# **RX / MEDICAL NECESSITY FORM**

PATIENT INFORMATION				
AHMADI	ABOLFATH			
LAST NAME	FIRST NAME	MI		
MALE	12/01/1945	4582540448	SHIPPING METHOD:  SHIP TO PATIENT'S HOME ADDRESS	
GENDER	DATE OF BIRTH	PHONE NUMBER	SHIP TO PATIENT'S PHYSICIAN CLINIC	
2348 GRAND AVE	KLAMATH FALLS	OR 97601		
ADDRESS	CITY	STATE & ZIPCODE		
INSURANCE INFORMATION	ON			
MEDICARE				
PRIMARY INSURANCE		SECONDARY INSURANCE		
2MX7M37AP77				
MEMBER ID		MEMBER ID		
PHYSICIAN INFORMATIO	N			
JOEL KLAS, MD		1356800460		
PHYSICIAN NAME		NPI #		
		5412746733		
2821 DAGGETT AVE STE 100 O	R 97601	PHONE NUMBER		
PRACTICE LOCATION		5412742006		
		FAX NUMBER		
PRESCRIPTION SELECTI	ON			
L3670 - Shoulder Brace (Side:				
MEDICAL INFORMATION ICD 10 (Diagnosis Code(s)):	rthritis left knee thritis right knee r	M25.532- Pain   M25.531 - Pain   M25.531 - Pain   M19.072- Ostec   M19.071- Ostec   M25.522 Pain ir   M25.521 Pain ir   M54.2-Cervicale	in right wrist parthritis Left Ankle parthritis Right Ankle n left elbow n right elbow	

# **MEDICAL HISTORY**

**Previous treatments: RESTING** 

**Doctor's Notes:** The patient reports chronic **LEFT KNEE**, **RIGHT KNEE** pain for **OVER A YEAR**. Patient states pain is **ACHY** with a pain scale of **7** 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:\_

JOEL KLAS, MD

PHYSICIAN NAME:

DATE:

Patient Name: ABOLFATH AHMADI

Patient Address: 2348 GRAND AVE KLAMATH FALLS OR 97601

Patient Phone: 4582540448

Physician Name: JOEL KLAS, MD

Address: 2821 DAGGETT AVE STE 100 OR 97601

Telephone: **5412746733** Fax: **5412742006** 

Patient: ABOLFATH AHMADI Date of Birth: 12/01/1945 Visit Date: 09/11/2024 Reason for visit: CHECK-UP

# **Clinical Summary**

**Patient Demographics** 

Patient Name:	ABOLFATH AHMADI	Date of Birth:	12/01/1945
Age:	78	Phone Number:	4582540448
Address:	2348 GRAND AVE	City:	KLAMATH FALLS
State:	OR	Zip Code:	97601
Gender:	MALE	Height:	5'9
Weight:	190	Waist Size	MEDIUM

#### **Patient Insurance**

Provider:	MEDICARE	Member ID:	2MX7M37AP77	

#### Medications

Current Medication	ELIQUIS INSULIN
Medical History	DIABETES

# **Medical Diagnosis**

The pain level was indicated on a scale of 1-10 as the following: 7

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: RESTING

The patient described their pain as the following: ACHY

The activities that make the patient's pain worse is as follows: BENDING

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 09/11/2024

# **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 **A YEAR**. Patient states pain is **ACHY** with a pain scale of **7** 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 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 **ACHY** and occurs **SOMETIMES**. The patient rated their pain on a scale of 1-10 (10 being the worst) on a level **7**. The following activities make the patient's pain worse: **BENDING**. Patient needs a **BACK**, **LEFT KNEE**, **RIGHT KNEE**, **RIGHT WRIST AND LEFT WRIST** Brace to provide support and reduce pain level.

#### **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 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.

D9-12-2024

### **Physician Information**

Provider Name: JOEL KLAS, MD

Address: 2821 DAGGETT AVE STE 100 OR 97601

Physician's Signature:

Date:

Patient Name: ABOLFATH AHMADI

Patient Address: 2348 GRAND AVE KLAMATH FALLS OR 97601

Patient Phone: 4582540448

# LETTER OF MEDICAL NECESSITY

Re: ABOLFATH AHMADI

Orthotic Device Need Assessment

Exam Date: 09/11/2024

Height: **5'9** Weight: **190** DOB: **12/01/1945** 

Mr AHMADI 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.

Mr AHMADI reports chronic LEFT KNEE, RIGHT KNEE pain for A YEAR. Patient states pain is ACHY with a pain scale of 7 and pain worsens with BENDING. 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 Mr AHMADI 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 **BENDING**, 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. **Mr AHMADI** has been provided a phone number to call if there are any additional comments or questions regarding this examination, and I have recommended that **Mr AHMADI** continue medical follow-up as part of an ongoing plan of care.

#### Re: ABOLFATH AHMADI...... DOB: December 01, 1945

I, JOEL KLAS, 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.

Date Signed: 17-11- WW

signature

# <u>Comprehensive Knee Laxity Test (Check All Applicable)</u>

**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