

RX / MEDICAL NECESSITY FORM

MEDICAL INFORMATION	
ICD 10 (Diagnosis Code(s)):	
<input checked="" type="checkbox"/> M54.50- Low back pain, unspecified <input type="checkbox"/> M17.12- Unilateral primary osteoarthritis left knee <input 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 neck
Length of Need:	
<input checked="" type="checkbox"/> 12+ months (long term)	<input type="checkbox"/> _____ # of months (1-11)

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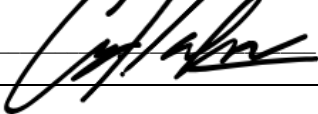
MEDICAL HISTORY

Previous treatments: TAKING MEDICATION

Doctor's Notes: The patient reports chronic **Back** pain for **A YEAR**. Patient states pain is **ACHY** with a pain scale of **5** and pain worsens with movements. Pain is caused by **ARTHRITIS** 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: ROBERT CALLAHAN MD

DATE: 10-16-2024

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Patient Name: **CAROLE NADEAU**
Patient Address: **3518 BELMAR DR DES MOINES IA 50317**
Patient Phone: **5152658423**

Physician Name: **ROBERT CALLAHAN MD**
Address: **4326 HICKMAN RD SUITE 100 DES MOINES IA 50310**
Telephone: **5152716333**
Fax: **5152716379**

Patient: **CAROLE NADEAU**
Date of Birth: **01/03/1938**
Visit Date: **July 16, 2024**
Reason for visit: **Check-up**

Clinical Summary

Patient Demographics

Patient Name:	CAROLE NADEAU	Date of Birth:	01/03/1938
Age:	86	Phone Number:	5152658423
Address:	3518 BELMAR DR	City:	DES MOINES
State:	IA	Zip Code:	50317
Gender:	FEMALE	Height:	5'8
Weight:	145	Waist Size	M

Patient Insurance

Provider:	MEDICARE	Member ID:	9KD8X46WQ63
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Medications

Current Medication	TYLENOL
Medical History	NONE

Medical Diagnosis

The pain level was indicated on a scale of 1-10 as the following: 5
The patient's pain started on or around A YEAR
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: ACHY
The activities that make the patient's pain worse is as follows: BENDING, LIFTING
The pain is located in the patient's Back
The patient's pain is caused by ARTHRITIS
The last time the patient has seen the doctor was on July 16, 2024

Chief Complaint

The patient's main complaint is that they experience chronic pain located in the following location(s): Back

Subjective Notes

The patient reports chronic Back pain for A YEAR . Patient states pain is ACHY with a pain scale of 5 and pain worsens with movement. The pain is caused by ARTHRITIS and is experienced SOMETIMES . 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 A YEAR located in their Back related to M54.50- Low back pain, unspecified . Patient has been to a physical therapist and hasn't had previous surgery to treat this pain.
Patient's chronic pain is described ACHY and occurs SOMETIMES . The patient rated their pain on a scale of 1-10 (10 being the worst) on a level 5 . The following activities make the patient's pain worse: BENDING, LIFTING . Patient needs a Back Brace to provide support and reduce pain level.

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Plan & Treatment Goals

Based on my evaluation of the patient's condition, I am ordering the following device(s) **L0457 (TLSO, FLEXIBLE, PROVIDES TRUNK SUPPORT, THORACIC REGION, RIGID POSTERIOR PANEL AND SOFT ANTERIOR APRON, EXTENDS FROM THE SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO THE SCAPULAR SPINE, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL PLANE, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS, INCLUDES STRAPS AND CLOSURES, PREFABRICATED, OFF-THE-SHELF)**, 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 arthritis 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 arthritis 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)

M54.50- Low back pain, unspecified

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 CALLAHAN MD**

Address: **4326 HICKMAN RD SUITE 100 DES MOINES IA 50310**

Physician's Signature:



Date:

10-16-2024

Patient Name: **CAROLE NADEAU**

Patient Address: **3518 BELMAR DR DES MOINES IA 50317**

Patient Phone: **5152658423**

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LETTER OF MEDICAL NECESSITY

Re: **CAROLE NADEAU**
Orthotic Device Need Assessment
Exam Date: **10/15/2024**
Height: **5'8**
Weight: **145**
DOB: **01/03/1938**

Ms NADEAU is inquiring about utilizing orthotic bracing for his/her current conditions. His/her chief complaint at the time of this assessment is: **Back**.

Ms NADEAU reports chronic **Back** pain for **A YEAR**. Patient states pain is **ACHY** with a pain scale of **5** and pain worsens with **BENDING, LIFTING**. Pain is experienced **SOMETIMES**. Previous treatments with heat, ice, medication and rest have been unsuccessful to control pain levels.

Diagnosis includes: **M54.50- Low back pain, unspecified**. Based on my conversation with **Ms NADEAU** and evaluation of his/her condition, I am ordering the following: **L0457 (TLSO, FLEXIBLE, PROVIDES TRUNK SUPPORT, THORACIC REGION, RIGID POSTERIOR PANEL AND SOFT ANTERIOR APRON, EXTENDS FROM THE SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO THE SCAPULAR SPINE, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL PLANE, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS, INCLUDES STRAPS AND CLOSURES, PREFABRICATED, OFF-THE-SHELF)**.

Patient is ambulatory and has weakness of the **Back** requiring stabilization for improvement of functionality. I am prescribing this **Back** orthosis for the following indication(s): to aid when the patient is **BENDING, LIFTING**, to aid in stabilization of the **Back**. My treatment goal(s) for the use of the prescribed **Back** 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 NADEAU** 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 NADEAU** continue medical follow-up as part of an ongoing plan of care.

Re: **CAROLE NADEAU..... DOB: January 03, 1938**

I, **ROBERT CALLAHAN 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.


Signature

Date Signed: 10-16-2024