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

TEAM MAKENA

Physician:	Surgery Date:
Patient Name:	Patient SS#

***DOS: Location: ☐ Home ☐ Sx Ctr. ☐ Doctor ☐ Phys.Therapy Other Time:

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

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

BRACING ☐ Right ☐ Left ☐ Custom ☐ Prefabricated (OTS)

☐ Ligament Knee ☐ Cartilage Knee ☐ Unloader/OA Knee ☐ **Medial** ☐ **Lateral** ☐ Post-op Knee Brace w/ ROM

Certificate of Medical Necessity-Bracing

For Medicare, medical justification must also be documented in the patient's medical record (i.e., chart notes). Please attach ALL supporting documentation.

Describe below why your patient needs a knee brace AND check ALL conditions that apply:

☐ Alleviate pressure on medial or lateral compartment ☐ Meniscal cartilage derangement ☐ Knee ligamentous disruption
☐ Failed total knee arthroplasty ☐ Aseptic necrosis of tibia/fibula ☐ Tibial plateau fracture
☐ Restricted ROM requirements post-surgery ☐ Knee instability Other_____

For CUSTOM BRACES, check ALL the conditions that exist:

☐ Documented neurological, circulatory, or cutaneous status that requires a custom
☐ Deformity of the leg or knee that precludes fitting with a prefabricated orthosis ☐ Disproportionate size of thigh & calf
☐ Minimal muscle mass upon which to suspend an orthosis ☐ Redundant/excessive soft tissue
☐ Leg size, cannot fit into non-custom or pediatric brace Other_____

Describe ALL condition(s) that pertain to this patient. Please be specific.

Custom Brace Prescribing Information (ATTACH CHART NOTES FOR MEDICARE)

Neuromuscular Stimulators ☐ Kneehab/TENS unit with conductive garment and supplies: 4 month rental, rent to purchase or purchase

Certificate of Medical Necessity-Stimulator

Item Description: FDA 510k Approved powered muscular stimulator Treatment Sessions / Day: 3 Minutes or Hours, 20 minutes per sessions/1 hour/day

The physician certifies the following: The patient suffers from a condition that requires the use of the Kneehab XP Conductive Garment and NMES Controller to treat disuse atrophy of the quadriceps muscles: Reference ICD-9 Codes(s) _____, _____

☐ The patient is being treated for disuse atrophy using the Kneehab XP Conductive Garment and Controller following an injury or surgery where the nerve supply to the muscle is intact.

☐ Patient has disuse atrophy of the VMO and needs this device to help the patient at home to do therapy.

The patient cannot manage without the Kneehab XP Conductive Garment because:

☐ Patient requires the conductive garment due to the large area or number of sites to be stimulated & would have to be delivered so frequently that it is not feasible to use conventional electrodes.

☐ The patient has a medical condition that precludes the application of conventional electrodes

☐ The non-neurological reason for the patient is disuse atrophy of the quadriceps muscle & needs the Kneehab device to help in regaining function of that muscle

CPM: ☐ Knee Length of Use: ☐ 21 Days ☐ 14 Days ☐ 7 Days **Indications Relating to Medical Necessity:** ☐ Increase/Maintain R.O.M. ☐ Increase Circulation

HOT/COLD THERAPY ☐ Cold Therapy ☐ Contrast Therapy ☐ Reduce Inflammation ☐ Manage Acute or Post-Op Pain ☐ Continued Pain & Swelling

Certificate of Medical Necessity-Contrast Therapy

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.

COMPRESSION Therapy ☐ Vascutherm DVT ☐ DVT CareCa5 ☐ DVT Cothera ☐ DVT Venapro

Certificate of Medical Necessity-Deep Vein Thrombosis Therapy

In my evaluation of this patient I have noted there is a higher risk of developing Deep Venous Thrombosis (DVT), due to the type of surgery performed combined with other risk factors. I am Prescribing DVT Prophylaxis involving the use of a pneumatic compression device and the necessary appliances. This patient will have decreased ability and duration of ambulation following surgery, which will significantly increase the risk factors associated with DVT, Pulmonary Embolism (PE). DVT and PE can be major complications associated with these surgeries.

The plantar and lower leg wraps have added the advantage of reproducing the physiological mechanism of venous return. Impaired venous blood flow in post abdominal/orthopedic surgeries, trauma, and other conditions that impede or significantly decrease ambulation of patients most certainly will decrease circulation which can result in edema, pain delayed healing and increased risk of DVT and PE.

For these reasons, PIC device and compression wraps are prescribed for this patient to maximize the most positive outcome of surgery and minimize the potential for serious complications. I feel this protocol is the most beneficial and cost effective treatment of my patients in greatly reducing the development of DVT.

Miscellaneous Products:

☐ Mobi-Crutch x 2 E0117 ☐ Crutches ☐ FWW ☐ Cane
☐ 3 in 1 Commode ☐ Walker/Seat Other_____

Indications Relating to Medical Necessity:

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

In my judgment, the above-prescribed item(s) is(are) medically indicated & necessary, and consistent with current accepted standards of medical practice and treatment of this patient's physical condition.

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.

Doctor Signature _____Date:_____