

DV MEDICAL SUPPLY

RX / MEDICAL NECESSITY FORM

<b>PATIENT INFORMATION</b>			<b>SHIPPING METHOD:</b> <input checked="" type="checkbox"/> SHIP TO PATIENT'S HOME ADDRESS <input type="checkbox"/> SHIP TO PATIENT'S PHYSICIAN CLINIC
<b>PAYNE</b>	<b>BETTY</b>		
LAST NAME	FIRST NAME	MI	
<b>FEMALE</b>	<b>12/02/1948</b>	<b>5407183176</b>	
GENDER	DATE OF BIRTH	PHONE NUMBER	
<b>10397 CARROL CT</b>	<b>KING GEORGE</b>	<b>VA 22485</b>	
ADDRESS	CITY	STATE & ZIPCODE	

<b>INSURANCE INFORMATION</b>	
<b>MEDICARE</b>	
PRIMARY INSURANCE	SECONDARY INSURANCE
<b>3AQ0Q17NQ23</b>	
MEMBER ID	MEMBER ID

<b>PHYSICIAN INFORMATION</b>	
<b>SARAH LEE M.D.</b>	<b>1760917090</b>
PHYSICIAN NAME	NPI #
	<b>8044233636</b>
	PHONE NUMBER
<b>2384 COLONY CROSSING PL MIDLOTHIAN VA 23112</b>	<b>8044233637</b>
PRACTICE LOCATION	FAX NUMBER

<b>PRESCRIPTION SELECTION</b>	
<input type="checkbox"/> <b>L3670</b> – Shoulder Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size: ) <input type="checkbox"/> <b>L3960</b> – Shoulder Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size: ) <input type="checkbox"/> <b>L3660</b> – Shoulder Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size: ) <input type="checkbox"/> <b>L0650</b> – Lumbar Brace (Waist: ) <input type="checkbox"/> <b>L0642</b> – Lumbar Brace (Waist: ) <input checked="" type="checkbox"/> <b>L0457</b> – Lumbar Brace (Waist: <b>LARGE</b> ) <input type="checkbox"/> <b>L0648</b> – Lumbar Brace (Waist: ) <input type="checkbox"/> <b>E0100</b> – Electric Heat Pad <input type="checkbox"/> <b>L1690</b> – Hip Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Waist: ) <input type="checkbox"/> <b>L1686</b> – Hip Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Waist: ) <input type="checkbox"/> <b>L2624</b> – Hip Joint Adjustable Flexion, Extension (Side: <input type="checkbox"/> L <input type="checkbox"/> R) <input type="checkbox"/> <b>L3760</b> – Elbow Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R)	<input type="checkbox"/> <b>L3761</b> – Elbow Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size: ) <input type="checkbox"/> <b>L3916</b> – Wrist Hand Finger (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size: ) <input type="checkbox"/> <b>L3915</b> - Wrist Hand Finger (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size: ) <input type="checkbox"/> <b>L1851</b> – Knee Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size: ) <input type="checkbox"/> <b>L1833</b> – Knee Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size: ) <input type="checkbox"/> <b>L2397</b> – Knee Sleeve (Size: ) (Qty: ) <input type="checkbox"/> <b>E0100</b> – Cane <input type="checkbox"/> <b>L2425</b> – Dial Lock Hinge ROM <input type="checkbox"/> <b>L2820</b> – Lower Extremity Ortho <input checked="" type="checkbox"/> <b>L1906</b> – Ankle Brace (Side: <input checked="" type="checkbox"/> L <input checked="" type="checkbox"/> R) (Shoe Size: <b>6</b> ) <input type="checkbox"/> <b>L1971</b> – Ankle Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Shoe Size: ) <input type="checkbox"/> <b>L0174</b> – Cervical Brace <input checked="" type="checkbox"/> <b>L3170</b> – Heel Stabilizer (Side: <input checked="" type="checkbox"/> L <input checked="" type="checkbox"/> R)

<b>MEDICAL INFORMATION</b>	
<b>ICD 10 (Diagnosis Code(s)):</b>	
<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 checked="" type="checkbox"/> M19.072- Osteoarthritis Left Ankle <input checked="" 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
<b>Length of Need:</b> <input checked="" type="checkbox"/> 12+ months (long term) <input type="checkbox"/> _____ # of months (1-11)	

## DV MEDICAL SUPPLY

**MEDICAL HISTORY****Previous treatments: TAKING MEDICATION**

**Doctor's Notes:** The patient reports chronic **LOWER BACK, RIGHT ANKLE AND LEFT ANKLE** pain for **MORE THAN A YEAR**. Patient states pain is **ACHY** with a pain scale of **8** and pain worsens with movements. Pain is caused by **ARTHRITIS** 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:

**SARAH LEE M.D.**

DATE:

08-05-2024

DV MEDICAL SUPPLY

Patient Name: **BETTY PAYNE**  
Patient Address: **10397 CARROL CT KING GEORGE VA 22485**  
Patient Phone: **5407183176**

