Piedmont Medical SOLUTIONS

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Phone: 336-602-1668
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Patient Name: _____ Date of Order: _____
Patient Phone Number: (_____) _____ Date of Birth: _____
Diagnosis(s): _____
ICD10 Code(s): _____
Start Date: _____(if different from order date)

SPINAL

- ☐ L0650 – SleeQ/Aspen LSO
- ☐ L0648 – SleeQ (without lateral panels)
- ☐ L0642 – X-Back/Posture Correx
- ☐ L0457 – Spinomed TLSO
- ☐ L1005 – Aspen Peak Scoliosis Brace
- ☐ L0172 – Aspen Cervical Collar
- ☐ L0180 – Aspen Multi-Post Cervical Collar

Medicaid Solutions

- ☐ L0637 – SleeQ/Aspen LSO
- ☐ L0627 – X-Back/Posture Correx
- ☐ L0631 – SleeQ (without lateral panels)
- ☐ L0456 – Spinomed TLSO

Medical records document the spinal orthosis was ordered for one of the following indications:

- Reduce pain by restricting mobility of the trunk; or
- Facilitate healing following an injury to the spine or related soft tissue; or
- Facilitate healing following a surgical procedure on the spine or related soft tissue; or
- Otherwise support weak spinal muscles and/or a deformed spine.

KNEE

Circle One: Left – Right - Both

- ☐ L1833 – Hinged Knee Brace
- ☐ L1852 – ACL Knee Brace
- ☐ L1851 – OA Knee Brace
  - ☐ L2810 – Condylar Pad
  - ☐ L2397 – Suspension Sleeve

Medicaid Solutions

- ☐ L1832 – Warrior II Knee Brace/Trend ROM
- ☐ L1845 – ACL Knee Brace
- ☐ L1843 – OA Knee Brace

Medical records document the knee orthosis was ordered for one of the following indications:

- One of the Following:
  1 – Recent Injury to or surgery to the knee; or
  2 – Knee Instability documented by an objective description of joint laxity (e.g., Varus/Valgus Drawer Test, Anterior/Posterior Drawer Test).
- AND
  1 – Patient is ambulatory; and has a
  2 – Covered Diagnosis ***(see list on back of form)***

OTHER

Circle One: Left – Right - Both

- ☐ L3670 – Shoulder Orthosis
- ☐ L3916 – Wrist Brace
- ☐ L1902 – Ankle Brace
- ☐ L1951 – AFO – Foot Drop
- ☐ L4361 –Walker Boot
- ☐ E0730 – 4 Lead TENS Unit
  - ☐ A4595 – TENS Supply Kits 2/Month

Medicaid Solutions

- ☐ L3915 – Wrist Brace
- ☐ L4360 – Walker Boot

☐ Other: _____

☐ E0849 – Cervical Traction

The Medical Record MUST document:

1 – The patient has a musculoskeletal or neurologic impairment requiring traction equipment; and
2 – The appropriate use of a home cervical traction device has been demonstrated to the patient and they ***tried and tolerated*** the selected device; and
3 – The treating physician orders and/or documents the medical necessity for ***GREATER THAN 20 LBS*** of cervical traction in the HOME setting.

I certify that the items listed above are medically necessary for the treatment of the patient for the above condition.

Physician Name **(Print)**:_____ Phone #: (____) _____

Physician Signature: _____ Date: _____ /_____ /_____

Physician NPI#: _____