PRESCRIPTION AND CERTIFICATION OF MEDICAL NECESSITY FOR CONTINUOUS PASSIVE MOTION (CPM)

PHYSICIAN: **NPI:**
ADDRESS:
CITY: **STATE:** **ZIP:**
PHONE:

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1) **PRIMARY DIAGNOSIS CODE & CPT CODES:**____
2) **MEDICAL NECESSITY**

I CERTIFY THAT THIS TREATMENT IS MEDICALLY NECESSARY FOR THE FOLLOWING REASONS:

1. MAINTAINING AND INCREASING RANGE OF MOTION AND HELPING PREVENT STIFFNESS OF THE JOINT.
2. ENHANCES NUTRITIONAL AND METABOLIC ACTIVITY OF THE ARTICULAR CARTILAGE
3. REDUCES SWELLING AROUND THE JOINT
4. ACCELERATES HEALING OF ARTICULAR CARTILAGE AND PERIARTICULAR TISSUE
5. REGENERATES CARTILAGE
6. DECREASES PAIN

3) **MEDICARE NOTICE:** CONTINUOUS PASSIVE MOTION (CPM) IS COVERED FOR PATIENTS WHO HAVE RECEIVED A TOTAL KNEE REPLACEMENT. THE USE OF THIS DEVICE MUST COMMENCE WITHIN 48 HOURS FOLLOWING SURGERY. COVERAGE IS LIMITED TO 21 DAYS AFTER PLACEMENT.

CERTIFICATE OF MEDICAL NECESSITY

SURGERY DATE_____________________
PATIENT'S NAME_______________________________________ **DOB**_______________________
ADDRESS:____
____
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CIRCLE:	**SHOULDER CPM**	**HAND CPM**	**KNEE CPM**	**ANKLE CPM**	**ELBOW CPM**
OTHER___________________________________			**LEFT**	**RIGHT**	**BOTH**

THIS RX IS GOOD FOR 21 DAYS OF USE UNLESS OTHERWISE NOTED BELOW:
2 WEEKS
1 MONTH
OTHER (PLEASE SPECIFY):____
STARTING ROM:_________________________ **TARGET ROM:**_________________________

PHYSICIAN'S SIGNATURE:___________________________________ **DATE:**___________ **TIME**________