

FIRST STEP DME INC,

RX / MEDICAL NECESSITY FORM**PATIENT INFORMATION**

ANGEL

LAST NAME

DELORES

FIRST NAME

MI

FEMALE

GENDER

09/24/1944

DATE OF BIRTH

9135684850

PHONE NUMBER

10349 W CHAPARRAL DR

ADDRESS

SUN CITY

CITY

AZ 85373

STATE & ZIPCODE

SHIPPING METHOD:

- ☒ SHIP TO PATIENT'S HOME ADDRESS
☐ SHIP TO PATIENT'S PHYSICIAN CLINIC

INSURANCE INFORMATION

MEDICARE

PRIMARY INSURANCE

6UQ0M56VX10

MEMBER ID

SECONDARY INSURANCE

MEMBER ID

PHYSICIAN INFORMATION

TIMOTHY RIDER MD

PHYSICIAN NAME

1215998364

NPI #

6235613000

PHONE NUMBER

26900 N LAKE PLEASANT PKWY SUITE 210 PEORIA AZ 85383

PRACTICE LOCATION

6025613009

FAX NUMBER

PRESCRIPTION SELECTION

- ☐ L3670 – Shoulder Brace (Side: ☐ L ☐ R) (Size:)
☐ L3960 – Shoulder Brace (Side: ☐ L ☐ R) (Size:)
☐ L3660 – Shoulder Brace (Side: ☐ L ☐ R) (Size:)
☐ L0650 – Lumbar Brace (Waist:)
☐ L0642 – Lumbar Brace (Waist:)
☐ L0457 – Lumbar Brace (Waist:)
☐ L0648 – Lumbar Brace (Waist:)
☐ E0100 – Electric Heat Pad
☐ L1690 – Hip Brace (Side: ☐ L ☐ R) (Waist:)
☐ L1686 – Hip Brace (Side: ☐ L ☐ R) (Waist:)
☐ L2624 – Hip Joint Adjustable Flexion, Extension (Side: ☐ L ☐ R)
☐ L3760 – Elbow Brace (Side: ☐ L ☐ R)

- ☐ L3761 – Elbow Brace (Side: ☐ L ☐ R) (Size:)
☐ L3916 – Wrist Hand Finger (Side: ☐ L ☐ R) (Size:)
☐ L3915 – Wrist Hand Finger (Side: ☐ L ☐ R) (Size:)
☒ L1852 – Knee Brace (Side: ☒ L ☒ R) (Size: **MEDIUM**)
☐ L1833 – Knee Brace (Side: ☐ L ☐ R) (Size:)
☒ L2397 – Knee Sleeve (Size: **MEDIUM**) (Qty: 2)
☐ E0100 – Cane
☐ L2425 – Dial Lock Hinge ROM
☐ L2820 – Lower Extremity Ortho
☐ L1971 – Ankle Brace (Side: ☐ L ☐ R) (Shoe Size:)
☐ L1906 – Ankle Brace (Side: ☐ L ☐ R) (Shoe Size:)
☐ L0174 – Cervical Brace
☐ L3170 – Heel Stabilizer (Side: ☐ L ☐ R)

MEDICAL INFORMATION**ICD 10 (Diagnosis Code(s)):**

- ☐ M54.50- Low back pain, unspecified
☒ M17.12- Unilateral primary osteoarthritis left knee
☒ M17.11- Unilateral primary osteoarthritis right knee
☐ M25.512- Pain in the left shoulder
☐ M25.511- Pain in the right shoulder
☐ M25.552- Pain in Left Hip
☐ M25.551- Pain in Right Hip

- ☐ M25.532- Pain in left wrist
☐ M25.531 - Pain in right wrist
☐ M19.072- Osteoarthritis Left Ankle
☐ M19.071- Osteoarthritis Right Ankle
☐ M25.522 Pain in left elbow
☐ M25.521 Pain in right elbow
☐ M54.2- Cervicalgia Pain in Neck

Length of Need: ☒ 12+ months (long term) ☐ _____ # of months (1-11)

FIRST STEP DME INC,


MEDICAL HISTORY**Previous treatments: TAKING MEDICATION**

Doctor's Notes: The patient reports chronic **LEFT KNEE, RIGHT KNEE** pain for **6 MONTHS**. Patient states pain is **DULL** with a pain scale of **6** and pain worsens with movements. Pain is caused by **WEAR AND TEAR** and is experienced **SOMETIMES**. 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: _____

