Prescription/CMN for Lumbar-Sacral Orthosis Back Support

Patient Name: _____ Patient DOB: _____

Address: _____ City: _____ NC: _____ ZIP: _____

Patient Phone: _____ Medicare/Insurance # _____

Treating Physician: _____

Physician Address: _____

Physician Phone: _____ Physician Fax: _____

INSTRUCTIONS: The above named patient has requested that you fill out this order form. Please complete the entire form and fax to the number below. Per Medicare guidelines we are required to obtain **progress notes** along with this **signed CMN** 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.

Item to be ordered:

_____ L0648 Provides anterior and posterior spinal support.
_____ L0650 Modular brace, provides anterior, lateral and posterior support,
_____ L0457 TLSO - Covers S1 - T4, full spine support (includes shoulder straps)
_____ Other: _____

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: 3-6 Months During Ambulation or (# 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 FORM WITH QUALIFYING CLINICAL NOTES

FAX TO 704-821-7777