

**Prescription for Rehabilitation and  
Certification of Medical Necessity**



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 low-load prolonged stretch (LLPS) device. It allows resisted active / passive motion within a restricted - projected range. The elite seat® sustains a set level of tension using a patient controlled low load progressive stretch using a ratcheted internal cabling system that is spring loaded. This allows the patient to have control of the prescription values. This will help correct the loss of knee extension, increase range of motion, decrease knee pain and improve overall function. **The elite seat® is a medically necessary modality for the patient in the rehabilitation process.**

**Deemed Medically Necessary:**

1. 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 limitation, 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 medically necessary. The equipment is both reasonable and necessary in reference to accepted standards of medical practice in the treatment of this patient's condition. **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 _____
Date elite seat® Used as an In-Patient _____	Hospital Name _____
Date Discharged From Hospital _____	HCPCS Code: _____