Letter of Medical Necessity

Patient Name:_____ Date of Birth:_____

ID#: _____ ClaIm #:_____

Payor Name: _____

Bone Growth Stimulator Medical Necessity Summary

Date of Injury: _____ ICD9 Codes: _____

Diagnoses: ☐ Non Union Fracture ☐ Failed Joint Fusion

☐ Other: _____

Location:

☐ Prox ☐ Mid ☐ Left ☐ Right

Type:

☐ Bilateral ☐ Open ☐ Closed

Bone Site:

☐ Tibia
☐ Fibula
☐ Tibia/Fibula
☐ Femur
☐ Ulna
☐ Humerus
☐ Radius
☐ Clavicle

☐ Medial Mallelous (tibia)
☐ Lateral Malleolus (Fibula)
☐ Metatarsal ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
☐ Metacarpal ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
☐ Phalanges (Finger) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
☐ Phalanges (Toe) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
☐ Scaphoid
☐ Other_____

Additonal Risk Factors:

Alcohol use ☐ ☐ Obesity
Osteoporosis ☐ ☐ Arthritis
AVN ☐ ☐ Osteomyelitis
Diabetes ☐ ☐ Tobacco Use

Prior Surgical Procedure(s)

☐ Osteotomy
☐ Internal Fixation
☐ IM Rod
☐ Cast

☐ Bone Graft
☐ Screws
☐ Wire
☐ Fixator Removal

☐ Debridement
☐ Plate
☐ External Fixation

☐ Other_____

☐ Both an ostectomy and join fusion were performed. The specific healing status of each is noted below

☐ Fracture status and site specificall indentified in the diagnostic interpretation as summarized below

☐ I am Trained to interpret the x-rays. The x-ray interpretations are noted in my progress notes and are summarized below

Date of 1st diagnostic test and description of fracture or fusion:_____

_____

Date of last diagnostic test and description of fracture or fusion status:_____

_____

The information with the box checked describes the patient's fracture gap.

☐ This is a Fracture that does not have a measurable gap

☐ Fracture gap less than 1 cm. How many mm_____

☐ Fracture site was adequately immobilized and patient was able to compy with non-weight bearing

Reason why patient is not a good candidate for surgery:_____

_____

Other Conservative Measures:_____

Date Of Service:_____ **Not Placed:**_____

Physician Name: _____

Physician Address: _____

_____

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 information included in this document.

Physician Signature: _____ Date: _____