

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

LAST NAME

BRENDA

FIRST NAME

MI

FEMALE

GENDER

07/07/1954

DATE OF BIRTH

7062918149

PHONE NUMBER

368 CARPENTER RD NE

ADDRESS

CALHOUN

CITY

GA 30701

STATE & ZIPCODE

SHIPPING METHOD:

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

INSURANCE INFORMATION**MEDICARE**

PRIMARY INSURANCE

7MA3W45EN99

MEMBER ID

SECONDARY INSURANCE

MEMBER ID

PHYSICIAN INFORMATION**ANANDITA ARORA MD**

PHYSICIAN NAME

1154731925

NPI #

7622352495

PHONE NUMBER

1825 MARTHA BERRY BOULEVARD, ROME GA 30165

PRACTICE LOCATION

7062388013

FAX NUMBER

PRESCRIPTION SELECTION

- | | |
|---|--|
| <input type="checkbox"/> L3670 – Shoulder Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size:) | <input checked="" type="checkbox"/> L3761 – Elbow Brace (Side: <input checked="" type="checkbox"/> L <input type="checkbox"/> R) (Size: LARGE) |
| <input type="checkbox"/> L3960 – Shoulder Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size:) | <input checked="" type="checkbox"/> L3916 – Wrist Hand Finger (Side: <input checked="" type="checkbox"/> L <input checked="" type="checkbox"/> R) (Size: LARGE) |
| <input type="checkbox"/> L3660 – Shoulder Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size:) | <input type="checkbox"/> L3915 – Wrist Hand Finger (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size:) |
| <input type="checkbox"/> L0650 – Lumbar Brace (Waist:) | <input checked="" type="checkbox"/> L1852 – Knee Brace (Side: <input checked="" type="checkbox"/> L <input checked="" type="checkbox"/> R) (Size: LARGE) |
| <input type="checkbox"/> L0642 – Lumbar Brace (Waist:) | <input type="checkbox"/> L1851 – Knee Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size:) |
| <input type="checkbox"/> L0457 – Lumbar Brace (Waist:) | <input type="checkbox"/> L1833 – Knee Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size:) |
| <input type="checkbox"/> L0648 – Lumbar Brace (Waist:) | <input checked="" type="checkbox"/> L2397 – Knee Sleeve (Size: LARGE) (Qty: 2) |
| <input type="checkbox"/> E0100 – Electric Heat Pad | <input type="checkbox"/> E0100 – Cane |
| <input type="checkbox"/> L1690 – Hip Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Waist:) | <input type="checkbox"/> L2425 – Dial Lock Hinge ROM |
| <input type="checkbox"/> L1686 – Hip Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Waist:) | <input type="checkbox"/> L2820 – Lower Extremity Ortho |
| <input type="checkbox"/> L2624 – Hip Joint Adjustable Flexion, Extension (Side: <input type="checkbox"/> L <input type="checkbox"/> R) | <input type="checkbox"/> L1971 – Ankle Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Shoe Size:) |
| <input type="checkbox"/> L3760 – Elbow Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) | <input type="checkbox"/> L1906 – Ankle Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Shoe Size:) |
| | <input type="checkbox"/> L0174 – Cervical Brace |
| | <input type="checkbox"/> L3170 – 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 | <input checked="" type="checkbox"/> M25.532- Pain in left wrist |
| <input checked="" type="checkbox"/> M17.12- Unilateral primary osteoarthritis left knee | <input checked="" type="checkbox"/> M25.531 - Pain in right wrist |
| <input checked="" type="checkbox"/> M17.11-Unilateral primary osteoarthritis right knee | <input type="checkbox"/> M19.072- Osteoarthritis Left Ankle |
| <input type="checkbox"/> M25.512-Pain in the left shoulder | <input type="checkbox"/> M19.071- Osteoarthritis Right Ankle |
| <input type="checkbox"/> M25.511-Pain in the right shoulder | <input checked="" type="checkbox"/> M25.522 Pain in left elbow |
| <input type="checkbox"/> M25.552- Pain in Left Hip | <input type="checkbox"/> M25.521 Pain in right elbow |
| <input type="checkbox"/> M25.551- Pain in Right Hip | <input type="checkbox"/> 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 **LEFT KNEE, RIGHT KNEE LEFT WRIST AND RIGHT WRIST, LEFT ELBOW** pain for **MORE THAN A YEAR**. Patient states pain is **SHARP, THROBBING** with a pain scale of **9** and pain worsens with movements. Pain is caused by **WEAR AND TEAR, ARTHRITIS** and is experienced **SOMETIMES**. 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.

ANANDITA ARORA MD

PHYSICIAN SIGNATURE: _____ PHYSICIAN NAME: _____ DATE: _____

DV MEDICAL SUPPLY

Patient Name: **BRENDA GRAVITTE**
Patient Address: **368 CARPENTER RD NE CALHOUN GA 30701**
Patient Phone: **7062918149**

Physician Name: **ANANDITA ARORA MD**
Address: 1825 MARTHA BERRY BOULEVARD, ROME GA 30165
Telephone: 7622352495
Fax: 7062388013

Patient: **BRENDA GRAVITTE**
Date of Birth: **07/07/1954**
Visit Date: **08/05/2024**
Reason for visit: **CHECK-UP**

Clinical Summary

Patient Demographics

Patient Name:	BRENDA GRAVITTE	Date of Birth:	07/07/1954
Age:	70	Phone Number:	7062918149
Address:	368 CARPENTER RD NE	City:	CALHOUN
State:	GA	Zip Code:	30701
Gender:	FEMALE	Height:	5'3
Weight:	220	Waist Size	L

