 6 FOR SPINAL ELECTRICAL OSTEOGENESIS STIMULATOR. ANSWER QUESTION 1 AND 7 FOR ULTRASONIC OSTEOGENESIS STIMULATOR. (Circle Y for Yes, N for No or D for Does Not Apply For questions about months, enter 1-99 or D. If less than one month enter 1.)
Y N D	1) In a fracture, has there been no clinically significant radiographic evidence of healing for a minimum of 90 days?
a) Y N D b) Y N D	2) (a) Does the patient have a failed fusion of a joint other that the spine? (b) How many months prior to ordering the device did the patient have the fusion?
Y N D	3) Does the patient have a congenital pseudoarthrosis?
a) Y N D b) _____	4) (a) Is the device being ordered as a treatment of a failed single level spinal fusion surgery in a patient who has not had a recent repeat fusion? (b) How many months prior to ordering the device did the patient have the fusion?
a) Y N D b) _____ c) _____	5) (a) Is the device being ordered as an adjunct to repeat single level spinal fusion surgery in a patient with a previously failed spinal fusion at the same level(s)? (b) How many months prior to ordering the device did the patient have the repeat fusion? (c) How many months prior to ordering the device did the patient have the previously failed fusion?
Y N D	6) Is the device being ordered following multi-level spinal fusion surgery?
Y N D	7) Has there been at least one open surgical intervention for treatment of the fracture?

To expedite timely review, medical records to support the above statement must be submitted at the time of request.

Name of person answering section B questions, if other than the physician (PLEASE PRINT):

Name _____ Title _____ Employer _____

SECTION C **Narrative Description of Equipment and Cost**.

(1) Narrative description of all items, accessories, and options ordered; (2) Supplier's charge, and (3) Fee Schedule Allowance for each item, accessory, and option.

SECTION D **PHYSICIAN Attestation and Signature/Date**

I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed, and signed by me. I certify that the medical necessity information in Section B is true, accurate, and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE _____ / _____ / _____