

GLOBAL MEDICAL EQUIPMENT

RX / MEDICAL NECESSITY FORM

PATIENT INFORMATION			SHIPPING METHOD: <input checked="" type="checkbox"/> SHIP TO PATIENT'S HOME ADDRESS <input type="checkbox"/> SHIP TO PATIENT'S PHYSICIAN CLINIC
REID	DIANE		
LAST NAME	FIRST NAME	MI	
FEMALE	12/16/1949	8315961079	
GENDER	DATE OF BIRTH	PHONE NUMBER	
2279 PEREZ ST #291	SALINAS	CA 93906	
ADDRESS	CITY	STATE & ZIPCODE	

INSURANCE INFORMATION	
MEDICARE	
PRIMARY INSURANCE	SECONDARY INSURANCE
8JW4TU9CY84	
MEMBER ID	MEMBER ID

PHYSICIAN INFORMATION	
ROBERT FERNANDEZ, MD	1114927258
PHYSICIAN NAME	NPI #
	8316247070
5 LOWER RAGSDALE DR SUITE 100 MONTEREY CA 93940	PHONE NUMBER
PRACTICE LOCATION	8316243612
	FAX NUMBER

PRESCRIPTION SELECTION	
<input type="checkbox"/> L3960 / L3670 – Shoulder Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size:) <input type="checkbox"/> L3660 – Shoulder Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size:) <input type="checkbox"/> L0650 – Lumbar Brace (Waist:) <input type="checkbox"/> L0642 – Lumbar Brace (Waist:) <input type="checkbox"/> L0457 – Lumbar Brace (Waist:) <input type="checkbox"/> L0648 – Lumbar Brace (Waist:) <input type="checkbox"/> E0100 – Electric Heat Pad <input type="checkbox"/> L1690 – Hip Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Waist:) <input type="checkbox"/> L1686 – Hip Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Waist:) <input type="checkbox"/> L2624 – Hip Joint Adjustable Flexion, Extension (Side: <input type="checkbox"/> L <input type="checkbox"/> R) <input type="checkbox"/> L3760 – Elbow Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R)	<input type="checkbox"/> L3761 – Elbow Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size:) <input type="checkbox"/> L3916 – Wrist Hand Finger (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size:) <input type="checkbox"/> L3915 - Wrist Hand Finger (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size:) <input checked="" type="checkbox"/> L1852 – Knee Brace (Side: <input checked="" type="checkbox"/> L <input checked="" type="checkbox"/> R) (Size: MEDIUM) <input type="checkbox"/> L1851 – Knee Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size:) <input type="checkbox"/> L1833 – Knee Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size:) <input checked="" type="checkbox"/> L2397 – Knee Sleeve (Size: MEDIUM) (Qty: 2) <input type="checkbox"/> E0100 – Cane <input type="checkbox"/> L2425 – Dial Lock Hinge ROM <input type="checkbox"/> L2820 – Lower Extremity Ortho <input type="checkbox"/> L1906 / L1971 – Ankle Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Shoe Size:) <input type="checkbox"/> L0174 – Cervical Brace <input type="checkbox"/> L3170 – Heel Stabilizer (Side: <input type="checkbox"/> L <input type="checkbox"/> R)

MEDICAL INFORMATION	
ICD 10 (Diagnosis Code(s)):	
<input type="checkbox"/> M54.50- Low back pain, unspecified <input checked="" type="checkbox"/> M17.12- Unilateral primary osteoarthritis left knee <input checked="" type="checkbox"/> M17.11-Unilateral primary osteoarthritis right knee <input type="checkbox"/> M25.512-Pain in the left shoulder <input type="checkbox"/> M25.511-Pain in the right shoulder <input type="checkbox"/> M25.552- Pain in Left Hip <input type="checkbox"/> M25.551- Pain in Right Hip	<input type="checkbox"/> M25.532- Pain in left wrist <input type="checkbox"/> M25.531 - Pain in right wrist <input type="checkbox"/> M19.072- Osteoarthritis Left Ankle <input type="checkbox"/> M19.071- Osteoarthritis Right Ankle <input type="checkbox"/> M25.522 Pain in left elbow <input type="checkbox"/> M25.521 Pain in right elbow <input type="checkbox"/> M54.2-Cervicalgia Pain in Neck
Length of Need: <input checked="" type="checkbox"/> 12+ months (long term) <input type="checkbox"/> ____ # of months (1-11)	

GLOBAL MEDICAL EQUIPMENT

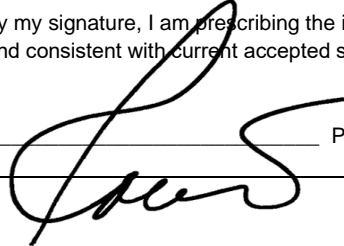
MEDICAL HISTORY**Previous treatments: TAKING MEDICATION AND PHYSICAL THERAPY**

Doctor's Notes: The patient reports chronic **LEFT KNEE AND RIGHT KNEE** pain for **6 YEARS**. Patient states pain is **DULL AND SHARP** with a pain scale of **6** and pain worsens with movements. Pain is caused by **ARTHRITIS AND OSTEONECROSIS** and is experienced **CONSTANTLY**. Previous treatments with heat, ice and rest have been unsuccessful to control pain level.

