Advanced Pain Solutions, LLC _____
Accredited DME Provider
13730 Cypress Terrace Cir. Unit 401
Fort Myers, FL 33907
Phone (239) 275-7575 Fax (239) 275-7035

CERTIFICATE OF MEDICAL NECESSITY FOR LUMBAR ORTHOTIC
DETAILED WRITTEN ORDER

ORDERING PRACTITIONER:
_____
_____
_____

REGARDING PATIENT:
_____
DOB: _____

Date of the face-to-face examination: (required within past 6 months) _____

[ ] L0648: DDS 500 lumbar-sacral orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to t-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf

[ ] L0650: DDS Double lumbar-sacral orthosis, sagittal-coronal control, with rigid anterior and posterior frame/panel(s), posterior extends from sacrococcygeal junction to t-9 vertebra, lateral strength provided by rigid lateral frame/panel(s), produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf

Please CHECK ALL that applies. Describe why this patient requires the product prescribed above.
[ ] To reduce pain by restricting mobility of the trunk.
[ ] To facilitate healing following an injury to the spine or related soft tissues.
[ ] To facilitate healing following a surgical procedure on the spine or related soft tissue.
[ ] To otherwise support weak spinal muscles and/or a deformed spine.

ESTIMATED LENGTH OF NEED (# of Months) _____ 1-99 (if left blank = Lifetime)

Please CHECK ALL that applies. What is the patient's **Diagnosis Code?**

[ ] M43.10 Spondylolisthesis, site unspecified
[ ] M47.817 Spondylosis lumbosacral
[ ] M47.819 Spondylosis site unspecified
[ ] M48.06 Spinal stenosis, lumbar region
[ ] M51.26 Disc bulge/herniation lumbar
[ ] M51.27 Disc bulge/herniation lumbosacral
[ ] M51.36 Disc degeneration lumbar
[ ] M51.37 Disc degeneration lumbosacral
[ ] M54.5 Lumbago - low back pain
[ ] M54.16 Radiculopathy, lumbar region
[ ] M54.17 Radiculopathy, lumbosacral region
[ ] M54.30 Sciatica, unspecified side
[ ] _____ Other
[ ] _____ Other

SUPPORTING DOCUMENTATION:
[ ] Imaging (X-Ray/ MRI Report)
[ ] Physical Examination
[ ] Oswestry Low Back Evaluation

Medical Justification must be documented in the patient's medical record

Signature:_____ Date:_____
Printed Name: _____NPI: _____

By signing above, I authorize the use of this document as a legal prescription and I certify that the lumbar orthosis is medically necessary and reasonable, and is consistent with the current standards of medical practice and treatment of this patient's condition.

PLEASE FAX REQUEST TO (239) 275-7035