

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

LAST NAME

**DONNA**

FIRST NAME

MI

**FEMALE**

GENDER

**09/29/1966**

DATE OF BIRTH

**3023767056**

PHONE NUMBER

**900 JENNIFER LN**

ADDRESS

**MIDDLETOWN**

CITY

**DE 19709**

STATE &amp; ZIPCODE

**SHIPPING METHOD:**

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

**INSURANCE INFORMATION****MEDICARE**

PRIMARY INSURANCE

**4H81YU5DW14**

MEMBER ID

SECONDARY INSURANCE

MEMBER ID

**PHYSICIAN INFORMATION****STEPHEN DUGGAN, DO**

PHYSICIAN NAME

**1225014871**

NPI #

**3024493030**

PHONE NUMBER

**124 SLEEPY HOLLOW DR SUITE 203 MIDDLETOWN DE 19709**

PRACTICE LOCATION

**3024493024**

FAX NUMBER

**PRESCRIPTION SELECTION**

- |  |   |
|--|---|
| <input type="checkbox"/> <b>L3670</b> – Shoulder Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size: )<br><input type="checkbox"/> <b>L3960</b> – Shoulder Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size: )<br><input type="checkbox"/> <b>L3660</b> – Shoulder Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size: )<br><input type="checkbox"/> <b>L0650</b> – Lumbar Brace (Waist: )<br><input type="checkbox"/> <b>L0642</b> – Lumbar Brace (Waist: )<br><input type="checkbox"/> <b>L0457</b> – Lumbar Brace (Waist: )<br><input type="checkbox"/> <b>L0648</b> – Lumbar Brace (Waist: )<br><input type="checkbox"/> <b>E0100</b> – Electric Heat Pad<br><input type="checkbox"/> <b>L1690</b> – Hip Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Waist: )<br><input type="checkbox"/> <b>L1686</b> – Hip Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Waist: )<br><input type="checkbox"/> <b>L2624</b> – Hip Joint Adjustable Flexion, Extension (Side: <input type="checkbox"/> L <input type="checkbox"/> R)<br><input type="checkbox"/> <b>L3760</b> – Elbow Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) | <input checked="" type="checkbox"/> <b>L3761</b> – Elbow Brace (Side: <input checked="" type="checkbox"/> L <input checked="" type="checkbox"/> R) (Size: <b>MEDIUM</b> )<br><input checked="" type="checkbox"/> <b>L3916</b> – Wrist Hand Finger (Side: <input checked="" type="checkbox"/> L <input checked="" type="checkbox"/> R) (Size: <b>SMALL</b> )<br><input type="checkbox"/> <b>L3915</b> – Wrist Hand Finger (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size: )<br><input type="checkbox"/> <b>L1852</b> – Knee Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size: )<br><input type="checkbox"/> <b>L1851</b> – Knee Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size: )<br><input type="checkbox"/> <b>L1833</b> – Knee Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size: )<br><input type="checkbox"/> <b>L2397</b> – Knee Sleeve (Size: ) (Qty: )<br><input type="checkbox"/> <b>E0100</b> – Cane<br><input type="checkbox"/> <b>L2425</b> – Dial Lock Hinge ROM<br><input type="checkbox"/> <b>L2820</b> – Lower Extremity Ortho<br><input type="checkbox"/> <b>L1906</b> – Ankle Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Shoe Size: )<br><input type="checkbox"/> <b>L1971</b> – Ankle Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Shoe Size: )<br><input type="checkbox"/> <b>L0174</b> – Cervical Brace<br><input type="checkbox"/> <b>L3180</b> – Heel Stabilizer (Side: <input type="checkbox"/> L <input type="checkbox"/> R) |
|--|---|

**MEDICAL INFORMATION****ICD 10 (Diagnosis Code(s)):**

- |  |  |
|--|--|
| <input type="checkbox"/> M54.50- Low back pain, unspecified<br><input type="checkbox"/> M17.12- Unilateral primary osteoarthritis left knee<br><input type="checkbox"/> M17.11- Unilateral primary osteoarthritis right knee<br><input type="checkbox"/> M25.512- Pain in the left shoulder<br><input type="checkbox"/> M25.511- Pain in the right shoulder<br><input type="checkbox"/> M25.552- Pain in Left Hip<br><input type="checkbox"/> M25.551- Pain in Right Hip | <input checked="" type="checkbox"/> M25.532- Pain in left wrist<br><input checked="" type="checkbox"/> M25.531 - Pain in right wrist<br><input type="checkbox"/> M19.072- Osteoarthritis Left Ankle<br><input type="checkbox"/> M19.071- Osteoarthritis Right Ankle<br><input checked="" type="checkbox"/> M25.522 Pain in left elbow<br><input checked="" type="checkbox"/> M25.521 Pain in right elbow<br><input type="checkbox"/> M54.2- Cervicalgia Pain in Neck |
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**Length of Need:**    ☒ 12+ months (long term)    ☐ \_\_\_\_\_ # of months (1-11)

## MEDICAL HISTORY

**Previous treatments:** HEATING PAD, ICE PACKS AND PHYSICAL THERAPY

**Doctor's Notes:** The patient reports chronic **LEFT WRIST, RIGHT WRIST, RIGHT ELBOW AND LEFT ELBOW** 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.

