CMN for Lumbar-Sacral Orthosis Back Support

Patient Name: _____ Patient DOB: _____

Medicare # _____ Patient Phone: _____

Treating Physician: _____

Physician Address: _____

Physician Phone: _____ Physician Fax: _____

INSTRUCTIONS: The above named patient has requested that you fill out this order form. Please complete *entire* form and fax to the number below. Per Medicare guidelines we are required to obtain **progress notes** along with this **signed RX** and **qualifying diagnosis code(s)** for product sought by your patient. Please make sure the supporting documentation is faxed to validate **medical necessity** in order to facilitate your patients' request. Unfortunately, without these necessary documents we will not be able to supply the product requested by your patient.

Item to be ordered:

_____ **L0650 Modular brace, provides anterior, lateral and posterior support,**
_____ **L0648 Provides anterior and posterior spinal support.**
_____ **L0456 TLSO - Covers S1 - T4, full spine support (includes shoulder straps)**

Please indicate which of the following conditions apply to the patient. Check all that apply.

- ☐ To reduce pain by restricting mobility of the truck: or
- ☐ To facilitate healing following an injury to the spine or related soft tissues: or
- ☐ To facilitate healing following a surgical procedure on the spine or related soft tissue: or
- ☐ To otherwise support weak spinal muscles and/or a deformed spine.

Please choose ICD-10

☐ S33.5XXA - Lumbar Strains/Sprain	☐ M54.5 - Lumbago	☐ M62.81 - Muscle Weakness
☐ M51.36 - Lumbar Disc Degeneration	☐ M05.9 Arthritis, Rheumatoid	
☐ M47.817 - Lumbosacral Spondylosis	☐ Q76.2 – Spondylolisthesis	☐ R20.2 Paresthesia
☐ M19.90 Osteoarthritis, Degenerative	☐ M25.60 Joint Stiffness	☐ S33.5 Lumbar Sprain/Strain
☐ M62.50 Disuse Atrophy	☐ M62.81 Muscle Weakness	☐ M51.36 Degeneration of lumbar or lumbosacral disc
☐ M53.2X9 Spinal Instability	☐ M51.26 - Lumbar Disc Displacement	☐ Other: _____

Estimated length of need (# of months) _____ (99 = lifetime)

BY SIGNING BELOW, I AUTHORIZE the use of this document as a legal prescription and I certify that the above prescribed equipment is medically necessary and reasonable, and is consistent with the current standards of medical practice and treatment of this patient's condition. I will maintain an original, signed copy of this physician order in my medical records and make it available to Medicare, their authorized agents, or other insurer, if required. ***** Medical justification must be documented in the patient's medical record *****

Physicians Signature: _____ NPI# _____ Date: _____

Please FAX this order to: 704-821-7777

Questions Call: Mobility & More 704-821-7777

REF ID