

PREScription (Rx) AND LETTER OR MEDICAL NECESSITY

Patient Name: _____

Surgery Date: _____

Diagnosis : _____

Equipment Prescribed:

0 CPM for R/L Shoulder (E0936) CPM Duration : _____:

Special Instruction: _____

CPM for R/L Knee (E0935) CPM Duration: _____

Special Instruction: _____

Other CPM for R/L _____ (E0936) CPM Duration: _____

Special Instruction: _____

Reason for prescribing Equipment:

By using a motorized device to very gradually move the joint, it is possible to significantly accelerate recovery time by decreasing soft tissue stiffness, increasing range of motion , promoting healing of joint surface and soft tissue, and preventing the development of motion-limiting adhesions (scar tissue). This is accomplished without patient effort (passively) as the machine moves a joint through a defined (prescribed) range of motion for an extended period of time. Studies have shown that patient using CPM devices require less pain medication, recover faster and therefore, need less physical therapy .

Moreover, the Therapy Circulating Pump following surgery or musculoskeletal and soft tissue injury has long been accepted in the medical field as an effective tool for reducing inflammation, pain , and swelling. In the Cold Therapy and Compression Circulating Pump, motorized pump both circulate cold water and may also provide pneumatic compression. When used in conjunction with the CPM machine for the first 2 weeks post surgery, this device helps not only with swelling and pain, thus enhancing CPM's ability to improve ROM and return patient to normal function quicker, but also helps with control of the overmedicating for pain. CTU is used with a pad or a cry cuff that connects to the cold therapy unit. The pad is joint specific and can stay attached to the joint even during the operation of the CPM. With the cryo cuff on, patients are able to tolerate applications of cold therapy better than they try to apply the traditional ice pack due to the much more efficient temperature controlling mechanism of the Cold Therapy Circulating Pump and the ability of the cryo cuff to circulate the water to the pump and maintain the appropriate temperature, this, in turn promotes compliance and insures appropriate recovery.

Physician Signature



Physician NPI#: 1932233715 .

Physician LIC#: _____

Physician Name and Address: Dr. Anjani Sinha .

164-10 Northern Blvd., Ste 204

Flushing, NY 11358

PRESCRIPTION/LETTER OF MEDICAL NECESSITY
COLD THERAPY CIRCULATING PUMP

Patient Name: _____

Date of Surgery: 10/12/2019

Date of Accident: _____

ICD-10 Code: _____

PRESCRIBED DURATION OF USE: ☐ 14 DAYS ☐ 21 DAYS ☒ 28 DAYS OTHER _____

PART OF THE BODY:

☐ Articulated Knee Wrap ☐ Shoulder Wrap ☐ Straight Leg Wrap
Left ☐ Right ☐ Left ☐ Right ☐

☐ Ankle Wrap ☐ Lumbar Wrap ☐ CT-Spine Wrap

OTHER _____

Request for:

COLD COMPRESSION CIRCULATING PUMP

Please approve coverage for the Cold Therapy Circulating Pump. It is part of my plan of care for my patient's post-operative and rehabilitative path to recovery. It is my opinion that this device is medically necessary and reasonable in reference to current medical practice act standards for treatment of my patient's condition. I am prescribing this medical device as it will prevent unnecessary suffering and delays in recovery time. Please call my office with questions regarding this therapy system.

This device is a pneumatic cold compression therapy system that provides patients with adjustable cold and intermittent compression. These are proven, effective techniques in rehabilitative care to effectively reduce recovery time as well as reducing edema, swelling, and pain. This device is medically indicated for my patient's diagnosis and conditions.



Physician Signature _____

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