Rx: Certificate of Medical Necessity and Written Confirmation of Physician Order to

TEAM MAKENA

Acct Rep:
Fax: (949) 251-5120
Cell
@teammakena.com

Physician:	DOS:
Patient Name:	Patient SS#
***DOB: Location: ☐ Home ☐ Sx Ctr. ☐ Doctor ☐ Phys.Therapy ☐ Other	Time:

Diagnosis/ICD9: **Preferred Vendor is Team Makena** NPI: 1548457278 Tax ID: 26-0872070

BRACING

☐ **Custom** ☐ **Prefabricated (OTS)**
☐ Ligament Knee Brace ☐ **Right** ☐ **Left**
☐ Unloader/OA Knee Brace ☐ **Right** ☐ **Left**
☐ **Medial** ☐ **Lateral**
☐ Patella-Femoral Stabilizer Brace (Hinged)
☐ Post-op Knee Brace w/ ROM
☐ AFO Dynamic ☐ Night Splint
☐ CAM Boot – Pneumatic Walker Boot
☐ Functional Arm/Elbow Brace/Post op Elbow
☐ Shoulder Immobilizer With Abduction
☐ Static Progressive Splint / Mackie / JAS
☐ Wrist ☐ Elbow ☐ Knee ☐ Ankle ☐ Knee
☐ Spinomed L0456 ☐ Ossur Hip Brace
☐ Philly Collar ☐ Cervical Collar _____
☐ LSO w/ Lat. Panels ☐ LSO w/non-Lat ☐ TLSO

Indications Relating to Medical Necessity:

☐ Manage Osteoarthritic Pain/Symptoms
☐ Correct Varus/Valgus Deformity
☐ Abnormal Limb Contour/Deformity
☐ Protect/Stabilize Joint ☐ Instability ☐ Pain
☐ Limit Range of Motion ☐ Deformity & Stabilization
☐ Protect Ligament Injury
☐ Correct Patella-Femoral Mal-alignment
☐ Protect Surgical Repair ☐ Abduction Positioning
☐ To reduce pain by restricting mobility of the trunk
☐ Correct Drop Foot ☐ Increase Range of Motion
☐ Disproportionate thigh to calf
☐ Manage Plantar Fasciitis Pain
☐ _____

HOT/COLD THERAPY & COMPRESSION

☐ Contrast ☐ Cold Therapy ☐ Compression
☐ Vascutherm DVT ☐ DVT CareCa5 ☐ Calf Cuffs x2

Indications Relating to Medical Necessity:

☐ Reduce Inflammation ☐ Manage Acute or Post-Op Pain
☐ Prevent Venous Thromboembolism ☐ Continued Pain and Swelling

CPM PRODUCTS:

☐ Knee ☐ Shoulder ☐ Elbow

Indications Relating to Medical Necessity:

☐ Increase/Maintain R.O.M. ☐ Increase Circulation

NMES, TENS, & BONE GROWTH STIMULATORS

☐ Kneehab/TENS unit with conductive garment and supplies, 4 month rental or rent to purchase
☐ Recovery Back/TENS unit with conductive garment and supplies, 13 month rental or rent to purchase
☐ JSTIM ☐ hand ☐ knee
☐ IF / Tens Unit Purchase with Conductive Garment
_____
☐ Bone Growth Stimulator ☐ Long Bone ☐ Spine

Indications Relating to Medical Necessity:

☐ Treat disuse atrophy and supply a garment because there is such a large area to be stimulated and is not feasible with conventional electrodes. 728.2
☐ enable patient with spinal cord injury (SCI) to maintain muscle tone and strength while non-ambulatory
☐ Rheumatoid Arthritis 714.0 ☐ Osteoarthritis 715.96
☐ Garment because there is such a large area to be stimulated and is not feasible with conventional electrodes.
☐ Manage chronic pain ☐ Manage Acute Post-operative pain
☐ Increase/Maintain ROM ☐ Relieve Muscle spasm
☐ Reduce Swelling ☐ Increase Circulation
_____
☐ Non-Union Fracture 733.82 ☐ Multi-level spine fusion V45.4
Risk Factors: ☐ Smoker ☐ Obese ☐ Diabetic ☐ Alcoholic

Length of Use: ☐ Purchase ☐ 21 Days ☐ 31 to 60 Days ☐ 4 Months ☐ Other: _____

Miscellaneous Products: ☐ Saunders Traction
☐ Mobi-Crutch x 2 E0117 ☐ Crutches ☐ FWW
☐ 3 in 1 Commode ☐ Cane ☐ Walker/Seat
Other_____

Indications Relating to Medical Necessity:

☐ Maintain a natural wrist angle
☐ Prevent damage to thoracic nerve ☐ Improve ADL's/functioning
☐ Recovery ☐ Increased well-being and function in the community

I, the undersigned, confirm the order for the above named patient. I also certify that the prescribed treatment is medically reasonable and necessary in reference to accepted standards of medical practice within the community for treatment of this patient's condition.

Signature:_____Date:

PRESCRIPTION AND
PHYSICIAN'S CERTIFICATE OF MEDICAL NECESSITY
HCPCS: E0217 (CONTRAST THERAPY)

Patient Name:_____

Date of Surgery: _____

Goals / Reason Prescription: Hot therapy is intended to promote blood circulation and relive muscle tension at a localized site. Cold Therapy is intended to reduce pain and soft tissue swelling resulting from surgery or trauma at a localized site.

EQUIPMENT PRESCRIBED:

CONTRAST WRAPS: ☐ **ANKLE** ☐ **KNEE** ☐ **WRIST** ☐ **ELBOW**

☐ **SHOULDER** ☐ **BACK** ☐ **HIP**

***SIDE OF BODY*:** ☐ **RIGHT** ☐ **LEFT** ☐ **BILATERAL**

O ✓ Water Circulating Heat Pad with Pump (E0217) and appropriate appliance

Diagnosis: ◊ _____ ◊ _____
ICD-9: Primary ICD-9: Secondary

Duration of therapy: This equipment is medically necessary for a purchase.

The contrast therapy unit has been prescribed because the system has the ability to reduce pain, muscle spasms, tissue damage, swelling, and it increases the healing process. This system should be used at home following surgery. By applying the flexible wraps the system delivers contrast temperature controlled therapy. Due to the local anesthetic value of this product, medication use, and subsequent rehabilitation costs are reduced. This form of post acute injury therapy, in my opinion, is the absolute best course of action and protocol to follow to manage this patient's rehabilitation and ambulation. Without this device, there is potential to cause unnecessary delay in this patient recovery.

Frequency: ☐ 1 time/day ☐ 2 times/day ☐ 3 times/day ☐ Continuous

Treatment time: Every: ☐ 15 min. ☐ 30 min. ☐ 60 min. ☐ 90 min.

Temperature Setting: ☐ 49 degrees ☐ 105 degrees ☑ **Contrast**

_____ _____
Physician Signature **Date**

_____ _____
UPIN **NPI#**