RX / MEDICAL NECESSITY FORM

PATIENT INFORMATION					
CASTANEDA	ALFONSO				
LAST NAME	FIRST NAME	MI			
MALE	09/18/45	8319059691	SHIPPING METHOD:		
GENDER	DATE OF BIRTH	PHONE NUMBER	☐ SHIP TO PATIENT'S HOME ADDRESS☐ SHIP TO PATIENT'S PHYSICIAN CLINIC		
814 HOLLY OAK CT	HOLLISTER	CA 95023			
ADDRESS	CITY	STATE & ZIPCODE			
INSURANCE INFORMATION	ON				
MEDICARE		SECONDARY INSURANCE			
PRIMARY INSURANCE 8NX2M20AD09					
MEMBER ID		MEMBER ID	MEMBER ID		
WILINDLINID					
PHYSICIAN INFORMATIO	N				
MARIE CLAUDETTE GRAGEDA	, MD	1891998159	1891998159		
PHYSICIAN NAME		NPI #			
		831-636-7494			
930 SUNNYSLOPE RD HOLLIST	TER CA 95023	PHONE NUMBER			
PRACTICE LOCATION		831-636-7496			
		FAX NUMBER			
PRESCRIPTION SELECTION	ON	1			
□ L3670 – Shoulder Brace (Side: □ L □ R) (Size:) □ L3960 – Shoulder Brace (Side: □ L □ R) (Size:) □ L3660 – Shoulder Brace (Side: □ L □ R) (Size:) □ L0650 – Lumbar Brace (Waist:) □ L0642 – Lumbar Brace (Waist: 38) □ L0457 – Lumbar Brace (Waist: 38) □ 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: MEDIUM) L3915 - Wrist Hand Finger (Side: □ L □ R) (Size:) L1852 - Knee Brace (Side: □ L □ R) (Size:) L1851 - Knee Brace (Side: □ L □ R) (Size:) L1833 - Knee Brace (Side: □ L □ R) (Size:) L2397 - Knee Sleeve (Size:) (Qty:) E0100 - Cane L2425 - Dial Lock Hinge ROM L2820 - Lower Extremity Ortho L1906 - Ankle Brace (Side: □ L □ R) (Shoe Size:) L1971 - Ankle Brace (Side: □ L □ R) (Shoe Size:) L0174 - Cervical Brace L3170 - Heel Stabilizer (Side: □ L □ R)			
MEDICAL INFORMATION ICD 10 (Diagnosis Code(s)):	rthritis left knee rthritis right knee r		i in right wrist oarthritis Left Ankle oarthritis Right Ankle n left elbow n right elbow		

MEDICAL HISTORY

Previous treatments: TAKING MEDICATION

Doctor's Notes: The patient reports chronic **Back, Left Wrist, Right Wrist** pain for **MORE THAN A YEAR**. Patient states pain is **DULL** with a pain scale of **6** 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: ______ DA

DATE:

199/26/2

Patient Name: ALFONSO CASTANEDA

Patient Address: 814 HOLLY OAK CT HOLLISTER CA 95023

Patient Phone: 8319059691

Physician Name: MARIE CLAUDETTE GRAGEDA, MD Address: 930 SUNNYSLOPE RD HOLLISTER CA 95023

Telephone: **831-636-7494** Fax: **831-636-7496**

Patient: ALFONSO CASTANEDA Date of Birth: 09/18/45 Visit Date: 1 WEEK AGO Reason for visit: Check-up

Clinical Summary

Patient Demographics

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Patient Name:	ALFONSO CASTANEDA	Date of Birth:	09/18/45	
Age:	79	Phone Number:	8319059691	
Address:	814 HOLLY OAK CT	City:	HOLLISTER	
State:	CA	Zip Code:	95023	
Gender:	MALE	Height:	5'8	
Weight:	190	Waist Size	38	

Patient Insurance

Provider:	MEDICARE	Member ID:	8NX2M20AD09
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Medications

Current Medication	METFORMIN
Medical History	DIABETES

Medical Diagnosis

The pain level was indicated on a scale of 1-10 as the following: 6

The patient's pain started on or around MORE THAN A YEAR

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: **DULL**

The activities that make the patient's pain worse is as follows: STANDING, WALKING

The pain is located in the patient's Back, Left Wrist, Right Wrist

The patient's pain is caused by WEAR AND TEAR

The last time the patient has seen the doctor was on 1 WEEK AGO

Chief Complaint

The patient's main complaint is that they experience chronic pain located in the following location(s): Back, Left Wrist, Right Wrist

Subjective Notes

The patient reports chronic **Back**, **Left Wrist**, **Right Wrist** pain for **MORE THAN A YEAR**. Patient states pain is **DULL** with a pain scale of **6** 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 MORE THAN 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 **DULL** and occurs **CONSTANTLY**. The patient rated their pain on a scale of 1-10 (10 being the worst) on a level **6**. The following activities make the patient's pain worse: **STANDING**, **WALKING**. Patient needs a **Back**, **Left Wrist**, **Right 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) 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 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.

Maren.

Physician Information

Provider Name: MARIE CLAUDETTE GRAGEDA, MD

Address: 930 SUNNYSLOPE RD HOLLISTER CA 95023

Physician's Signature:

Patient Name: ALFONSO CASTANEDA

Patient Address: 814 HOLLY OAK CT HOLLISTER CA 95023

Patient Phone: 8319059691

LETTER OF MEDICAL NECESSITY

Re: ALFONSO CASTANEDA

Orthotic Device Need Assessment

Exam Date: 09/25/2024

Height: **5'8** Weight: **190** DOB: **09/18/45**

Mr CASTANEDA 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.

Mr CASTANEDA reports chronic Back, Left Wrist, Right Wrist pain for MORE THAN A YEAR. Patient states pain is DULL with a pain scale of 6 and pain worsens with STANDING, WALKING. 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 Mr CASTANEDA 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 **STANDING, WALKING**, 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. **Mr CASTANEDA** 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 CASTANEDA** continue medical follow-up as part of an ongoing plan of care.

Re: ALFONSO CASTANEDA...... DOB: September 18, 1945

I, MARIE CLAUDETTE GRAGEDA, 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.

MARIE CLAUDETTE GRAGEDA, MD

Signature

Date Signed: 1262