Bone Growth Stimulator Medical Necessity Summary Date of Injury: ICD9 Codes: Diagnoses: Multi Level Spinal Fusion Failed Spinal Fusion Single Level Fusion With Risk Other: Primary Diagnosis Degenerative Disc Disease Sclerosis Herniated Nucleous Pulposus Internal Disc Disruption Lumbar Instability Spondylolisthesis/ Grade Low Back Pain Radiculopathy Spinal Stenosis Other: Planned Procedure: Date of Surgery: Fusion Levels: to Other: Prior Surgical Procedure(s) Fusion Surgery Date: Levels: to Disectomy Date: Levels: to Laminectomy Date: Levels: to Other Date: Levels: to All That Apply Are Checked: Multi Level Fusion Alcohol use Obesity Mixed Graft Osteopyrosis Arthritis Allograft Osteomyletis Tobacco Use (ppd) Autograft Failed Fusion Spondylolisthesis AVN Diabetes Stenosis		Letter of Med	dical Necessity	
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	<u>-</u>	Diabetes	•	
	Previous Back Surgery	Other :		
DOS: Length of Treatment: (number of months) Not Placed:	DOS: Length o	of Treatment:	(number of months) Not	Placed:
Physician Name:				
Physician Address:	Physician Address:			
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My signature below means that, in my judgment, the above-prescribed item is medically indicated and necessary, and consistent with current accepted standards of medical practice and treatment of this patient's physical condition. My signature also serves	to confirm the veracity of all informati	ion included in this document.		
	Physician Signature:		Date:	