

Letter of Medical Necessity Cold & Compression Therapy Unit

Patient: _____

Date of Birth: _____

Date of Surgery: _____ Time Needed: _____

DME Description: Cold Compression Therapy

HCPCS Code: E 1399

Vasopneumatic Compression

Controlled Thermal Therapy

Cold/Compression Wrap

Diagnosis: _____

ICD-10 Code: _____

ICD-10 Code: _____

ICD-10 Code: _____

I hereby certify that this device is medically necessary to treat the acute and chronic aspects of the inflammatory reaction that accompanies trauma and surgery.

Prescriber Name: _____

NPI: _____

Prescriber Signature: _____

Date: _____