D&J Medical
ORTHOTICS PROSTHETICS COMPRESSION

Maryland Orthotics & Prosthetics
A D&J MEDICAL COMPANY

Locations

HARFORD COUNTY OFFICE
8 Newport Drive
Forest Hill, MD 21050
410.893.1116 *office*
410.420.2773 *fax*

TOWSON OFFICE
GBMC
6569 North Charles Street
Physician's Pavilion West, Suite 705
Baltimore, MD 21204
443.617.1090 *office*
443.773.0423 *fax*

BALTIMORE OFFICES
301 St. Paul Place
Baltimore, MD 21202
410.659.2831 *office*
410.951.7962 *fax*

8517 Loch Raven Boulevard
Baltimore, MD 21286
410.665.8200 *office*
410.665.2401 *fax*

HOWARD COUNTY OFFICE
10772 Hickory Ridge Road
Columbia, MD 21044
410.561.6227 *office*
443.451.8625 *fax*

CARROLL COUNTY OFFICE
15 East Main Street, Suite 116
Westminster, MD 21157
410.876.6584 *office*
410.665.2401 *fax*

Hours

Monday – Friday, 9 am to 5 pm
Baltimore Office: 8:30 am - 4:30 pm
Westminster: Limited Hours

Please call for an appointment

Fax Cover Sheet - Orthotic Request

Date: _____

To: _____ Fax#: _____

From: _____ Phone: _____

Number of pages _____ *(including cover sheet)*

Dear Doctor,

Our office was recently contacted by one of your patients with a request to complete an evaluation and provide an orthotic device to aid and assist in their activities of daily living. A copy of the practitioner's evaluation is included in this fax.

The device recommended for your consideration is:

_____

As noted in Medicare's Guidelines (and other insurances), in addition to a prescription, the patient's physician treatment notes are also required for coverage of this device. According to the Medicare Guidelines, the Physician treatment notes must include: Patient name, DOB, Date of injury or disease that necessitates the use of device, Type of orthosis as well as how this device will improve the patient's activities of daily living, and length of use.

This treatment note is also required to be produced after a face to face encounter with the patient. Realizing that most physicians are unaware of this requirement, we have formulated a Physician Treatment Note template. This template addresses all Medicare requirements for an orthosis. The treatment note can be included into your patient file or the data can be incorporated into your treatment note format. We have also placed this note in a writable PDF file version. Please remember this is a Medicare requirement.

We have included a copy of the treatment note or you can retrieve a PDF version on the Resources page of our website: dandjmedical.com/helpful-links

Please FAX the prescription and completed treatment note to 410.343.9876

Thank you, D&J Medical and MDOP

Prescription & Letter of Medical Necessity

Patient Name: _____ DOB: _____

Rx INFORMATION

Item Description: _____

Diagnosis: _____ Order Date: _____

HCPCS: _____

Medical Necessity: This patient has an orthopedic or functional condition that requires an orthotic or prosthetic device.

This patient has: *(Check all that apply)*

- ☐ **Instability** — Device required for preventing future injury
- ☐ **Fracture** — Device needed for stabilization to promote healing
- ☐ **Post-Operative Support** — Device required for achieving optimal results
- ☐ **Immobilization** — Device needed to preserve stabilization
- ☐ **Ambulatory Aid** — Device needed to assist in daily activities
- ☐ **ROM Assist** — Device needed to assist in rehabilitation
- ☐ **Functional Support** — Device needed to assist in activities of daily life

The patient's prognosis with required device is: ☐ Good ☐ Fair ☐ Poor

Expected length of need for device: ☐ Months ☐ Years ☐ Lifetime

PHYSICIAN INFORMATION

Name: _____ NPI: _____

Address: _____

Phone #: _____ Fax #: _____

Signature: _____ Date: _____

Physician Treatment Notes for Orthotics

Physician: _____ Date: _____

Patient First Name: _____ Last Name: _____

DOB: _____ Height: _____ Weight: _____ Male / Female

History of Present Condition: *(History of present condition(s) and past medical history that is relevant to functional capabilities)*

_____

_____

Date of Condition Onset: _____

Side of Condition that Necessitates the Orthotic Device: ☐ Right ☐ Left ☐ Bilateral

Type of Orthotic Device: _____

OTS / Custom Orthosis *(Circle one)*

Patient's Potential to Benefit Functionally with the Prescribed Orthotic Device: _____

_____

Does Patient Have Weakness or Deformity Requiring Stabilization for Medical Reasons: ☐ Yes ☐ No

Describe: _____

_____

Clinical Course: ☐ Patient in Hospital ☐ Patient in Inpatient Rehabilitation ☐ Patient at Home

Therapeutic Interventions: ☐ Yes ☐ No *If yes, what type:* ☐ PT ☐ OT ☐ Home Health Care

MUSCULOSKELETAL EXAMINATION

Arm Strength: ☐ Good ☐ Poor ☐ Need for Therapeutic Intervention ☐ Not Applicable

Leg Strength: ☐ Good ☐ Poor ☐ Need for Therapeutic Intervention ☐ Not Applicable

Upper Extremity ROM: ☐ Good ☐ Limited ☐ Poor ☐ Need for Therapeutic Intervention ☐ Not Applicable

Lower Extremity ROM: ☐ Good ☐ Limited ☐ Poor ☐ Need for Therapeutic Intervention ☐ Not Applicable

NEUROLOGICAL EXAMINATION

Gait: ☐ Good ☐ Limited ☐ Poor ☐ Need for Therapeutic Intervention ☐ Not Applicable

Balance and Coordination: ☐ Good ☐ Limited ☐ Poor ☐ Need for Therapeutic Intervention ☐ Not Applicable

Are there Limitations of Patients ADL's: ☐ Yes ☐ No

If yes, what limitations: ☐ Self-care ☐ Home Activities (such as cooking & cleaning) ☐ Care of Dependents

Ambulatory Assistance Used: ☐ Cane ☐ Crutches ☐ Walker ☐ Wheelchair ☐ Not Applicable

How Long Will the Patient Require Prescribed Device: *(Permanent, Longer than 6 months)* _____

_____

Physician Treatment Notes for Orthotics

Patient First Name: _____ Last Name: _____

Patients Current Activities: ☐ Severe Limitations ☐ Moderate Limitations ☐ Marginal Limitations
☐ No Limitations ☐ Other: _____

Additional: _____

This patient and I met face-to-face for _____ minutes.

Physician Signature: _____ Date: _____

Physician Name (printed): _____

NPI: _____