TIMOTHY RIDER MD

DATE: _____

09-03-2024

FIRST STEP DME INC,

Patient Name: **DELORES ANGEL**Patient Address: **10349 W CHAPARRAL DR SUN CITY AZ 85373**Patient Phone: **9135684850**Physician Name: **TIMOTHY RIDER MD**Address: **26900 N LAKE PLEASANT PKWY SUITE 210 PEORIA
AZ 85383**Telephone: **6235613000**Fax: **6025613009**Patient: **DELORES ANGEL**Date of Birth: **09/24/1944**Visit Date: **WITHIN A YEAR**Reason for visit: **CHECK-UP**

Clinical Summary

Patient Demographics

Patient Name:	DELORES ANGEL	Date of Birth:	09/24/1944
Age:	79	Phone Number:	9135684850
Address:	10349 W CHAPARRAL DR	City:	SUN CITY
State:	AZ	Zip Code:	85373
Gender:	FEMALE	Height:	5'7
Weight:	180	Waist Size	L

Patient Insurance

Provider:	MEDICARE	Member ID:	6UQ0M56VX10
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Medications

Current Medication	TYLENOL
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 MONTHS
The surgery addressed the following: NA
The pain is experienced SOMETIMES
The patient has attempted the following previous treatments/therapies: TAKING MEDICATION
The patient described their pain as the following: DULL
The activities that make the patient's pain worse is as follows: WALKING AND STNADING
The pain is located in the patient's LEFT KNEE, RIGHT KNEE
The patient's pain is caused by WEAR AND TEAR
The last time the patient has seen the doctor was on WITHIN A YEAR

Chief Complaint

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

The patient reports chronic LEFT KNEE, RIGHT KNEE pain for 6 MONTHS . Patient states pain is DULL with a pain scale of 6 and pain worsens with movement. The pain is caused by WEAR AND TEAR and is experienced SOMETIMES . Previous treatments with heat, ice, and rest have been unsuccessful to control pain level.
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Objective of Assessment (Review of Symptoms)

Patient has chronic pain for 6 MONTHS located in their LEFT KNEE, 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 occurs SOMETIMES . 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: WALKING AND STNADING . Patient needs a BACK, LEFT KNEE, RIGHT KNEE, RIGHT WRIST AND LEFT WRIST Brace to provide support and reduce pain level.

FIRST STEP DME INC,

Plan & Treatment Goals

Based on my evaluation of the patient's condition, I am ordering the following device(s) **L1852 KNEE ORTHOSIS (KO), SINGLE 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 (ADDITION TO LOWER EXTREMITY ORTHOSIS, 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: **TIMOTHY RIDER MD**

Address: **26900 N LAKE PLEASANT PKWY SUITE 210 PEORIA AZ 85383**

Physician's Signature:



Date:

09-03-2024

Patient Name: **DELORES ANGEL**

Patient Address: **10349 W CHAPARRAL DR SUN CITY AZ 85373**

Patient Phone: **9135684850**

FIRST STEP DME INC,

LETTER OF MEDICAL NECESSITY

Re: **DELORES ANGEL**
Orthotic Device Need Assessment
Exam Date: **09/03/2024**
Height: **5'7**
Weight: **180**
DOB: **09/24/1944**

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

Ms ANGEL reports chronic **LEFT KNEE, RIGHT KNEE** pain for **6 MONTHS**. Patient states pain is **DULL** with a pain scale of 6 and pain worsens with **WALKING AND STNADING**. Pain is experienced **SOMETIMES**. 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 ANGEL** and evaluation of his/her condition, I am ordering the following: **L1852 KNEE ORTHOSIS (KO), SINGLE 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 (ADDITION TO LOWER EXTREMITY ORTHOSIS, SUSPENSION SLEEVE)**

Patient is ambulatory and has weakness of the **LEFT KNEE, 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 **WALKING AND STNADING**, 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 ANGEL** 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 ANGEL** continue medical follow-up as part of an ongoing plan of care.

Re: **DELORES ANGEL**..... DOB: **September 24, 1944**

I, **TIMOTHY RIDER 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.


TIMOTHY RIDER MD
Signature

Date Signed 09-03-2024

FIRST STEP DME INC,

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