

FIRST STEP DME INC.

RX / MEDICAL NECESSITY FORM

TALMON

LAST NAME

FEMALE

GENDER

1158 E TUCKEY LN

ADDRESS

CAROL

FIRST NAME

01/20/1954

DATE OF BIRTH

PHOENIX

CITY

MI

6025705599

PHONE NUMBER

AZ 85014

STATE & ZIPCODE

SHIPPING METHOD:

☒ SHIP TO PATIENT'S HOME ADDRESS

☐ SHIP TO PATIENT'S PHYSICIAN CLINIC

INSURANCE INFORMATION

MEDICARE

PRIMARY INSURANCE

4XA8T35HW46

MEMBER ID

SECONDARY INSURANCE

MEMBER ID

PHYSICIAN INFORMATION

GERALD S ASIN, M.D.

PHYSICIAN NAME

10565 N TATUM BLVD STE B116 PARADISE VALLEY AZ 85253

PRACTICE LOCATION

1770576365

NPI #

4806590448

PHONE NUMBER

4806591498

FAX NUMBER

PRESCRIPTION SELECTION

☒ L3670 – Shoulder Brace (Side: ☐ L ☒ R) (Size: **MEDIUM**)

☐ L3960 – Shoulder Brace (Side: ☐ L ☐ R) (Size: )

☐ L3660 – Shoulder Brace (Side: ☐ L ☐ R) (Size: )

☐ L0650 – Lumbar Brace (Waist: )

☐ L0642 – Lumbar Brace (Waist: )

☒ L0457 – Lumbar Brace (Waist: **LARGE**)

☐ L0648 – Lumbar Brace (Waist: )

☐ E0100 – Electric Heat Pad

☐ L1690 – Hip Brace (Side: ☐ L ☐ R) (Waist: )

☐ L1686 – Hip Brace (Side: ☐ L ☐ R) (Waist: )

☐ L2624 – Hip Joint Adjustable Flexion, Extension (Side: ☐ L ☐ R)

☐ L3760 – Elbow Brace (Side: ☐ L ☐ R)

☐ L3761 – Elbow Brace (Side: ☐ L ☐ R) (Size: )

☐ L3916 – Wrist Hand Finger (Side: ☐ L ☐ R) (Size: )

☐ L3915 – Wrist Hand Finger (Side: ☐ L ☐ R) (Size: )

☒ L1852 – Knee Brace (Side: ☒ L ☒ R) (Size: **MEDIUM**)

☐ L1851 – Knee Brace (Side: ☐ L ☐ R) (Size: )

☐ L1833 – Knee Brace (Side: ☐ L ☐ R) (Size: )

☒ L2397 – Knee Sleeve (Size: **MEDIUM**) (Qty: **2**)

☐ E0100 – Cane

☐ L2425 – Dial Lock Hinge ROM

☐ L2820 – Lower Extremity Ortho

☐ L1906 / L1971 – Ankle Brace (Side: ☐ L ☐ R) (Shoe Size: )

☐ L0174 – Cervical Brace

☐ L3170 – Heel Stabilizer (Side: ☐ L ☐ R)

MEDICAL INFORMATION

ICD 10 (Diagnosis Code(s)):

☒ M54.50- Low back pain, unspecified

☒ M17.12- Unilateral primary osteoarthritis left knee

☒ M17.11- Unilateral primary osteoarthritis right knee

☐ M25.512- Pain in the left shoulder

☒ M25.511- Pain in the right shoulder

☐ M25.552- Pain in Left Hip

☐ M25.551- Pain in Right Hip

☐ M25.532- Pain in left wrist

☐ M25.531 - Pain in right wrist

☐ M19.072- Osteoarthritis Left Ankle

☐ M19.071- Osteoarthritis Right Ankle

☐ M25.522 Pain in left elbow

☐ M25.521 Pain in right elbow

☐ M54.2- Cervicalgia Pain in Neck

Length of Need:

☒ 12+ months (long term)

☐ \_\_\_\_\_ # of months (1-11)

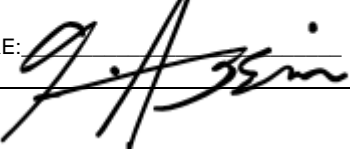
## FIRST STEP DME INC.

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

**Doctor's Notes:** The patient reports chronic **LOWER BACK, LEFT KNEE, RIGHT KNEE, RIGHT SHOULDER** pain for **SEVERAL YEARS**. Patient states pain is **ACHY** with a pain scale of **8** and pain worsens with movements. Pain is caused by **WEAR AND TEAR** 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: GERALD S ASIN, M.D. DATE: 10-16-2024

Patient Name: **CAROL TALMON**  
Patient Address: **1158 E TUCKEY LN PHOENIX AZ 85014**  
Patient Phone: **6025705599**

Physician Name: **GERALD S ASIN, M.D.**  
Address: 15655 37TH AVE N STE 100 PLYMOUTH MN 55446  
Telephone: 4806590448  
Fax: 4806591498

Patient: **CAROL TALMON**  
Date of Birth: **01/20/1954**  
Visit Date: **WITHIN 12 MONTHS**  
Reason for visit: **REGULAR CHECK-UP**

