Rx Physician's Prescription

DATE OF SURGERY: _____/ _____/ _____

PATIENT NAME:

ICD-10 CODE: **DO NOT SUBSTITUTE (DAW)** _____

PRODUCT: **Cold Therapy System, including Control Unit and Wrap**

I am prescribing a Cold Therapy System (Game Ready/Vascutherm/Cryocuff/Iceman) due to my patient's needs and diagnosis. I certify that the cold therapy device is medically indicated and in my opinion is reasonable and necessary with reference to the accepted standards of medical practice and treatment of this patient's condition.

INITIAL RENTAL - LENGTH OF NEED: ☐ **7 Days** ☐ **14 Days** ☐ **21 Days** ☐ **28 Days** ☐ **Other** _____

RENTAL EXTENSION – LENGTH OF NEED: ☐ **7 Days** ☐ **14 Days** ☐ **21 Days** ☐ **28 Days** ☐ **Other** _____

SALE / PURCHASE REQUESTED: ☐ **Sale of Game Ready Device & Wrap ~ Est. Length of Need:** _____

PRODUCT: ☐ **Game Ready** ☐ **Vascutherm** ☐ **Cryocuff** ☐ **Iceman, complete w/Wrap for Cold Therapy only**

WRAP: ☐ Knee ☐ Articulated Knee ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Ankle ☐ Back ☐ Hip

SIDE: ☐ Right ☐ Left

Rx Physician's Letter of Medical Necessity

I am writing on behalf of my patient that you approve coverage for a cold therapy system. I consider this device medically necessary, and I am prescribing this device for the purpose of musculoskeletal injury treatment and/or post-operative treatment.

The cold therapy system is intended to treat post-surgical and acute injuries to reduce edema, swelling and pain where cold and compression are indicated.

RICE (Rest, Ice, Compression, and Elevation) has long been used to treat acute and chronic injury and assist in rehabilitation following orthopedic surgery. Game Ready combines the two most difficult-to-manage aspects of the RICE regimen (Ice and Compression) by offering adjustable cold and intermittent compression in one easy-to-use system.

The anatomically-designed wraps are engineered for all major body parts, and utilize intermittent compression and fluid circulation technology, simultaneously delivering circumferential cold and compression to most major joints.

My post-operative and rehabilitative care plan calls for the use of the cold therapy device to reduce pain and swelling. Failure to control pain not only causes unnecessary suffering, but can delay my patient's recovery. Therefore, need for compliance with the required treatment is high. I certify that the above-described product is medically indicated and in my opinion is reasonable and necessary. Given the safety and effectiveness of this unit, I prescribe and recommend that the patient use this device daily. Without use of this device, there is potential to cause unnecessary delay in the patient's recovery.

If you have any questions, please feel free to contact my office.

Physician Signature: _____ **Date:** _____

Physician Printed Name: _____ **NPI:** _____

Physician Telephone Number: _____