

Review Request for Electrical Bone Growth Stimulator

Please fax the completed form to **1-800-823-5520**.

If you have questions, call **1-866-902-1689** during regular business hours.

Policy Last Review Date: 8/28/08	Policy Effective Date: 10/01/08	Provider Tool Effective Date: 8/10/09
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Member Name:	Date of Birth:
Insurance Identification Number:	Member Phone Number:

Ordering Provider Name and Specialty:	Provider ID Number:
Office Address:	
Office Phone Number:	Office Fax Number:

Rendering Provider Name and Specialty:	Provider ID Number:
Office Address:	
Office Phone Number:	Office Fax Number:

Facility Name:	Facility ID Number:
Facility Address:	

Date/Date Range of Service:	Place of Service: <input type="checkbox"/> Home <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Other: _____
Service Requested (CPT if known):	
Diagnosis (ICD-9) if known:	

Please check all that apply to the member:

- Request is for Invasive method of electrical bone growth stimulation (EBGS)
- Request is for the Noninvasive method of electrical bone growth stimulation (EBGS)
- Request is for the Semi-Invasive method of electrical bone growth stimulation (EBGS)
- Request is for electrical bone growth stimulation as an adjunct to spinal fusion for a member who is high risk for pseudoarthrosis (check all that apply):
 - One or more previous failed spinal fusion(s)
 - Grade III or worse spondylolisthesis
 - Fusion to be performed at more than one level
 - Current smoking habit
 - Diabetes
 - Other metabolic disease where bone growth is poor (please list disease): _____
 - Renal disease
 - Documented history of alcoholism
 - Member weighs greater than 50% over his/her ideal body weight
 - Other (please list): _____
- Member with failed spinal fusion (fusion has not healed for minimum of 6 months after original surgery as documented by serial x-rays over a course of 3 months during the latter portion of the 6-month period)
- Member has a nonunion fracture of long or short bones of the appendicular system: (check all that apply)
 - At least 45 days have passed since date of fracture or the date of surgical treatment of fracture
 - Serial radiographs confirm no progressive signs of healing have occurred
 - Bone gap greater than one half the diameter of the bone at the point of nonunion
- Treatment is for conditions of the long or short bones of the appendicular system and member has:
 - Failed joint fusions
 - Congenital pseudoarthroses
 - Synovial pseudoarthroses
 - Draining osteomyelitis
- Treatment is for joint fusion secondary to failed arthrodesis of the ankle or knee
- Treatment of fresh fractures or delayed/incomplete union fractures
- Other indications not listed above (please list): _____

This request is being submitted:

- Pre-Claim
- Post-Claim. If checked, please attach the claim or indicate the claim number: _____
- By checking this box, I attest the information provided is true and accurate to the best of my knowledge. I understand that BlueChoice HealthPlan Medicaid may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

Name and Title of Provider or Provider Representative
Completing Form (Please Print)*

Date

***The attestation fields must be completed by a provider or provider representative in order for the tool to be accepted.**