

Prescription and Certification of Medical Necessity
CPM (Continuous Passive Motion) Device

Patient Name: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

Date of Surgery: _____ Dx Code: _____ Procedure: _____

Lower Extremity CPM Upper Extremity CPM

Description and Reason Device is Prescribed:

A CPM (Continuous Passive Motion) Device is prescribed to increase the range of motion, function, and strength. It is also used to reduce vascular complications, adhesions, patient pain, swelling, and the need for additional surgery. This accelerates rehabilitation, which results in a significant reduction in treatment costs. A CPM allows the patient to have their affected joint go through a predetermined range of motion at a pre-determined speed.

Patient Benefits:

- Less post-operative pain and edema (swelling)
- Decrease length of time for wound and soft tissue healing.
- Decrease rehabilitation and recovery time.
- Reduction in incidence of deep venous thrombosis.
- Maintains range of motion between physical therapy sessions.
- Reduction in length of hospital stays.
- Reduction in length of time to reach desired range of motion.

Prescription

Length of Prescription: _____ **(Estimated) From:** _____

I, the undersigned, certify that the following prescribed equipment is medically necessary to this patient's well being. The equipment is both reasonable and necessary in reference to accepted standards of medical practice in treatment of this patient's condition and is not prescribed as "convenience" equipment.

Physician Signature: _____ **Date:** _____

Physician Name: (please print) _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone Number: _____ **Fax:** _____

Medicare Information

Date of Surgery: _____ **Type of Surgery** _____

Date CPM Commenced in Hospital _____ **Hospital Name:** _____

Date Discharged From Hospital: _____ **HCPC CODE E0935RR**