AIM PLUS
MEDICAL SUPPLIES

Certificate of Medical Necessity of Certifying Provider for Lumbar Sacral Orthosis (LSO and TLSO)

Please fax form with Provider's Signature to 866-496-7054

PATIENT INFORMATION

Name: _____ Date of Birth ____/____/_____
Primary Phone: _____ Secondary Phone: _____
Address: _____ City/State/Zip: _____
Primary Insurance: _____ ID#: _____
Secondary Insurance: _____ ID#: _____
Contact Person (If other than Patient): _____

It is my expert opinion that an LSO, HCPCS Code ___ L0450, ___L0642, ___L0648, or ___L0650, is medically necessary to facilitate the management of this patient's diagnosis. This prescription also acts as a Letter of Medical Necessity. Please dispense as follows:

___ To facilitate healing following a surgical procedure on the spine or related soft tissue.
Procedure Date: _____ Description: _____ **or**
___ To facilitate healing following an injury to the spine or related soft tissue **or**
___ To reduce pain by restricting mobility of the trunk **or**
___ To otherwise support weak spinal muscles and/or a deformed spine.

I certify that the following is true: (Check all that apply)

___ Lumbago (724.2)
___ Lumbar Strain/Sprain (847.2)
___ Spondylolisthesis (756.12)
___ Lumbar Disk Displacement (722.10)
___ Lumbosacral Sponsylosis (721.3)
___ Muscle Weakness (728.87)
___ Lumbar/Lumbosacral Intervertebral
___Disc Degeneration (722.52)
___Spinal Stenosis (724.0)
___Spinal Disorder (724.9)
___Other _____

*For Relevant ICD 10 Codes, See
https://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD10ClinicalConceptsOrthopedics1.pdf

Duration: Patient has had this condition for a period of ____ month(s) ____ year(s). (Chronic = 3 months or more)
Estimated Length of Back Brace Need ___ month(s) ____ 1-99 (99 = Lifetime)

I have determined through my evaluation that the patient would benefit from the following back pain management Lumbar Sacral Orthosis (LSO) product. Check the appropriate box below for 1 Back Brace:

Preferred Brace:
___ Transformer2 Back Brace (Small to 4X)
___ Weave Series (Small to 4X)
___ APEX LSO2 and APEX TLSO Back Brace (Universal)
___ Concord Adjustable LSO (Small to XL)
___ Lumbo Lite Lumbar Orthosis (Small to 4X)
___ T.L.S.O. Support (S-3X)
___ Other: _____

Requested Size: ___S___M___L___XL ___2X___3X ___4X ___ Universal (U)

This patient is being treated under a comprehensive plan of care. I, the undersigned, certify that above prescribed is 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 and will be made available upon request.

Provider Name (Print): _____ Provider NPI# _____
Provider Phone Number: _____ Provider Fax: _____
Provider Signature: _____ **Date**: _____