Physician Name: **SARAH LEE M.D.**  
Address: 2384 COLONY CROSSING PL MIDLOTHIAN VA 23112  
Telephone: 8044233636  
Fax: 8044233637

Patient: **BETTY PAYNE**  
Date of Birth: **12/02/1948**  
Visit Date: **WITHIN A YEAR**  
Reason for visit: **CHECK-UP**

Clinical Summary

Patient Demographics

Patient Name:	BETTY PAYNE	Date of Birth:	12/02/1948
Age:	75	Phone Number:	5407183176
Address:	10397 CARROL CT	City:	KING GEORGE
State:	VA	Zip Code:	22485
Gender:	FEMALE	Height:	4'11
Weight:	160	Waist Size	L

Patient Insurance

Provider:	MEDICARE	Member ID:	3AQ0Q17NQ23
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Medications

Current Medication	TYLENOL (2X A DAY)
Medical History	NONE

Medical Diagnosis

The pain level was indicated on a scale of 1-10 as the following: <b>8</b>
The patient's pain started on or around <b>MORE THAN A YEAR</b>
The surgery addressed the following: <b>NA</b>
The pain is experienced <b>CONSTANTLY</b>
The patient has attempted the following previous treatments/therapies: <b>TAKING MEDICATION</b>
The patient described their pain as the following: <b>ACHY</b>
The activities that make the patient's pain worse is as follows: <b>WALKING</b>
The pain is located in the patient's <b>LOWER BACK, RIGHT ANKLE AND LEFT ANKLE</b>
The patient's pain is caused by <b>ARTHRITIS</b>
The last time the patient has seen the doctor was on <b>WITHIN A YEAR</b>

Chief Complaint

The patient's main complaint is that they experience chronic pain located in the following location(s): <b>LOWER BACK, RIGHT ANKLE AND LEFT ANKLE</b>
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Subjective Notes

The patient reports chronic <b>LOWER BACK, RIGHT ANKLE AND LEFT ANKLE</b> pain for <b>MORE THAN A YEAR</b> . Patient states pain is <b>ACHY</b> with a pain scale of <b>8</b> and pain worsens with movement. The pain is caused by <b>ARTHRITIS</b> and is experienced <b>CONSTANTLY</b> . 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 <b>MORE THAN A YEAR</b> located in their <b>LOWER BACK, RIGHT ANKLE AND LEFT ANKLE</b> related to <b>M54.50- Low back pain, unspecified, M19.072- Osteoarthritis Left Ankle, M19.071- Osteoarthritis Right Ankle</b> . Patient has been to a physical therapist and hasn't had previous surgery to treat this pain.
Patient's chronic pain is described <b>ACHY</b> and occurs <b>CONSTANTLY</b> . The patient rated their pain on a scale of 1-10 (10 being the worst) on a level <b>8</b> . The following activities make the patient's pain worse: <b>WALKING</b> . Patient needs a <b>BACK, RIGHT ANKLE AND LEFT ANKLE</b> Brace to provide support and reduce pain level.

## DV MEDICAL SUPPLY

## Plan &amp; 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), L1906 ANKLE FOOT ORTHOSIS, MULTILIGAMENTOUS ANKLE SUPPORT, PREFABRICATED, OFF-THE-SHELF ICLUDES L3170 HEEL STABILIZER.**, 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)

**M54.50- Low back pain, unspecified, M19.072- Osteoarthritis Left Ankle, M19.071- Osteoarthritis Right Ankle**

## 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: **SARAH LEE M.D.**

Address: **2384 COLONY CROSSING PL MIDLOTHIAN VA 23112**

Physician's Signature:



Date:

**08-05-2024**

Patient Name: **BETTY PAYNE**

Patient Address: **10397 CARROL CT KING GEORGE VA 22485**

Patient Phone: **5407183176**

## DV MEDICAL SUPPLY

## LETTER OF MEDICAL NECESSITY

Re: **BETTY PAYNE**  
Orthotic Device Need Assessment  
Exam Date: **06/07/2024**  
Height: **4'11**  
Weight: **150**  
DOB: **12/02/1948**

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

**Ms PAYNE** reports chronic **LOWER BACK, RIGHT ANKLE AND LEFT ANKLE** pain for **MORE THAN A YEAR**. Patient states pain is **ACHY** with a pain scale of 8 and pain worsens with **WALKING**. Pain is experienced **CONSTANTLY**. Previous treatments with heat, ice, medication and rest have been unsuccessful to control pain levels.

Diagnosis includes: **M54.50- Low back pain, unspecified, M19.072- Osteoarthritis Left Ankle, M19.071- Osteoarthritis Right Ankle**. Based on my conversation with **Ms PAYNE** 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), L1906 ANKLE FOOT ORTHOSIS, MULTILIGAMENTOUS ANKLE SUPPORT, PREFABRICATED, OFF-THE-SHELF INCLUDES L3170 HEEL STABILIZER**.

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

Re: **BETTY PAYNE**..... DOB: **December 02, 1948**

I, **SARAH LEE M.D.**, 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.

**SARAH LEE M.D.**

Signature

Date Signed: 08-05-2024