FAX: Documentation Request

Fax to Name		Fax from Name	
Company		Company	
Phone		Phone	
Fax		Fax	
Patient	Date of Birth		No. of Pages

We have received a referral from your office to provide a spinal orthosis for the above patient. Please be advised that Medicare's documentation requirements state that payment for an orthosis is based solely on the information in the physician's records (not the Orthotist's). Therefore we need the following information from your medical records in order to be in compliance with Medicare and receive reimbursement. We appreciate your cooperation.

- **Criteria for coverage:** <u>One</u> of the following indications must be documented:
    1. To reduce pain by restricting mobility of the trunk; OR
    2. To facilitate healing following an injury to the spine or related soft tissues; OR
    3. To facilitate healing following a surgical procedure on the spine or related soft tissue; OR
    4. To otherwise support weak spinal muscles and/or a deformed spine
- **If custom fabricated:** If orthosis will be custom fabricated over a positive patient model, there must be a detailed reason documented in the medical record as to why a prefabricated (custom-fit/OTS) device could not be fit (e.g underlying deformity or body somatotype which would preclude the use of a prefabricated brace).
- **Recent physical exam specific to the abnormality/deformity with objective assessment of the condition necessitating the brace:** Include (if applicable) presence of abnormality/deformity, swelling, tenderness, muscle spasm; objective assessment of joint laxity/stability; range of motion; weight, height, weight loss/gain; neurological; etc.
- **History of condition necessitating the orthosis:** Diagnosis; Affected Side; Clinical Course; Therapeutic Interventions and Results; and Prognosis.
- **Functional limitations:** Daily activities and how they are impacted by deficit(s), Diagnoses causing these symptoms; other Co-morbidities.
- **Status/condition of current orthosis (if applicable):** Describe the orthosis. Does it need to be repaired or replaced? Select one replacement reason and document it.
    1. **Damage:** If damaged, describe the incident.
    2. **Repair:** If the device needs repair there needs to be a statement of continued medical need
    3. **Wear and Tear:** Useful lifetime is 5 years, so it cannot be replaced for normal wear and tear before that.
    4. **Patient's Condition:** If patient's condition has changed, describe why device is no longer appropriate (e.g. weight gain/loss, decreased stability, etc.).
- **Past experience with orthoses/braces and other failed treatments**
- **Recommendation for the new orthosis:** Include the type of device (brand name not required), a statement that patient has the potential to benefit functionally with the device, <u>and your rational for ordering it (based on the information above)</u>. *Each note must have your signature, date, printed name & credential; and each page should clearly identify the patient.*

Please fax the signed documents to: _____ at

(_____) _____