A D MEDICAL, INC.
America's Dietitians
Phone: 888-785-7370 • Fax: 888-785-7380
www.americasdietitians.com

CERTIFICATE OF MEDICAL NECESSITY FOR LUMBAR ORTHOSIS

Patient Name: _____ Phone: _____

Address: _____ Sex: ☐ **M** ☐ **F**

City: _____ State: _____ Zip: _____

DOB: _____ Medicare: _____ Secondary: _____

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.

ITEMS TO BE ORDERED:

A lumbar-sacral orthosis _____L0648 or _____L0650 is covered when it is ordered for one of the following indications:

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 codes that apply.

☐ M12.9 Arthropathy, unspecified	☐ M19.90 Osteoarthritis, De-generative	☐ M06.9 Arthritis, Rheumatoid
☐ M25.60 Joint Stiffness	☐ S33.5XXA Lumbar Sprain/Strain	☐ M54.5 Chronic Low Back Pain
☐ M48.06 Spinal Stenosis	☐ M62.81 Muscle Weakness	☐ M47.817 Lumbosacral Spondylosis
☐ Other: _____		

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

This patient is being treated under a comprehensive plan of care for arthritis/pain. I, the undersigned certify that the above prescribed is medically necessary for the patients' overall well being. In my opinion, the following orthotic/arthritic relief products are both reasonable and necessary in reference to accepted standards of medical practice in the treatment of the patient's condition and/or rehabilitation. I certify that the patient's medical records reflect the need for the item ordered and will be made available upon request.

Physician:_____ NPI:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Fax: _____

Physician's Signature: _____ **Date:** _____

PLEASE COMPLETE AND FAX TO 888-785-7380