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

Certificate of Medical Necessity-Bracing

This patient is being treated under a comprehensive plan of care for back pain management. I, the undersigned, certify that the prescribed orthosis is medically necessary for the patient's overall well-being. In my opinion, the following lumbar orthosis products are both reasonable and necessary in reference to accepted standards of medical practice in the treatment of the patient's condition and/or rehabilitation.

I certify that the following diagnosis is true:

☐ Lumbago 724.2	☐ Lumbosacral Sponsylosis 721.3	☐ Lumbar Disc Displacement 722.10
☐ Spinal Stenosis 724.0	☐ Sponsylosis 756.12	☐ Lumbar/Lumbosacral Interverebral Disc Degeneration 722.52
☐ Muscle weakness 728.87	☐ Lumbar Strains/Sprain 847.2	☐ Spinal Disorder 724.9

Check ALL the conditions that exist:

☐ To reduce pain by restricting mobility of the trunk ☐ To facilitate healing following a surgical procedure on the spine or related soft tissue
☐ To facilitate healing following an injury to the spine or related soft tissues ☐ To otherwise support weak spinal muscles and/or a deformed spine

Our evaluation of the above patient has determined that providing the following back pain management Lumbar orthosis product will benefit this patient.

☐ Lumbar Orthosis(Miami Lumbar/Aspen)- Sagittal control with posterior support that extends from L-1 below L-5; beneficial multiple level decompression, laminectomy, posterior lateral fusion. Commonly referred to as L0627 or L0642

☐ Lumbar Sacral Orthosis(Miami Lumbar/Aspen)- - Sagittal control with posterior support that extends from Sacrococygeal junction to T-9 vertebra; beneficial for thoracolumbar injury, evision surgery, multi-level fusion. Commonly referred to as L0631 or L0647

☐ Lumbar Sacral Orthosis(Miami Lumbar/Aspen)- - Sagittal & Coronal control with posterior support that extends from Sacrococygeal junction to T-9 vertebra; beneficial for multiple level decompression, laminectomy, posterior lateral fusion, spondylolysis, spondylolisthesis & mechanical back pain. Commonly referred to as L0637 or L0650

☐ Lumbar Orthosis (Miami Posteo/Spinomed)- TLSO, provides trunk support, thoracic region, rigid posterior panel and soft anterior apron, extends from Sacrococygeal junction and terminates just inferior to the scapular spine. Reduces gross trunk motion in the sagittal plane, produces intercavitary pressure to reduce load on intervertebral discs. Commonly referred to as L0456 or L0457

☐ Cervical Collar ☐ Miami J ☐ Aspen ☐ Philadelphia Collar

Neuromuscular Stimulators

☐ Recovery Back/NMES 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: _____Session(s), _____ minutes per session(s)/day

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

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

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

The patient cannot manage without the Recovery Back 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 muscle & needs the Recovery Back device to help in regaining function of that muscle

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.

Bone Growth Stimulators-Spine

☐Multi-level fusion V45.4 Risk Factors: ☐ Diabetic ☐Obese ☐Smoker ☐Alcohol Use

Certificate of Medical Necessity-Bone Growth Stimulator

In my evaluation of this patient I have noted a diagnosis that corresponds with medical policy for a bone growth stimulator for the reasons noted above. Criteria for a non-invasive bone growth stimulator may be considered medically necessary due to the following criteria:Conservative Treatment Failed ☐Yes ☐No, Device being ordered following multi-level spinal fusion☐Yes ☐No
Device being ordered as an adjunct to repeat single level spinal fusion surgery in a patient with a previously failed spinal fusion at the same level(s) ☐Yes☐No
Device being ordered as a treatment of a failed single level spinal fusion surgery in a patient who has not had a recent repeat fusion ☐Yes ☐No

COMPRESSION Therapy

☐ Vascutherm DVT ☐ DVTCare ☐ DVT V-Pulse ☐ 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:_____