

ADDICKS MEDICAL SUPPLY

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
TOLBERT	MARY		
LAST NAME	FIRST NAME	MI	
FEMALE	02/04/1948	8047486742	
GENDER	DATE OF BIRTH	PHONE NUMBER	
9641 SHAMROCK DR	CHESTERFIELD	VA 23237	
ADDRESS	CITY	STATE & ZIPCODE	

INSURANCE INFORMATION	
MEDICARE	
PRIMARY INSURANCE	SECONDARY INSURANCE
2KU9MF7KM23	
MEMBER ID	MEMBER ID

PHYSICIAN INFORMATION	
PETER COUTLAKIS MD	1528064482
PHYSICIAN NAME	NPI #
	8043231401
	PHONE NUMBER
1401 JOHNSTON WILLIS DR RICHMOND VA 23235	8043231878
PRACTICE LOCATION	FAX NUMBER

PRESCRIPTION SELECTION	
<input type="checkbox"/> L3670 – Shoulder Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size:) <input type="checkbox"/> L3960 – Shoulder Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size:) <input type="checkbox"/> L3660 – Shoulder Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size:) <input type="checkbox"/> L0650 – Lumbar Brace (Waist:) <input type="checkbox"/> L0642 – Lumbar Brace (Waist:) <input checked="" type="checkbox"/> L0457 – Lumbar Brace (Waist: MEDIUM) <input type="checkbox"/> L0648 – Lumbar Brace (Waist:) <input type="checkbox"/> E0100 – Electric Heat Pad <input type="checkbox"/> L1690 – Hip Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Waist:) <input type="checkbox"/> L1686 – Hip Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Waist:) <input type="checkbox"/> L2624 – Hip Joint Adjustable Flexion, Extension (Side: <input type="checkbox"/> L <input type="checkbox"/> R) <input type="checkbox"/> L3760 – Elbow Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R)	<input type="checkbox"/> L3761 – Elbow Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size:) <input checked="" type="checkbox"/> L3916 – Wrist Hand Finger (Side: <input checked="" type="checkbox"/> L <input checked="" type="checkbox"/> R) (Size: SMALL) <input type="checkbox"/> L3915 - Wrist Hand Finger (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size:) <input type="checkbox"/> L1852 – Knee Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size:) <input type="checkbox"/> L1851 – Knee Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size:) <input type="checkbox"/> L1833 – Knee Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size:) <input type="checkbox"/> L2397 – Knee Sleeve (Size:) (Qty:) <input type="checkbox"/> E0100 – Cane <input type="checkbox"/> L2425 – Dial Lock Hinge ROM <input type="checkbox"/> L2820 – Lower Extremity Ortho <input type="checkbox"/> L1906 – Ankle Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Shoe Size:) <input type="checkbox"/> L1971 – Ankle Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Shoe Size:) <input type="checkbox"/> L0174 – Cervical Brace <input type="checkbox"/> L3170 – Heel Stabilizer (Side: <input type="checkbox"/> L <input type="checkbox"/> R)

MEDICAL INFORMATION	
ICD 10 (Diagnosis Code(s)):	
<input checked="" type="checkbox"/> M54.50- Low back pain, unspecified	<input checked="" type="checkbox"/> M25.532- Pain in left wrist
<input type="checkbox"/> M17.12- Unilateral primary osteoarthritis left knee	<input checked="" type="checkbox"/> M25.531 - Pain in right wrist
<input type="checkbox"/> M17.11-Unilateral primary osteoarthritis right knee	<input type="checkbox"/> M19.072- Osteoarthritis Left Ankle
<input type="checkbox"/> M25.512-Pain in the left shoulder	<input type="checkbox"/> M19.071- Osteoarthritis Right Ankle
<input type="checkbox"/> M25.511-Pain in the right shoulder	<input type="checkbox"/> M25.522 Pain in left elbow
<input type="checkbox"/> M25.552- Pain in Left Hip	<input type="checkbox"/> M25.521 Pain in right elbow
<input type="checkbox"/> M25.551- Pain in Right Hip	<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: PAIN MEDICATION, ICE PACKS, HEATING PADS

Doctor's Notes: The patient reports chronic **Back, Left Wrist, Right Wrist** pain for **A YEAR**. Patient states pain is **SHARP** with a pain scale of **9** 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: PETER COUTLAKIS MD

