



17 Charles Street
Binghamton, NY 13905
607-584-5560
Fax: 607-584-5561

Letter of Medical Necessity for Lumbar Traction

Patient's Name: _____ DOB: _____
Insurance ID#: _____ ICD-9 Code: _____

The above named patient has been under my care since _____ receiving treatment for the referenced diagnosis.

Due to the serious nature of the patient's condition, I feel it medically necessary to embark on a regimen of home lumbar traction. The patient has been prescribed the lumbar traction device which will be instrumental in relieving symptoms.

The therapeutic effects of daily axial-extension traction are as follows:

1. Axial unloading of pain-sensitive spinal joints and soft tissues, including the intervertebral disc, facet joints, spinal ligaments, and paraspinal musculature, for pain control.
2. More successful restoration of the normal lumbar curvature.
3. Relaxation of the paraspinal musculature.
4. Promotion of circulation within the soft tissues to reduce inflammation, and facilitate healing.

Axial-extension lumbar traction is a valuable modality when performed properly on a daily basis. The lumbar traction device is specifically indicated in this case.

As it is not practical or cost effective to have a patient come to our office on a daily basis to receive treatment, the home lumbar traction regimen allows maximal rehabilitation without the expense of daily office visits. In addition, prescription of this home care device promotes control of medical costs, and discourages physician dependency. Insurance reimbursement for the lumbar traction device will increase the patient's recovery rate and minimize the chance for exacerbation and future spinal injuries, thereby both reducing overall treatment time and costs.

I certify that I am the attending physician of this patient and the durable medical equipment prescribed to the patient and discussed to the patient and discussed above is reasonable and medically necessary. It is not a convenience item. If you have questions regarding my statement please contact my office.

Sincerely,

Signature of Prescribing Physician

Date

Print Physician's Name

Address

Phone #