## Clinical Summary

### Patient Demographics

Patient Name:	CAROL TALMON	Date of Birth:	01/20/1954
Age:	70	Phone Number:	6025705599
Address:	1158 E TUCKEY LN	City:	PHOENIX
State:	AZ	Zip Code:	85014
Gender:	FEMALE	Height:	5'1
Weight:	150	Waist Size	LARGE

### Patient Insurance

Provider:	MEDICARE	Member ID:	4XA8T35HW46
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### Medications

Current Medication	TYLENOL, GABAPENTIN
Medical History	NONE

### Medical Diagnosis

The pain level was indicated on a scale of 1-10 as the following: 8
The patient's pain started on or around SEVERAL YEARS AGO
The surgery addressed the following: NA
The pain is experienced CONSTANTLY
The patient has attempted the following previous treatments/therapies: TAKING MEDICATION
The patient described their pain as the following: ACHY
The activities that make the patient's pain worse is as follows: DOING DAILY ACTIVITIES
The pain is located in the patient's LOWER BACK, LEFT KNEE, RIGHT KNEE, RIGHT SHOULDER
The patient's pain is caused by WEAR AND TEAR
The last time the patient has seen the doctor was on WITHIN 12 MONTHS

### Chief Complaint

The patient's main complaint is that they experience chronic pain located in the following location(s): LOWER BACK, LEFT KNEE, RIGHT KNEE, RIGHT SHOULDER
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### Subjective Notes

The patient reports chronic LOWER BACK, LEFT KNEE, RIGHT KNEE, RIGHT SHOULDER pain for SEVERAL YEARS. Patient states pain is ACHY with a pain scale of 9 and pain worsens with movement. The pain is caused by WEAR AND TEAR 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 SEVERAL YEARS located in their LOWER BACK, LEFT KNEE, RIGHT KNEE, RIGHT SHOULDER related to M54.50- Low back pain, unspecified, M17.11-Unilateral primary osteoarthritis right knee, M17.12- Unilateral primary osteoarthritis left knee, M25.511-Pain in the right shoulder. 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 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 LOWER BACK, LEFT KNEE, RIGHT KNEE, RIGHT SHOULDER Brace to provide support and reduce pain level.

## FIRST STEP DME INC.

## 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, L1852 KNEE BRACE - KNEE ORTHOSIS (KO), DOUBLE 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 SUSPENSION SLEEVE, L3670 SHOULDER ORTHOSIS, ACROMIO/CLAVICULAR (CANVAS AND WEBBING TYPE), 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, M17.11-Unilateral primary osteoarthritis right knee, M17.12- Unilateral primary osteoarthritis left knee, M25.511-Pain in the right shoulder**

## Agreements


We understand that you are choosing to use our professional medical services to receive a prescription for your new brace.

## Physician Information

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Provider Name: **GERALD S ASIN, M.D.**

Address: **10565 N TATUM BLVD STE B116 PARADISE VALLEY AZ 85253**

Physician's Signature:

 10-16-2024

Date:

Patient Name: **CAROL TALMON**

Patient Address: **1158 E TUCKEY LN PHOENIX AZ 85014**

Patient Phone: **6025705599**

## FIRST STEP DME INC.

## LETTER OF MEDICAL NECESSITY

Re: **CAROL TALMON**  
Orthotic Device Need Assessment  
Exam Date: **10/15/2024**  
Height: **5'1**  
Weight: **150**  
DOB: **01/20/1954**

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

**Ms TALMON** reports chronic **LOWER BACK, LEFT KNEE, RIGHT KNEE, RIGHT SHOULDER** pain for **SEVERAL YEARS**. Patient states pain is **ACHY** with a pain scale of 8 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.

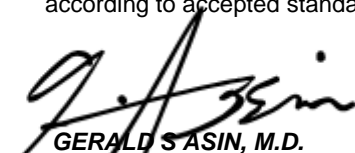
Diagnosis includes: **M54.50- Low back pain, unspecified, M17.11-Unilateral primary osteoarthritis right knee, M17.12- Unilateral primary osteoarthritis left knee, M25.511-Pain in the right shoulder**. Based on my conversation with **Ms TALMON** and evaluation of his/her condition, I am ordering the following: **L0457 - TLSO, FLEXIBLE, PROVIDES TRUNK SUPPORT, THORACIC REGION, RIGID POSTERIOR PANEL AND SOFT ANTERIOR APRON, EXTENDS FROM THE SACROCCYGEAL 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, L1852 KNEE BRACE - KNEE ORTHOSIS (KO), DOUBLE 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 SUSPENSION SLEEVE, L3670 SHOULDER ORTHOSIS, ACROMIO/CLAVICULAR (CANVAS AND WEBBING TYPE), PREFABRICATED, OFF-THE-SHELF**.

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

Re: **CAROL TALMON** ..... DOB: **JANUARY 20, 1954**

I, **GERALD S ASIN, 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.

  
**GERALD S ASIN, M.D.**  
Signature

Date Signed:

**10-16-2024**

## FIRST STEP DME INC.

## 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