DATE: 08-30-2024

Patient Name: **MARY TOLBERT**
Patient Address: **9641 SHAMROCK DR CHESTERFIELD VA 23237**
Patient Phone: **8047486742**

Physician Name: **PETER COUTLAKIS MD**
Address: **1401 JOHNSTON WILLIS DR RICHMOND VA 23235**
Telephone: **8043231401**
Fax: **8043231878**

Patient: **MARY TOLBERT**
Date of Birth: **02/04/1948**
Visit Date: **WITHIN A YEAR**
Reason for visit: **Check-up**

Clinical Summary

Patient Demographics

Patient Name:	MARY TOLBERT	Date of Birth:	02/04/1948
Age:	76	Phone Number:	8047486742
Address:	9641 SHAMROCK DR	City:	CHESTERFIELD
State:	VA	Zip Code:	23237
Gender:	FEMALE	Height:	4'10
Weight:	200	Waist Size	M

Patient Insurance

Provider:	MEDICARE	Member ID:	2KU9MF7KM23
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Medications

Current Medication	GABAPENTIN, HIGHBLOOD PRESSURE PILL, DIABETES PILL
Medical History	DIABETES, HIGH BLOOD PRESSURE

Medical Diagnosis

The pain level was indicated on a scale of 1-10 as the following: 9
The patient's pain started on or around A YEAR
The surgery addressed the following: NA
The pain is experienced CONSTANTLY
The patient has attempted the following previous treatments/therapies: PAIN MEDICATION, ICE PACKS, HEATING PADS
The patient described their pain as the following: SHARP
The activities that make the patient's pain worse is as follows: DOING DAILY ACTIVITIES
The pain is located in the patient's Back, Left Wrist, Right Wrist
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): Back, Left Wrist, Right Wrist
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Subjective Notes

The patient reports chronic Back, Left Wrist, Right Wrist pain for A YEAR . Patient states pain is SHARP with a pain scale of 9 and pain worsens with movement. The pain is caused by ARTHRITIS and is experienced CONSTANTLY . 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 A YEAR located in their Back, Left Wrist, Right Wrist related to M54.50- Low back pain, unspecified, M25.532- Pain in left wrist, M25.531- Pain in right wrist . Patient has been to a physical therapist and hasn't had previous surgery to treat this pain.
Patient's chronic pain is described SHARP and occurs CONSTANTLY . The patient rated their pain on a scale of 1-10 (10 being the worst) on a level 9 . The following activities make the patient's pain worse: DOING DAILY ACTIVITIES . Patient needs a Back, Left Wrist, Right Wrist 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), L3916 (WRIST HAND ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), ELASTIC BANDS, TURNBUCKLES, MAY INCLUDE SOFT INTERFACE, STRAPS, 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 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, M25.532- Pain in left wrist, M25.531- Pain in right wrist

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: **PETER COUTLAKIS MD**

Address: **1401 JOHNSTON WILLIS DR RICHMOND VA 23235**

Physician's Signature:



Date:

08-30-2024

Patient Name: **MARY TOLBERT**

Patient Address: **9641 SHAMROCK DR CHESTERFIELD VA 23237**

Patient Phone: **8047486742**

ADDICKS MEDICAL SUPPLY

LETTER OF MEDICAL NECESSITY

Re: **MARY TOLBERT**
Orthotic Device Need Assessment
Exam Date: **08/30/2024**
Height: **4'10**
Weight: **200**
DOB: **02/04/1948**

Ms TOLBERT is inquiring about utilizing orthotic bracing for his/her current conditions. His/her chief complaint at the time of this assessment is:
Back, Left Wrist, Right Wrist.

Ms TOLBERT reports chronic **Back, Left Wrist, Right Wrist** pain for **A YEAR**. Patient states pain is **SHARP** with a pain scale of **9** and pain worsens with **DOING DAILY ACTIVITIES**. 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, M25.532- Pain in left wrist, M25.531- Pain in right wrist**. Based on my conversation with **Ms TOLBERT** 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), L3916 (WRIST HAND ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), ELASTIC BANDS, TURNBUCKLES, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED, OFF-THE-SHELF).**

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

Re: **MARY TOLBERT**..... DOB: **February 04, 1948**

I, **PETER COUTLAKIS 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.


PETER COUTLAKIS MD
Signature

Date Signed: 08-30-2024