Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY: OSTEOGENESIS STIMULATORS

Identifying Information [This section may be completed by the provider.]

Individual	Prescriber	Provider
Name	Name	Name
Medicaid ID number	Medicaid provider number	Medicaid provider number
Date of birth	NPI	NPI
Height (in.) Weight (lbs.)	Telephone number	
Address*	*Note: Provision of or payment for equipment and supplies used by a resident of a long-term care facility (LTCF) is the responsibility of the LTCF.	

Description of requested unit

Certification [This section may be transcribed by the provider.]

Mark all items that apply.

Diagnosis code(s)	Date of evaluation

☐ This individual uses vital equipment that may be adversely affected by changes in electromagnetic fields.

The indicated equipment is being prescribed for the reasons specified.

☐ Spinal electrical osteogenesis stimulator
- ☐ This individual has undergone multilevel spinal fusion surgery.
- ☐ This individual has undergone spinal fusion surgery that has failed, and at least nine months have elapsed since the most recent operation.
- ☐ This individual has undergone spinal fusion surgery, and previous attempts at spinal fusion at the same site have failed. Dates of surgery: ___/___/_____, ___/___/_____, ___/___/_____

☐ Non-spinal electrical osteogenesis stimulator
- ☐ The fracture is in a long bone and has failed to unite for at least three months. Documentation is attached.
- ☐ This individual has congenital pseudarthrosis.
- ☐ This individual has undergone joint fusion surgery that has failed, and at least nine months have elapsed since the most recent operation. Dates of surgery: ___/___/_____, ___/___/_____, ___/___/_____

☐ Ultrasonic osteogenesis stimulator
- ☐ The fracture is in a long bone.
- ☐ The fracture is not tumor-related.
- ☐ The fracture has failed to unite for at least three months. Documentation is attached.

☐ This individual is younger than twenty-one years of age, and all of the following criteria are met:

There is radiological documentation that skeletal maturity has been attained.
The fracture gap is not more than one half of the diameter of the bone to be treated.
The fracture does not involve a vertebra.

Attestation [This section must be completed by the prescriber.]

I hereby attest that the certification information above is true, correct, and complete.	
Signature of prescriber	Date of signature

False certification constitutes Medicaid fraud.