

RX / MEDICAL NECESSITY FORM**PATIENT INFORMATION****SCHULTZ**

LAST NAME

JAMES

FIRST NAME

MI

MALE

GENDER

01/18/1958

DATE OF BIRTH

6084725109

PHONE NUMBER

620 DUCK CREEK AVE

ADDRESS

GRAND MARSH

CITY

WI 53936

STATE & ZIPCODE

SHIPPING METHOD:

- ☒ SHIP TO PATIENT'S HOME ADDRESS
☐ SHIP TO PATIENT'S PHYSICIAN CLINIC

INSURANCE INFORMATION**MEDICARE**

PRIMARY INSURANCE

8C36V93EU47

MEMBER ID

SECONDARY INSURANCE

MEMBER ID

PHYSICIAN INFORMATION**KEVIN BUTTERFIELD DO**

PHYSICIAN NAME

1184611592

NPI #

6088475000

PHONE NUMBER

1040 DIVISION ST MAUSTON WI 53948

PRACTICE LOCATION

6088479875

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: **32**)
☐ **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:)
☐ **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)):**

- ☒ 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)

MEDICAL HISTORY

Previous treatments: **TAKING MEDICATION**

Doctor's Notes: The patient reports chronic **LOWER BACK, LEFT SHOULDER** pain for **7 YEARS**. Patient states pain is **SHARP** 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.

KEVIN BUTTERFIELD DO

PHYSICIAN SIGNATURE: _____ PHYSICIAN NAME: _____ DATE: _____

Patient Name: **JAMES SCHULTZ**
Patient Address: **620 DUCK CREEK AVE GRAND MARSH WI 53936**
Patient Phone: **6084725109**

Physician Name: **KEVIN BUTTERFIELD DO**
Address: 1040 DIVISION ST MAUSTON WI 53948
Telephone: 6088475000
Fax: 6088479875

Patient: **JAMES SCHULTZ**
Date of Birth: **01/18/1958**
Visit Date: **JULY 24, 2024**
Reason for visit: **REGULAR CHECK-UP**

Clinical Summary

Patient Demographics

Patient Name:	JAMES SCHULTZ	Date of Birth:	01/18/1958
Age:	66	Phone Number:	6084725109
Address:	620 DUCK CREEK AVE	City:	GRAND MARSH
State:	WI	Zip Code:	53936
Gender:	MALE	Height:	5'7
Weight:	165	Waist Size	32

Patient Insurance

Provider:	MEDICARE	Member ID:	8C36V93EU47
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Medications

Current Medication	IBUPROFEN, ADVIL, AMLODIPINE, ATORVASTATIN
Medical History	HIGH BLOOD PRESSURE AND HIGH CHOLESTEROL

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 7 YEARS
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: SHARP
The activities that make the patient's pain worse is as follows: BENDING AND LAYING DOWN
The pain is located in the patient's LOWER BACK, LEFT SHOULDER
The patient's pain is caused by WEAR AND TEAR
The last time the patient has seen the doctor was on JULY 24, 2024

Chief Complaint

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

Subjective Notes

The patient reports chronic LOWER BACK, LEFT SHOULDER pain for 7 YEARS. Patient states pain is SHARP 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 7 YEARS located in their LOWER BACK, LEFT SHOULDER related to M54.50- Low back pain, unspecified, M25.512-Pain in the left shoulder. 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 6. The following activities make the patient's pain worse: BENDING AND LAYING DOWN. Patient needs a LOWER BACK, LEFT SHOULDER 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), 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, M25.512-Pain in the left shoulder

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: **KEVIN BUTTERFIELD DO**

Address: **1040 DIVISION ST MAUSTON WI 53948**

Physician's Signature:

Date:

Patient Name: **JAMES SCHULTZ**

Patient Address: **620 DUCK CREEK AVE GRAND MARSH WI 53936**

Patient Phone: **6084725109**

LETTER OF MEDICAL NECESSITY

Re: **JAMES SCHULTZ**
Orthotic Device Need Assessment
Exam Date: **08/13/2024**
Height: **5'7**
Weight: **165**
DOB: **01/18/1958**

Mr SCHULTZ 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 SHOULDER**.

Mr SCHULTZ reports chronic **LOWER BACK, LEFT SHOULDER** pain for **7 YEARS**. Patient states pain is **SHARP** with a pain scale of **6** and pain worsens with **BENDING AND LAYING DOWN**. 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, M25.512-Pain in the left shoulder**. Based on my conversation with **Mr SCHULTZ** 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), L3670 SHOULDER ORTHOSIS, ACROMIO/CLAVICULAR (CANVAS AND WEBBING TYPE), PREFABRICATED, OFF-THE-SHELF**.

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

Re: **JAMES SCHULTZ**..... DOB: **January 18, 1958**

I, **KEVIN BUTTERFIELD DO**, 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.

KEVIN BUTTERFIELD DO
Signature

Date Signed: _____