PHYSICIAN SIGNATURE

Physician Verification: By my signature, I am prescribing the items listed above and certifying that the above-prescribed item(s) is medically indicated and necessary and consistent with current accepted standards of medical practice and treatment of this patient's physical condition.

PHYSICIAN SIGNATURE: _____



PHYSICIAN NAME: _____

ROBERT FERNANDEZ, MD

DATE: _____

09/24/24

GLOBAL MEDICAL EQUIPMENT

Patient Name: **DIANE REID**
Patient Address: **2279 PEREZ ST #291 SALINAS CA 93906**
Patient Phone: **8315961079**

Physician Name: **ROBERT FERNANDEZ, MD**
Address: 5 LOWER RAGSDALE DR SUITE 100 MONTEREY CA 93940
Telephone: 8316247070
Fax: 8316243612

Patient: **DIANE REID**
Date of Birth: **12/16/1949**
Visit Date: **July 09, 2024**
Reason for visit: **CHECK-UP**

Clinical Summary

Patient Demographics

Patient Name:	DIANE REID	Date of Birth:	12/16/1949
Age:	74	Phone Number:	8315961079
Address:	2279 PEREZ ST #291	City:	SALINAS
State:	CA	Zip Code:	93906
Gender:	FEMALE	Height:	4'9
Weight:	125	Waist Size	MEDIUM

Patient Insurance

Provider:	MEDICARE	Member ID:	8JW4TU9CY84
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Medications

Current Medication	ASPIRIN, TYLENOL AND HIGH BLOOD PRESSURE PILL
Medical History	HIGH BLOOD PRESSURE

Medical Diagnosis

The pain level was indicated on a scale of 1-10 as the following: 6
The patient's pain started on or around 6 YEARS
The surgery addressed the following: NA
The pain is experienced CONSTANTLY
The patient has attempted the following previous treatments/therapies: TAKING MEDICATION AND PHYSICAL THERAPY
The patient described their pain as the following: DULL AND SHARP
The activities that make the patient's pain worse is as follows: DOING DAILY ACTIVITIES
The pain is located in the patient's LEFT KNEE AND RIGHT KNEE
The patient's pain is caused by ARTHRITIS AND OSTEONECROSIS
The last time the patient has seen the doctor was on July 09, 2024

Chief Complaint

The patient's main complaint is that they experience chronic pain located in the following location(s): LEFT KNEE AND RIGHT KNEE
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Subjective Notes

The patient reports chronic LEFT KNEE AND RIGHT KNEE pain for 6 YEARS. Patient states pain is DULL AND SHARP with a pain scale of 6 and pain worsens with movement. The pain is caused by ARTHRITIS AND OSTEONECROSIS and is experienced CONSTANTLY. Previous treatments with heat, ice, and rest have been unsuccessful to control pain level.

Objective of Assessment (Review of Symptoms)

Patient has chronic pain for 6 YEARS located in their LEFT KNEE AND RIGHT KNEE related to M17.11-Unilateral primary osteoarthritis right knee, M17.12- Unilateral primary osteoarthritis left knee. Patient has been to a physical therapist and hasn't had previous surgery to treat this pain.
Patient's chronic pain is described DULL AND SHARP and occurs CONSTANTLY. The patient rated their pain on a scale of 1-10 (10 being the worst) on a level 6. The following activities make the patient's pain worse: DOING DAILY ACTIVITIES. Patient needs a LEFT KNEE AND RIGHT KNEE Brace to provide support and reduce pain level.

GLOBAL MEDICAL EQUIPMENT

Plan & Treatment Goals

Based on my evaluation of the patient's condition, I am ordering the following device(s) **L1852 KNEE BRACE - KNEE ORTHOSIS (KO), DOUBLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, PREFABRICATED, OFF-THE-SHELF WHICH INCLUDES L2397 SUSPENSION SLEEVE**, including fitting and adjustment if needed. The patient has been instructed to wear the device daily, as needed. The benefits of this device, which is an alternative, non-invasive method to potentially relieve pain, has been explained to the patient who is interested in this treatment. Based on my assessment, I have determined it is medically necessary and appropriate to prescribe treatment today. For the patient's complaint, I am prescribing this device. The patient will benefit by helping her address any of the following: give support to weak muscles, improve patient's pain, improve patient's function, increase performance in activities of daily living, improve ambulation, reduce medications, slow degeneration, provide stability, provide support. Reduce pain by restricting the mobility of the trunk; reduce the risk of medical problems escalating the patient's present condition, facilitate healing following an injury or surgical procedure to the spine or related soft tissues; To support weak spinal muscles and/or a deformed spine. If the patient's pain persists or worsens and/or there is an acute trauma or injury related to this pain, the patient agrees and understands to go to the Emergency Room or follow-up with their Primary Care Physician for further testing and imaging that may be immediately necessary.

