PHYSICIAN'S WRITTEN ORDER

PATIENT INFORMATION: (Provide all information)

First Name MI Last Name Date of Birth

PREVIOUS TREATMENT(S): (Check all that apply)

☐ Surgery ☐ Physical Therapy ☐ Medications ☐ Other: _____

MUST CHECK ONE BOX IN EACH SECTION (1 THRU 7) TO PRESCRIBE FOR DISUSE ATROPHY

PRODUCTS PRESCRIBED (check one in each section)

1. **Kneehab® XP Controller:** (NMES Controller – E0745)
   ☐ 1 Controller **OR** ☐ 2 Controllers

2. **Kneehab XP Conductive Garment:** (E0731)
   ☐ Left Garment **OR** ☐ Right Garment **OR** ☐ 2 Garments (Left & Right)

3. **Kneehab Supply Kit:** (4 conductive gel pads per kit – A4595) 2 Kits per Month
   ☐ 4 conductive gel pads per kit - Garment **OR** ☐ 4 electrodes per kit - Lead wires

DIAGNOSIS CODES (complete both primary and secondary code sections)

4. **Primary ICD-10 Code(s):** (check appropriate box or boxes)

☐ M62.50	Muscle atrophy, unspecified site	☐ M62.559	Muscle atrophy, unspecified thigh	☐ Other (provide specific code)	
☐ M62.551	Muscle atrophy, right thigh	☐ M62.58	Muscle atrophy, other site	_____	
☐ M62.552	Muscle atrophy, left thigh	☐ M62.59	Muscle atrophy, multiple sites		

5. **Secondary ICD-10 Code(s):** (reference coding guide on backside – including 7th Digit Extension for S Codes)

List Code(s): _____ _____ _____ _____

LENGTH OF NEED

6. **Prescribed Length of Need:** (check one)
   ☐ 99 - Lifetime **OR** ☐ # of months _____

JUSTIFICATION FOR CONDUCTIVE GARMENT

7. **Justification:** (check one)

☐ Patient cannot manage without a conductive garment because of the large surface area that has many sites to be stimulated and the stimulation will be delivered so frequently that the use of conventional electrodes is not feasible.

OR ☐ Other _____

I certify that I am the physician identified on this form and that I conducted the exam within 6 months of the date on this form. The above prescribed equipment is medically indicated and, in my opinion, is reasonable and necessary with reference to the accepted standards of medical practice and treatment of this patient's condition and is not prescribed as "convenience" equipment. I certify that the Patient/Caregiver has successfully completed, or will be trained on, the proper use of products prescribed on this Written Order. The physician notes, product lists and other supporting documentation will be provided to the Supplier or its Authorized Distributor upon request. I ask that there be no equipment substitutions for the devices prescribed.

_____
Physician's Signature **(Required)**

_____
Date of Signature **(Required; date stamps not acceptable)**

_____
Physician's Printed Name **(Required)**

_____ ( ) –
NPI# Phone

Please make sure the above information is documented in your patient's chart notes – reference back of form.

Please fax signed form to the
Distributor/IR Fax Number here: (612) 234-4822

Or, fax signed form to **888-980-1195**

From: _____

PHYSICIAN'S PRESCRIBING GUIDE – KNEEHAB XP

PATIENT'S CHART NOTES MUST STATE THE FOLLOWING FOR JUSTIFICATION OF KNEEHAB XP:

1. Disuse atrophy of quadriceps muscles
2. Nerve supply to muscle is intact
3. Physical therapy alone is not sufficient to treat disuse atrophy
4. Large treatment area with multiple sites requires use of conductive garment

SECONDARY ICD-10 CODES: (list below is not all inclusive)

CATEGORY	DESCRIPTIONS FOR THE KNEE	SECONDARY ICD-10 CODES		
		Right	Left	Unspecified
Osteoarthritis	Bilateral Primary Osteoarthritis; Knee	—	—	M17.0
	Unilateral Primary Osteoarthritis; Knee	M17.11	M17.12	—
	Osteoarthritis; Unspecified Knee	—	—	M17.9
	Unspecified Osteoarthritis; Unspecified Site	—	—	M19.90
Pain in Joint (Lower Leg)	Pain in Knee	M25.561	M25.562	—
		"X" REQUIRES 7th DIGIT EXTENSION LETTER "A," "D" or "S		
Articular Cartilage	Tear of Articular Cartilage	S83.31 X	S83.32 X	—
Cruciate Ligament	Sprain; Unspecified Cruciate Ligament	S83.501 X	S83.502 X	—
	Sprain; Anterior Cruciate Ligament	S83.511 X	S83.512 X	S83.519 X
	Sprain; Posterior Cruciate Ligament	S83.521 X	S83.522 X	S83.529 X
Meniscus	Bucket-Handle Tear; Unspecified Meniscus	S83.200 X	S83.201 X	S83.202 X
	Bucket-Handle Tear; Medial Meniscus	S83.211 X	S83.212 X	—
	Bucket-Handle Tear; Lateral Meniscus	S83.251 X	S83.252 X	S83.259 X
	Peripheral Tear; Medial Meniscus	S83.221 X	S83.222 X	S83.229 X
	Peripheral Tear; Lateral Meniscus	S83.261 X	S83.262 X	S83.269 X
	Complex Tear; Medial meniscus	S83.231 X	S83.232 X	S83.239 X
	Complex Tear; Lateral Meniscus	S83.271 X	S83.272 X	S83.279 X
	Other Tear; Unspecified Meniscus	S83.203 X	S83.204 X	S83.205 X
	Other Tear; Medial Meniscus	S83.241 X	S83.242 X	—
	Other Tear; Lateral Meniscus	S83.281 X	S83.282 X	—
	Unspecified Tear; Unspecified Meniscus	S83.206 X	S83.207 X	—

7TH DIGIT EXTENSION LETTERS REQUIRED FOR S CODES:

A = Initial Encounter—patient is actively receiving treatment (such as surgical treatment, evaluation and treatment by a new MD)

D = Subsequent Encounter—patient is in the recovery / aftercare phase (such as cast changes and removal, physical therapy and follow up visits)

S = Sequelae—patient is experiencing after effects such as scarring or pain

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