

ADDICKS 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>GAIERO</b>	<b>SUSAN</b>		
LAST NAME	FIRST NAME	MI	
<b>FEMALE</b>	<b>07/18/1947</b>	<b>6038876607</b>	
GENDER	DATE OF BIRTH	PHONE NUMBER	
<b>298 FREMONT RD, UNIT 4</b>	<b>SANDOWN</b>	<b>NH 03873</b>	
ADDRESS	CITY	STATE & ZIPCODE	

<b>INSURANCE INFORMATION</b>	
<b>MEDICARE</b>	
PRIMARY INSURANCE	SECONDARY INSURANCE
<b>9AV4V14RD97</b>	
MEMBER ID	MEMBER ID

<b>PHYSICIAN INFORMATION</b>	
<b>AMANDA CARROZZA APRN</b>	<b>1730447772</b>
PHYSICIAN NAME	NPI #
	<b>6033824972</b>
	PHONE NUMBER
<b>127 PLAISTOW RD PLAISTOW NH 03865</b>	<b>6033829305</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 type="checkbox"/> <b>L0457</b> – Lumbar Brace (Waist: ) <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 checked="" type="checkbox"/> <b>L1852</b> – Knee Brace (Side: <input checked="" type="checkbox"/> L <input checked="" type="checkbox"/> R) (Size: <b>SMALL</b> ) <input type="checkbox"/> <b>L1833</b> – Knee Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size: ) <input checked="" type="checkbox"/> <b>L2397</b> – Knee Sleeve (Size: <b>SMALL</b> ) (Qty: 2) <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 type="checkbox"/> <b>L1971</b> – Ankle Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Shoe Size: ) <input type="checkbox"/> <b>L1906</b> – Ankle Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Shoe Size: ) <input type="checkbox"/> <b>L0174</b> – Cervical Brace <input type="checkbox"/> <b>L3170</b> – Heel Stabilizer (Side: <input type="checkbox"/> L <input type="checkbox"/> R)

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

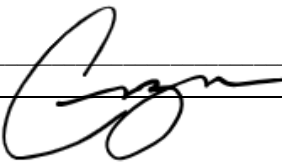
MEDICAL HISTORY

Previous treatments: PHYSICAL THERAPY

**Doctor's Notes:** The patient reports chronic **LEFT KNEE, RIGHT KNEE** pain for **A YEAR**. Patient states pain is **SHARP** with a pain scale of **8** 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: **AMANDA CARROZZA APRN**

DATE: **09-13-2024**

ADDICKS MEDICAL SUPPLY

Patient Name: **SUSAN GAIERO**  
Patient Address: **298 FREMONT RD, UNIT 4 SANDOWN NH 03873**  
Patient Phone: **6038876607**

Physician Name: **AMANDA CARROZZA APRN**  
Address: **127 PLAISTOW RD PLAISTOW NH 03865**  
Telephone: **6033824972**  
Fax: **6033829305**

Patient: **SUSAN GAIERO**  
Date of Birth: **07/18/1947**  
Visit Date: **WITHIN A YEAR**  
Reason for visit: **CHECK-UP**

Clinical Summary

Patient Demographics

Patient Name:	SUSAN GAIERO	Date of Birth:	07/18/1947
Age:	77	Phone Number:	6038876607
Address:	298 FREMONT RD, UNIT 4	City:	SANDOWN
State:	NH	Zip Code:	03873
Gender:	FEMALE	Height:	5'2
Weight:	100	Waist Size	S

Patient Insurance

Provider:	MEDICARE	Member ID:	9AV4V14RD97
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Medications

Current Medication	NONE
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>A YEAR</b>
The surgery addressed the following: <b>NA</b>
The pain is experienced <b>SOMETIMES</b>
The patient has attempted the following previous treatments/therapies: <b>PHYSICAL THERAPY</b>
The patient described their pain as the following: <b>SHARP</b>
The activities that make the patient's pain worse is as follows: <b>DOING DAILY ACTIVITIES</b>
The pain is located in the patient's <b>LEFT KNEE, RIGHT KNEE</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>LEFT KNEE, RIGHT KNEE</b>
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Subjective Notes

The patient reports chronic <b>LEFT KNEE, RIGHT KNEE</b> pain for <b>A YEAR</b> . Patient states pain is <b>SHARP</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>SOMETIMES</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>A YEAR</b> located in their <b>LEFT KNEE, RIGHT KNEE</b> related to <b>M17.11-Unilateral primary osteoarthritis right knee, M17.12- Unilateral primary osteoarthritis left knee</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>SHARP</b> and occurs <b>SOMETIMES</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>DOING DAILY ACTIVITIES</b> . Patient needs a <b>BACK, LEFT KNEE, RIGHT KNEE, RIGHT WRIST AND LEFT WRIST</b> Brace to provide support and reduce pain level.

## ADDICKS MEDICAL SUPPLY

## Plan &amp; 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: **AMANDA CARROZZA APRN**

Address: **127 PLAISTOW RD PLAISTOW NH 03865**

Physician's Signature:



Date:

**09-13-2024**

Patient Name: **SUSAN GAIERO**

Patient Address: **298 FREMONT RD, UNIT 4 SANDOWN NH 03873**

Patient Phone: **6038876607**

## ADDICKS MEDICAL SUPPLY

## LETTER OF MEDICAL NECESSITY

Re: **SUSAN GAIERO**  
Orthotic Device Need Assessment  
Exam Date: **09/13/2024**  
Height: **5'2**  
Weight: **100**  
DOB: **07/18/1947**

**Ms GAIERO** 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 GAIERO** reports chronic **LEFT KNEE, RIGHT KNEE** pain for **A YEAR**. Patient states pain is **SHARP** with a pain scale of 8 and pain worsens with **DOING DAILY ACTIVITIES**. 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 GAIERO** 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 **DOING 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 GAIERO** 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 GAIERO** continue medical follow-up as part of an ongoing plan of care.

Re: **SUSAN GAIERO**..... DOB: **July 18, 1947**

I, **AMANDA CARROZZA APRN**, 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.

  
**AMANDA CARROZZA APRN**  
Signature

Date Signed: 09-13-2024

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