



# DWO for Lumbar Supports/Bracing

FAX COMPLETED DWO, PATIENT DEMOGRAPHICS AND SUPPORTING MEDICAL NOTES TO 207-221-9622

DATE OF ORDER: \_\_\_\_\_

DATE OF LAST FACE TO FACE: \_\_\_\_\_

## PATIENT INFORMATION

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Emergency Contact \_\_\_\_\_ Emergency Contact Phone \_\_\_\_\_

## REFERRING PT OR CLINIC INFORMATION (if applicable)

Clinic Name \_\_\_\_\_ Therapist Name \_\_\_\_\_

Clinic Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Therapist Email \_\_\_\_\_

## PRODUCT PRESCRIBED

- L0642 Lumbar Orthosis  
Sagittal control, with rigid anterior and posterior panels, posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, OTS
- L0648 LSO (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, prefabricated, OTS
- L0457 TLSO (Thoracic lumbar-sacral orthosis)  
Flexible, provides trunk support, thoracic region, rigid posterior panel and soft anterior apron, extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral disks, includes straps and closures, prefabricated, OTS
- Other Lumbar Support/Brace \_\_\_\_\_

## DIAGNOSIS

- M47.817 Spondylosis w/o myelopathy or radiculopathy, lumbosacral region
- M51.26 Other intervertebral disc displacement, lumbar region
- M51.27 Other intervertebral disc displacement, lumbosacral region
- M51.36 Other intervertebral disc degeneration, lumbar region
- M51.37 Other intervertebral disc degeneration, lumbosacral region
- M51.06 Intervertebral disc disorders with myelopathy, lumbar region
- M51.07 Intervertebral disc disorders with myelopathy, lumbosacral region
- M48.00 Spinal stenosis, site unspecified
- M54.5 Low back pain
- M54.89 Other dorsalgia
- M54.9 Dorsalgia, unspecified
- M43.8X9 Other specified deforming dorsopathies, site unspecified
- M53.9 Dorsopathy, unspecified
- M62.81 Muscle weakness (generalized)
- Q76.2 Congenital spondylolisthesis
- Other \_\_\_\_\_

## CHECK ANSWERS THAT APPLY TO PATIENT

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the patient have chronic back pain that can be reduced by restricting trunk mobility?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is the back brace needed to promote healing of a recent injury or surgery to the back or soft tissues of the spine?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is the back brace needed to support weak spinal muscles or a deformed spine?

**NOTE:** Medicare and other insurance payers **require** that the ordering physician's chart notes substantiate the diagnosis listed above, and that physician chart notes state the need for the brace, what else has been tried, and how long for length of pain.

## PHYSICIAN INFORMATION (Must be MD, DO, NP or PA)

*By signing and dating, I attest to prescribing the above mentioned item(s). In my professional opinion, the item(s) is both reasonable and necessary in reference to the current accepted standards of medical practice and treatment of this patient's condition. All other related treatments have been tried/considered and ruled out.*

Physician Name \_\_\_\_\_ NPI# \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Physician Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date Signed \_\_\_\_\_