ICD 10 (Diagnostic Codes)

M17.11-Unilateral primary osteoarthritis right knee, M17.12- Unilateral primary osteoarthritis left knee

Agreements

We understand that you are choosing to use our professional medical services to receive a prescription for your new brace.

Physician Information

Provider Name: **ROBERT FERNANDEZ, MD**

Address: **5 LOWER RAGSDALE DR SUITE 100 MONTEREY CA 93940**

Physician's Signature:



Date: **09/24/24**

Patient Name: **DIANE REID**

Patient Address: **2279 PEREZ ST #291 SALINAS CA 93906**

Patient Phone: **8315961079**

GLOBAL MEDICAL EQUIPMENT

LETTER OF MEDICAL NECESSITY

Re: **DIANE REID**
Orthotic Device Need Assessment
Exam Date: **09/23/2024**
Height: **4'9**
Weight: **125**
DOB: **12/16/1949**

Ms REID is inquiring about utilizing orthotic bracing for his/her current conditions. His/her chief complaint at the time of this assessment is: **LEFT KNEE AND RIGHT KNEE**.

Ms REID reports chronic **LEFT KNEE AND RIGHT KNEE** pain for **6 YEARS**. Patient states pain is **DULL AND SHARP** with a pain scale of 6 and pain worsens with **DOING DAILY ACTIVITIES**. Pain is experienced **CONSTANTLY**. Previous treatments with heat, ice, medication and rest have been unsuccessful to control pain levels.

Diagnosis includes: **M17.11-Unilateral primary osteoarthritis right knee, M17.12- Unilateral primary osteoarthritis left knee**. Based on my conversation with **Ms REID** and evaluation of his/her condition, I am ordering the following: **L1852 KNEE BRACE - KNEE ORTHOSIS (KO), DOUBLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, PREFABRICATED, OFF-THE-SHELF WHICH INCLUDES L2397 SUSPENSION SLEEVE**.

Patient is ambulatory and has weakness of the **LEFT KNEE AND RIGHT KNEE** requiring stabilization for improvement of functionality. I am prescribing this **KNEE** orthosis for the following indication(s): to aid when the patient is **DOING DAILY ACTIVITIES**, to aid in stabilization of the **KNEE**. My treatment goal(s) for the use of the prescribed **KNEE** orthosis are: improvement in patient's function, improvement in patient's pain. The patient has been instructed to use the brace(s) daily, as needed.

Custom fitting of the orthosis is not required and the patient or an assisting caregiver can apply the prescribed orthotic device with minimal self-adjustment. **Ms REID** has been provided a phone number to call if there are any additional comments or questions regarding this examination, and I have recommended that **Ms REID** continue medical follow-up as part of an ongoing plan of care.

Re: **DIANE REID**..... DOB: **DECEMBER 16, 1949**

I, **ROBERT FERNANDEZ, MD**, verify and confirm this order for the above-named patient, and certify that I have personally performed the assessment of the patient for the prescribed treatment and device and verify that it is reasonably and medically necessary, according to accepted standards of medical practice within the community, for this patient's medical condition.


ROBERT FERNANDEZ, MD
Signature

Date Signed: 09/24/24

GLOBAL MEDICAL EQUIPMENT

Comprehensive Knee Laxity Test (Check All Applicable)

Objective Tests: (Check ALL applicable, a minimum of 2 tests is required for each knee with a brace prescribed.)

Caution: Advise Patients to stabilize themselves properly during any standing test to avoid a fall injury.

Pivot Shift Test (Stabilization to avoid fall advised for this test. Patient can stabilize themselves by holding onto a chair or kitchen counter.)

Positive: Patient knee gives out while pivoting or twisting indication joint laxity

Negative: Patient knee DOES NOT give out while pivoting or twisting.

LEFT:	Positive
RIGHT:	Positive

Cabot's Maneuver (figure of "4" knee bend)

Positive: Patient indicates lateral joint line pain, LCL instability and ligament laxity

Negative: Patient knee DOES NOT produce lateral knee pain

(Leave positive and negative both unchecked for the knee if did not perform this test on the knee.)

LEFT:	Positive
RIGHT:	Positive