

RX / MEDICAL NECESSITY FORM

MEDICAL INFORMATION

ICD 10 (Diagnosis Code(s)):

<input checked="" type="checkbox"/> M54.50- Low back pain, unspecified	<input type="checkbox"/> M25.532- Pain in left wrist
<input type="checkbox"/> M17.12- Unilateral primary osteoarthritis left knee	<input 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: ☒ 12+ months (long term) ☐ _____ # of months (1-11)

ADDICKS MEDICAL SUPPLY

MEDICAL HISTORY**Previous treatments: RESTING**

Doctor's Notes: The patient reports chronic **Back** pain for **SEVERAL YEARS**. Patient states pain is **ACHY** with a pain scale of **9** 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: _____



JON BULLMAN, MD

PHYSICIAN NAME: _____

DATE: _____

09-30-2024

Patient Name: **RENEE DUBOIS**
Patient Address: **2809 3RD AVE S BILLINGS MT 59101**
Patient Phone: **4065981744**

Physician Name: **JON BULLMAN, MD**
Address: **2019 BROADWATER AVE BILLINGS MT 59102**
Telephone: **4062375200**
Fax: **4062375205**

Patient: **RENEE DUBOIS**
Date of Birth: **10/02/1954**
Visit Date: **WITHIN 12 MONTHS**
Reason for visit: **Check-up**

Clinical Summary

Patient Demographics

Patient Name:	RENEE DUBOIS	Date of Birth:	10/02/1954
Age:	69	Phone Number:	4065981744
Address:	2809 3RD AVE S	City:	BILLINGS
State:	MT	Zip Code:	59101
Gender:	FEMALE	Height:	5'5
Weight:	125	Waist Size	MEDIUM

Patient Insurance

Provider:	MEDICARE	Member ID:	9U67JQ9EF79
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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: 7
The patient's pain started on or around SEVERAL YEARS
The surgery addressed the following: NA
The pain is experienced CONSTANTLY
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: DOING DAILY ACTIVITIES
The pain is located in the patient's Back
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): Back

Subjective Notes

The patient reports chronic Back pain for SEVERAL YEARS . Patient states pain is ACHY with a pain scale of 7 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.

Objective of Assessment (Review of Symptoms)

Patient has chronic pain for SEVERAL YEARS located in their Back related to M54.50- Low back pain, unspecified . 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- 7 . The following activities make the patient's pain worse: DOING DAILY ACTIVITIES . Patient needs a Back Brace to provide support and reduce pain level.

ADDICKS MEDICAL SUPPLY

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)**, 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 arthritis 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 arthritis 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

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: **JON BULLMAN, MD**

Address: **2019 BROADWATER AVE BILLINGS MT 59102**

Physician's Signature:



Date:

09-30-2024

Patient Name: **RENEE DUBOIS**

Patient Address: **2809 3RD AVE S BILLINGS MT 59101**

Patient Phone: **4065981744**

ADDICKS MEDICAL SUPPLY

LETTER OF MEDICAL NECESSITY

Re: **RENEE DUBOIS**
Orthotic Device Need Assessment
Exam Date: **09/28/2024**
Height: **5'5**
Weight: **125**
DOB: **10/02/1954**

Ms DUBOIS is inquiring about utilizing orthotic bracing for his/her current conditions. His/her chief complaint at the time of this assessment is: **Back**.

Ms DUBOIS reports chronic **Back** pain for **SEVERAL YEARS**. Patient states pain is **ACHY** 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**. Based on my conversation with **Ms DUBOIS** 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)**.

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

Re: **RENEE DUBOIS**..... DOB: **OCTOBER 02, 1954**

I, **JON BULLMAN, 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.


JON BULLMAN, MD
Signature

Date Signed: 09-30-2024