Patient Insurance

Provider:	MEDICARE	Member ID:	7MA3W45EN99
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Medications

Current Medication	ADVIL (AS NEEDED) OXYCODONE (EVERY 8 HOURS) HIGH BLOOD PRESSURE PILL (ONCE A DAY)
Medical History	HIGH BLOOD PRESSURE

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 MORE THAN A YEAR
The surgery addressed the following: NA
The pain is experienced SOMETIMES
The patient has attempted the following previous treatments/therapies: TAKING MEDICATION
The patient described their pain as the following: SHARP, 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 KNEE, RIGHT KNEE LEFT WRIST AND RIGHT WRIST, LEFT ELBOW
The patient's pain is caused by WEAR AND TEAR, ARTHRITIS
The last time the patient has seen the doctor was on 08/05/2024

Chief Complaint

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

Subjective Notes

The patient reports chronic LEFT KNEE, RIGHT KNEE LEFT WRIST AND RIGHT WRIST, LEFT ELBOW pain for MORE THAN A YEAR . Patient states pain is SHARP, THROBBING with a pain scale of 9 and pain worsens with movement. The pain is caused by WEAR AND TEAR, ARTHRITIS and is experienced SOMETIMES . 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 MORE THAN A YEAR located in their LEFT KNEE, RIGHT KNEE LEFT WRIST AND RIGHT WRIST, LEFT ELBOW related to M17.11-Unilateral primary osteoarthritis right knee, M17.12- Unilateral primary osteoarthritis left knee, M25.532- Pain in left wrist, M25.531- Pain in right wrist, M25.522 Pain in left elbow . Patient has been to a physical therapist and hasn't had previous surgery to treat this pain.
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DV MEDICAL SUPPLY

Patient's chronic pain is described **SHARP, THROBBING** and occurs **SOMETIMES**. 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 KNEE, RIGHT KNEE LEFT WRIST AND RIGHT WRIST, 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) **L1852 KNEE BRACE - KNEE ORTHOSIS (KO), DOUBLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, PREFABRICATED, OFF-THE-SHELF WHICH INCLUDES L2397 SUSPENSION SLEEVE, 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 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)

M17.11-Unilateral primary osteoarthritis right knee, M17.12- Unilateral primary osteoarthritis left knee, M25.532- Pain in left wrist, M25.531- Pain in right wrist, M25.522 Pain in left 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: **ANANDITA ARORA MD**

Address: **1825 MARTHA BERRY BOULEVARD, ROME GA 30165**

Physician's Signature:

Date:

Patient Name: **BRENDA GRAVITTE**

Patient Address: **368 CARPENTER RD NE CALHOUN GA 30701**

Patient Phone: **7062918149**

LETTER OF MEDICAL NECESSITY

Re: **BRENDA GRAVITTE**
Orthotic Device Need Assessment
Exam Date: **08/09/2024**
Height: **5'3**
Weight: **220**
DOB: **07/07/1954**

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

Ms GRAVITTE reports chronic **LEFT KNEE, RIGHT KNEE LEFT WRIST AND RIGHT WRIST, LEFT ELBOW** pain for **MORE THAN A YEAR**. Patient states pain is **SHARP, THROBBING** with a pain scale of 9 and pain worsens with **DOING DAILY ACTIVITIES**. Pain is experienced **SOMETIMES**. Previous treatments with heat, ice, medication and rest have been unsuccessful to control pain levels.

Diagnosis includes: **M17.11-Unilateral primary osteoarthritis right knee, M17.12- Unilateral primary osteoarthritis left knee, M25.532- Pain in left wrist, M25.531- Pain in right wrist, M25.522 Pain in left elbow**. Based on my conversation with **Ms GRAVITTE** and evaluation of his/her condition, I am ordering the following: **L1852 KNEE BRACE - KNEE ORTHOSIS (KO), DOUBLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, PREFABRICATED, OFF-THE-SHELF WHICH INCLUDES L2397 SUSPENSION SLEEVE, 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 KNEE, RIGHT KNEE LEFT WRIST AND RIGHT WRIST, LEFT ELBOW** requiring stabilization for improvement of functionality. I am prescribing this **KNEE AND WRIST, ELBOW** orthosis for the following indication(s): to aid when the patient is **DOING DAILY ACTIVITIES**, to aid in stabilization of the **KNEE AND WRIST, ELBOW**. My treatment goal(s) for the use of the prescribed **KNEE AND WRIST, 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 GRAVITTE** 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 GRAVITTE** continue medical follow-up as part of an ongoing plan of care.

Re: **BRENDA GRAVITTE**..... DOB: **July 07, 1954**

I, **DR. ANANDITA ARORA 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.

DR. ANANDITA ARORA MD
Signature

Date Signed: _____

Comprehensive Knee Laxity Test (Check All Applicable)

Objective Tests: (Check ALL applicable, a minimum of 2 tests is required for each knee with a brace prescribed.)

Caution: Advise Patients to stabilize themselves properly during any standing test to avoid a fall injury.

Pivot Shift Test (Stabilization to avoid fall advised for this test. Patient can stabilize themselves by holding onto a chair or kitchen counter.)

Positive: Patient knee gives out while pivoting or twisting indication joint laxity

Negative: Patient knee DOES NOT give out while pivoting or twisting.

LEFT: Positive

RIGHT: Positive

Cabot's Maneuver (figure of "4" knee bend)

Positive: Patient indicates lateral joint line pain, LCL instability and ligament laxity

Negative: Patient knee DOES NOT produce lateral knee pain

(Leave positive and negative both unchecked for the knee if did not perform this test on the knee.)

LEFT: Positive

RIGHT: Positive