

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

LAST NAME

CAROLINE

FIRST NAME

MI

FEMALE

GENDER

11/09/1966

DATE OF BIRTH

3479957740

PHONE NUMBER

192 HYLAN BLVD

ADDRESS

STATEN ISLAND

CITY

NY 10305

STATE & ZIPCODE

SHIPPING METHOD:

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

INSURANCE INFORMATION**MEDICARE**

PRIMARY INSURANCE

1U14FC5YU84

MEMBER ID

SECONDARY INSURANCE

MEMBER ID

PHYSICIAN INFORMATION**DOMINIC POMPA, MD**

PHYSICIAN NAME

1306813696

NPI #

718-351-7683

PHONE NUMBER

78 9TH STREET STATEN ISLAND NY 10306

PRACTICE LOCATION

718-351-7685

FAX NUMBER

PRESCRIPTION SELECTION

- ☐ **L3670** – Shoulder Brace (Side: ☐ L ☐ R) (Size:)
☐ **L3670** – 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:)
☐ **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: **LARGE**)
☐ **L3915** – Wrist Hand Finger (Side: ☐ L ☐ R) (Size:)
☐ **L1852** – Knee Brace (Side: ☐ L ☐ R) (Size:)
☐ **L1833 / L1851** – 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: **8**)
☐ **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: **RESTING**

Doctor's Notes: The patient reports chronic **LEFT ANKLE, RIGHT ANKLE, LEFT WRIST, RIGHT WRIST** pain for **SEVERAL YEARS**. Patient states pain is **THROBBING** 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: _____ PHYSICIAN NAME: **DOMINIC POMPA, MD** DATE: _____

FIRST STEP DME INC.

Patient Name: **CAROLINE CALABIO**
Patient Address: **192 HYLAN BLVD STATEN ISLAND NY 10305**
Patient Phone: **3479957740**

Physician Name: **DOMINIC POMPA, MD**
Address: 78 9TH STREET STATEN ISLAND NY 10306
Telephone: 718-351-7683
Fax: 718-351-7685

Patient: **CAROLINE CALABIO**
Date of Birth: **11/09/1966**
Visit Date: **03/01/2024**
Reason for visit: **REGULAR CHECK-UP**

Clinical Summary

Patient Demographics

Patient Name:	CAROLINE CALABIO	Date of Birth:	11/09/1966
Age:	57	Phone Number:	3479957740
Address:	192 HYLAN BLVD	City:	STATEN ISLAND
State:	NY	Zip Code:	10305
Gender:	FEMALE	Height:	5'4
Weight:	170	Waist Size	LARGE

Patient Insurance

Provider:	MEDICARE	Member ID:	1U14FC5YU84
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Medications

Current Medication	IBUPROFEN (AS NEEDED)
Medical History	ARTHRITIS

Medical Diagnosis

The pain level was indicated on a scale of 1-10 as the following: 9
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: RESTING
The patient described their pain as the following: THROBBING
The activities that make the patient's pain worse is as follows: DOING DAILY ACTIVITIES
The pain is located in the patient's LEFT ANKLE, RIGHT ANKLE, 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 03/01/2024

Chief Complaint

The patient's main complaint is that they experience chronic pain located in the following location(s): LEFT ANKLE, RIGHT ANKLE, LEFT WRIST, RIGHT WRIST

Subjective Notes

The patient reports chronic LEFT ANKLE, RIGHT ANKLE, LEFT WRIST, RIGHT WRIST pain for SEVERAL YEARS . Patient states pain is THROBBING 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 LEFT ANKLE, RIGHT ANKLE, LEFT WRIST, RIGHT WRIST related to M19.071- Osteoarthritis Right Ankle, M19.072- Osteoarthritis Left Ankle, 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 THROBBING 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 LEFT ANKLE, RIGHT ANKLE, 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) **L3916 (WRIST HAND ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), ELASTIC BANDS, TURNBUCKLES, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED, OFF-THE-SHELF), L1906 ANKLE FOOT ORTHOSIS, MULTILIGAMENTOUS ANKLE SUPPORT, PREFABRICATED, OFF-THE-SHELF INCLUDES L3170 HEEL STABILIZER** 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)

M19.071- Osteoarthritis Right Ankle, M19.072- Osteoarthritis Left Ankle, 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.

Physician Information

Provider Name: **DOMINIC POMPA, MD**

Address: **78 9TH STREET STATEN ISLAND NY 10306**

Physician's Signature:

Date:

Patient Name: **CAROLINE CALABIO**

Patient Address: **192 HYLAN BLVD STATEN ISLAND NY 10305**

Patient Phone: **3479957740**

LETTER OF MEDICAL NECESSITY

Re: **CAROLINE CALABIO**
Orthotic Device Need Assessment
Exam Date: **04/23/2024**
Height: **5'4**
Weight: **170**
DOB: **11/09/1966**

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

Ms CALABIO reports chronic **LEFT ANKLE, RIGHT ANKLE, LEFT WRIST, RIGHT WRIST** pain for **SEVERAL YEARS**. Patient states pain is **THROBBING** 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: **M19.071- Osteoarthritis Right Ankle, M19.072- Osteoarthritis Left Ankle, M25.532- Pain in left wrist, M25.531- Pain in right wrist**. Based on my conversation with **Ms CALABIO** 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), L1906 ANKLE FOOT ORTHOSIS, MULTILIGAMENTOUS ANKLE SUPPORT, PREFABRICATED, OFF-THE-SHELF INCLUDES L3170 HEEL STABILIZER**.

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

Re: **CAROLINE CALABIO**..... DOB: **NOVEMBER 09, 1966**

I, **DOMINIC POMPA, 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.

DOMINIC POMPA, MD
Signature

Date Signed: _____