

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
WOMMACK	BARBARA		
LAST NAME	FIRST NAME	MI	
FEMALE	03/04/46	4176783669	
GENDER	DATE OF BIRTH	PHONE NUMBER	
1204 W MEADOWOOD DR	AURORA	MO 65605	
ADDRESS	CITY	STATE & ZIPCODE	

INSURANCE INFORMATION	
MEDICARE	
PRIMARY INSURANCE	SECONDARY INSURANCE
3QC2VK8MP81	
MEMBER ID	MEMBER ID

PHYSICIAN INFORMATION	
KEITH A MEYER, MD	1770667925
PHYSICIAN NAME	NPI #
	4176785176
	PHONE NUMBER
550 S HUDSON AVE AURORA MO 65605	4176780675
PRACTICE LOCATION	FAX NUMBER

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

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

DV MEDICAL SUPPLY

MEDICAL HISTORY**Previous treatments: TAKING MEDICATIONS**

Doctor's Notes: The patient reports chronic **LEFT KNEE, RIGHT KNEE** pain for **1 MONTH**. Patient states pain is **THROBBING** with a pain scale of **10** 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: 

KEITH A MEYER, MD

PHYSICIAN NAME: _____

DATE: _____

10-23-2024

Patient Name: **BARBARA WOMMACK**
Patient Address: **1204 W MEADOWOOD DR AURORA MO 65605**
Patient Phone: **4176783669**

Physician Name: **KEITH A MEYER, MD**
Address: **550 S HUDSON AVE AURORA MO 65605**
Telephone: **4176785176**
Fax: **4176780675**

Patient: **BARBARA WOMMACK**
Date of Birth: **03/04/46**
Visit Date: **WITHIN A YEAR**
Reason for visit: **CHECK-UP**

Clinical Summary

Patient Demographics

Patient Name:	BARBARA WOMMACK	Date of Birth:	03/04/46
Age:	78	Phone Number:	4176783669
Address:	1204 W MEADOWOOD DR	City:	AURORA
State:	MO	Zip Code:	65605
Gender:	FEMALE	Height:	5'1
Weight:	150	Waist Size	MEDIUM

Patient Insurance

Provider:	MEDICARE	Member ID:	3QC2VK8MP81
-----------	----------	------------	-------------

Medications

Current Medication	TYLENOL
Medical History	NONE

Medical Diagnosis

The pain level was indicated on a scale of 1-10 as the following: 10
The patient's pain started on or around 1 MONTH
The surgery addressed the following: NA
The pain is experienced SOMETIMES
The patient has attempted the following previous treatments/therapies: TAKING MEDICATIONS
The patient described their pain as the following: THROBBING
The activities that make the patient's pain worse is as follows: PERFORMING DAILY ACTIVITIES
The pain is located in the patient's LEFT KNEE, RIGHT KNEE
The patient's pain is caused by ARTHRITIS
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

Subjective Notes

The patient reports chronic LEFT KNEE, RIGHT KNEE pain for 1 MONTH. Patient states pain is THROBBING with a pain scale of 10 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 1 MONTH 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 THROBBING and occurs SOMETIMES. The patient rated their pain on a scale of 1-10 (10 being the worst) on a level 10. The following activities make the patient's pain worse: PERFORMING DAILY ACTIVITIES. Patient needs a BACK, LEFT KNEE, RIGHT KNEE, RIGHT WRIST AND LEFT WRIST Brace to provide support and reduce pain level.

DV MEDICAL SUPPLY

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: **KEITH A MEYER, MD**

Address: **550 S HUDSON AVE AURORA MO 65605**

Physician's Signature:



10-23-2024

Date:

Patient Name: **BARBARA WOMMACK**

Patient Address: **1204 W MEADOWOOD DR AURORA MO 65605**

Patient Phone: **4176783669**

DV MEDICAL SUPPLY

LETTER OF MEDICAL NECESSITY

Re: **BARBARA WOMMACK**
Orthotic Device Need Assessment
Exam Date: **10/22/2024**
Height: **5'1**
Weight: **150**
DOB: **03/04/46**

Ms WOMMACK 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 WOMMACK reports chronic **LEFT KNEE, RIGHT KNEE** pain for **1 MONTH**. Patient states pain is **THROBBING** with a pain scale of 10 and pain worsens with **ARTHRITIS**. Pain is experienced **SOMETIMES**. Previous treatments with heat, ice, medication and rest have been unsuccessful to control pain levels.

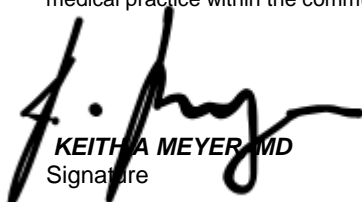
Diagnosis includes: **M17.11-Unilateral primary osteoarthritis right knee, M17.12- Unilateral primary osteoarthritis left knee**.. Based on my conversation with **Ms WOMMACK** and evaluation of his/her condition, I am ordering the following: **L1852 KNEE ORTHOSIS (KO), SINGLE UPRIGHT, THIGH AND CALF, 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 **PERFORMING 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 WOMMACK** 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 WOMMACK** continue medical follow-up as part of an ongoing plan of care.

Re: **BARBARA WOMMACK**..... DOB: **March 04,1946**

I, **KEITH A MEYER, 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.


KEITH A MEYER, MD
Signature

Date Signed

10-23-2024

DV MEDICAL SUPPLY

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