<table>
<tr><td rowspan="2"> </td><td rowspan="2">DETAILED WRITTEN ORDER
Homecare Dimensions</td><td>Document #:
09.DWO.HCD.17b
Effective:
09/15/2009</td><td>Rev.:
B</td></tr>
<tr><td colspan="2">Title:
Continuous Passive Motion Device
E0935</td><td>Page #:
1 of 1</td></tr>
</table>

Initial Date of Medical Necessity: ___________________

Patient Name: _______________________________________ **Medicare #:** ____________________________

Address: ____________________________________**City:** ____________________ **ST:** _____ **Zip Code**________

Phone #: _______________________ **Cell #:** _______________________ **DOB:** ___________________________

Email: ____ **Length of Need:** ____________ **(21 days max)**

Diagnosis Code: ____

Medical records: The patient's medical record, **to be supplied with this order**, must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable). Continuous passive motion devices are devices Covered for patients

ORDERED	CODE	DETAILED DESCRIPTION OF ORDERED ITEMS
	E0935	Continuous passive motion exercise device for use on knee only

who have received a total knee replacement.

Basic Coverage Criteria for Continuous Passive Motion Device (E0935): The Medical Records document that the patient received a total knee replacement (TKR). Include the following information:

Knee Replaced: ____ (left or right)

Date of Surgery: ____

Date CPM Applied: _______________________________________ (within 48 hours of surgery)

Date of Discharge: _______________________________________

Rate of Motion: ____

Arc of Motion: ____

Treating Physician Signature: ____ **Date:** ____________________

Treating Physician Name: ____ **NPI:** _____________________

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