***Innovative R P Inc***

***5116 Bissonnet Street, Suite 270***

***Bellaire, TX 77401***

**Phone 713-218-7959 Fax 866-716-9008**

**Certificate of Medical Necessity and Prescription for Comfortrac’s**

**Pneumatic Supine Cervical Traction Device (E0849)**

Patient Name: \_ ­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. The patient has a musculoskeletal or neurological impairment requiring traction equipment and,
2. The appropriate use of a home cervical traction device has been demonstrated to the patient and the patient tolerated the selected device.

MUST HAVE CRITERIA 1 and 2 above and either criteria 1, 2, or 3 below have been met:

1. The treating physician orders greater than 20 pounds of cervical traction in the home setting or,
2. The patient has:
3. A diagnosis of temporomandibular joint (TMJ) dysfunction; and
4. Received treatment for the TMJ condition or
5. The patient has distortion of the lower jaw or neck anatomy such that a chin halter is

unable to be utilized.

Prior Treatment:

1. Patient completed a 6 week course of physical therapy in the outpatient setting and still has pain.
2. Patient has failed medical therapy (NSAIDs, Pain Medications, Muscle relaxants)
3. Patient tried an Over the Door Unit (E0860) with no success

The patient has had a series of trials of this device in the outpatient setting before being sent home with one.

Duration:

□ 6-9 (Months) □ Purchase (99 Months) □ Other \_\_ \_\_ (Months)

The Comfortrac Traction unit provides up to 50 pounds of force to the patient while lying down (supine) and can be adjusted by the patient at home. The patient will apply 3-4 times a day and use for 20-30 minutes per treatment session.

**I hereby prescribe the Comfortrac Traction unit device for the above patient. (No Substitutes)**

**Physician Name (Printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_ \_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**