Prescription for Rehabilitation and Certification of Medical Necessity

ELITE SEAT®

COVERED BY US PATENT #7,534213B2 & 8,343,080B2
FLEXION CONTRACTURE TREATMENT DEVICE FOR THE KNEE

Patient Name:_____ Date of Birth: _____

Address: _____ City_____State & Zip _____

Patient Phone Number _____Date of Service: _____

Diagnosis Code _____***Procedure:*** _____

□ ***V54.81 Orthopedic Aftercare (Joint Replacement)*** □ ***V54.9 Orthopedic Aftercare***

Elite Seat: Left Knee _____ Right Knee _____ Bi-Lateral Unit_____

Description and Reason ELITE SEAT® Prescribed: The **ELITE SEAT®** is a proven contracture treatment device specifically prescribed to correct any loss of motion in the knee joint, which is the established protocol in the first line of treatment in the rehabilitation of the knee when a flexion contracture is present. **The ELITE SEAT® is a medically necessary modality for the patient in the rehabilitation process.**

Deemed Medically Necessary:

1. The Elite Seat is used as an adjunct to physical therapy for obtaining full knee extension after a knee injury, during the pre-operative or post-operative period of time in patients with symptoms of persistent knee stiffness or contracture and whose affected knee is not symmetric with the unaffected knee.
2. In the post operative period for patients with limited ROM and poses a meaningful functional purpose, as judged by the prescribing physician.
3. For patients unable to benefit from standard physical therapy modalities due to the inability to straighten the affected knee/leg.
4. In the acute post-operative period for patients who have undergone additional surgery to improve ROM of a previously affected joint for up to 4 months and if the patient improvement can be demonstrated.
5. For patients unable to benefit from standard physical therapy modalities due to the inability to exercise resulting from limited function due to lack of extension and pain.
6. In the Orthopedic aftercare or other orthopedic indications.

Prescription

Estimated Length of Prescription_____ Date Prescribed_____

I, the undersigned, certify that the following prescribed equipment, the **ELITE SEAT®**, is a proven Contracture Treatment Device for the knee and is medically necessary. The **ELITE SEAT®** is both reasonable and necessary in reference to accepted standards of medical practice in the treatment of the patient's condition and therefore,

NO SUBSTITUTIONS ALLOWED.

Physician Signature:_____ Date:_____
Physician Name:_____ NPI #_____
Address:_____ City_____State_____ Zip_____
Phone Number:_____ Fax Number:_____

Medicare Information
If surgery performed, date of Surgery_____ Type of Surgery_____
Hospital Name_____ Discharge Date_____

REV.RX 03-14

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OR
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