**STEPHEN DUGGAN, DO**

PHYSICIAN SIGNATURE: \_\_\_\_\_ PHYSICIAN NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

## FIRST STEP DME INC.

Patient Name: **DONNA HOLMBERG**  
Patient Address: **900 JENNIFER LN MIDDLETOWN DE 19709**  
Patient Phone: **3023767056**

Physician Name: **STEPHEN DUGGAN, DO**  
Address: **124 SLEEPY HOLLOW DR SUITE 203 MIDDLETOWN DE 19709**  
Telephone: **3024493030**  
Fax: **3024493024**

Patient: **DONNA HOLMBERG**  
Date of Birth: **09/29/1966**  
Visit Date: **08/19/2023**  
Reason for visit: **CHECK-UP**

## Clinical Summary

### Patient Demographics

Patient Name:	<b>DONNA HOLMBERG</b>	Date of Birth:	<b>09/29/1966</b>
Age:	<b>57</b>	Phone Number:	<b>3023767056</b>
Address:	<b>900 JENNIFER LN</b>	City:	<b>MIDDLETOWN</b>
State:	<b>DE</b>	Zip Code:	<b>19709</b>
Gender:	<b>FEMALE</b>	Height:	<b>5'2</b>
Weight:	<b>185</b>	Waist Size	<b>36</b>

### Patient Insurance

Provider:	<b>MEDICARE</b>	Member ID:	<b>4H81YU5DW14</b>
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### Medications

Current Medication	<b>TYLENOL (AS NEEDED), ASPIRIN (325MG - ONCE A DAY), TRAMADOL (2X A DAY), GLIMEPIRIDE (ONCE A DAY)</b>
Medical History	<b>DIABETES (TYPE 2)</b>

### Medical Diagnosis

The pain level was indicated on a scale of 1-10 as the following: <b>8</b>
The patient's pain started on or around <b>SEVERAL YEARS</b>
The surgery addressed the following: <b>NA</b>
The pain is experienced <b>CONSTANTLY</b>
The patient has attempted the following previous treatments/therapies: <b>HEATING PAD, ICE PACKS AND PHYSICAL THERAPY</b>
The patient described their pain as the following: <b>ACHY</b>
The activities that make the patient's pain worse is as follows: <b>DOING DAILY ACTIVITIES</b>
The pain is located in the patient's <b>LEFT WRIST, RIGHT WRIST, RIGHT ELBOW AND LEFT ELBOW</b>
The patient's pain is caused by <b>WEAR AND TEAR</b>
The last time the patient has seen the doctor was on <b>08/19/2023</b>

### Chief Complaint

The patient's main complaint is that they experience chronic pain located in the following location(s): <b>LEFT WRIST, RIGHT WRIST, RIGHT ELBOW AND LEFT ELBOW</b>
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### Subjective Notes

The patient reports chronic <b>LEFT WRIST, RIGHT WRIST, RIGHT ELBOW AND LEFT ELBOW</b> pain for <b>SEVERAL YEARS</b> . Patient states pain is <b>ACHY</b> with a pain scale of <b>8</b> and pain worsens with movement. The pain is caused by <b>WEAR AND TEAR</b> and is experienced <b>CONSTANTLY</b> . 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 <b>SEVERAL YEARS</b> located in their <b>LEFT WRIST, RIGHT WRIST, RIGHT ELBOW AND LEFT ELBOW</b> related to <b>M25.532- Pain in left wrist, M25.531- Pain in right wrist, M25.522 Pain in left elbow, M25.521 Pain in right elbow</b> . Patient has been to a physical therapist and hasn't had previous surgery to treat this pain.
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FIRST STEP DME INC.

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 **8**. The following activities make the patient's pain worse: **DOING DAILY ACTIVITIES**. Patient needs a **LEFT WRIST, RIGHT WRIST, RIGHT ELBOW AND LEFT ELBOW** 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) **L3916 (WRIST HAND ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), ELASTIC BANDS, TURNBUCKLES, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED, OFF-THE-SHELF), L3761: ELBOW ORTHOSIS (EO), WITH ADJUSTABLE POSITION LOCKING JOINT(S), 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 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)**

**M25.532- Pain in left wrist, M25.531- Pain in right wrist, M25.522 Pain in left elbow, M25.521 Pain in right elbow**

**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: **STEPHEN DUGGAN, DO**

Address: **124 SLEEPY HOLLOW DR SUITE 203 MIDDLETOWN DE 19709**

Physician's Signature:

Date:

Patient Name: **DONNA HOLMBERG**

Patient Address: **900 JENNIFER LN MIDDLETOWN DE 19709**

Patient Phone: **3023767056**

LETTER OF MEDICAL NECESSITY

Re: **DONNA HOLMBERG**  
Orthotic Device Need Assessment  
Exam Date: **04/22/2024**  
Height: **5'2**  
Weight: **185**  
DOB: **09/29/1966**

**Ms HOLMBERG** is inquiring about utilizing orthotic bracing for his/her current conditions. His/her chief complaint at the time of this assessment is: **LEFT WRIST, RIGHT WRIST, RIGHT ELBOW AND LEFT ELBOW**.

**Ms HOLMBERG** reports chronic **LEFT WRIST, RIGHT WRIST, RIGHT ELBOW AND LEFT ELBOW** 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: **M25.532- Pain in left wrist, M25.531- Pain in right wrist, M25.522 Pain in left elbow, M25.521 Pain in right elbow**. Based on my conversation with **Ms HOLMBERG** and evaluation of his/her condition, I am ordering the following: **L3916 (WRIST HAND ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), ELASTIC BANDS, TURNBUCKLES, MAY INCLUDE SOFT INTERFACE, STRAPS, 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), L3761: ELBOW ORTHOSIS (EO), WITH ADJUSTABLE POSITION LOCKING JOINT(S), PREFABRICATED, OFF-THE-SHELF**.

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

Re: **DONNA HOLMBERG..... DOB: SEPTEMBER 29, 1966**

I, **STEPHEN DUGGAN, 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.

**STEPHEN DUGGAN, DO**  
Signature

**Date Signed:** \_\_\_\_\_