DV MEDICAL SUPPLY

RX / MEDICAL NECESSITY FORM

PATIENT INFORMATION

PIRAINO	**JUDITH**	
LAST NAME	FIRST NAME	MI
FEMALE	**08/23/1939**	**8654585084**
GENDER	DATE OF BIRTH	PHONE NUMBER
204 COYATEE VIEW	**LOUDON**	**TN 37774**
ADDRESS	CITY	STATE & ZIPCODE

SHIPPING METHOD:

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

INSURANCE INFORMATION

MEDICARE	
PRIMARY INSURANCE	SECONDARY INSURANCE
5F90A66HW25	
MEMBER ID	MEMBER ID

PHYSICIAN INFORMATION

GAIL WALTER MD	**1619903192**
PHYSICIAN NAME	NPI #
	8659864450
	PHONE NUMBER
1018 HIGHWAY 321 N LENOIR CITY TN 37771	
PRACTICE LOCATION	**8339082124**
	FAX NUMBER

PRESCRIPTION SELECTION

- ☐ **L3671 –** 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:)
- ☒ **L0457 –** Lumbar Brace (Waist: **MEDIUM**
- ☐ **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:)
- ☐ **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
- ☐ **L317**0 – 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 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 **Back** pain for **A WEEK**. Patient states pain is **ACHY** with a pain scale of **7** and pain worsens with movements. Pain is caused by **ARTHRITIS** 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.

GAIL WALTER MD

PHYSICIAN SIGNATURE:_____ PHYSICIAN NAME: _____ DATE:_____

Patient Name: **JUDITH PIRAINO**
Patient Address: **204 COYATEE VIEW LOUDON TN 37774**
Patient Phone: **8654585084**

Physician Name: **GAIL WALTER MD**
Address: **1018 HIGHWAY 321 N LENOIR CITY TN 37771**
Telephone: **8659864450**
Fax: **8339082124**

Patient: **JUDITH PIRAINO**
Date of Birth: **08/23/1939**
Visit Date: **10/18/2023**
Reason for visit: **Check-up**

Clinical Summary

Patient Demographics

Patient Name:	**JUDITH PIRAINO**	Date of Birth:	**08/23/1939**
Age:	**84**	Phone Number:	**8654585084**
Address:	**204 COYATEE VIEW**	City:	**LOUDON**
State:	**TN**	Zip Code:	**37774**
Gender:	**FEMALE**	Height:	**5'1**
Weight:	**125**	Waist Size	**M**

Patient Insurance

Provider:	**MEDICARE**	Member ID:	**5F90A66HW25**

Medications

Current Medication	**TYLENOL**
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 **A WEEK**
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: **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 **ARTHRITIS**
The last time the patient has seen the doctor was on **10/18/2023**

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 **A WEEK.** Patient states pain is **ACHY** with a pain scale of **7** and pain worsens with movement. The pain is caused by **ARTHRITIS** 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 **A WEEK** 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.

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: **GAIL WALTER MD**

Address: **1018 HIGHWAY 321 N LENOIR CITY TN 37771**

Physician's Signature:

Date:

Patient Name: **JUDITH PIRAINO**
Patient Address: **204 COYATEE VIEW LOUDON TN 37774**
Patient Phone: **8654585084**

LETTER OF MEDICAL NECESSITY

Re: **JUDITH PIRAINO**
Orthotic Device Need Assessment
Exam Date: **06/27/2024**
Height: **5'1**
Weight: **125**
DOB: **08/23/1939**

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

Ms PIRAINO reports chronic **Back** pain for **A WEEK**. Patient states pain is **ACHY** with a pain scale of **7** 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 PIRAINO** 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).**

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 PIRAINO** 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 PIRAINO** continue medical follow-up as part of an ongoing plan of care.

Re: JUDITH PIRAINO..... DOB: August 23, 1939
I, **GAIL WALTER 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.

GAIL WALTER MD ***Date Signed***: _____
Signature