Fax orders to (817)473-1839 or email imsexpertsintake@att.net

Rep Name: _____

IMS Experts Physician Detail Written Order and Letter of Medical Necessity (LMN) Scoliosis Brace

PATIENT NAME:		**ICD-10/ DX:**	
DOB:		**HCPC CODE:**	**L1005**
PHYSICIAN:		**NPI:**	
PHYSICIAN PH #:		**MED LICENSE:**	

These prescribed durable medical equipment product(s) are for treatment of the referenced patient. It is both reasonable and medically necessary to effectuate a maximum and expedient recovery.

SCOLIOSIS BRACE INDICATIONS FOR PRESCRIBED PT:

A Scoliosis Brace will often be prescribed if one or more of the following conditions are met:

◯ Cobb angle has reached at least 25 degrees and the patient still has significant growth left until skeletal maturity

◯ Cobb angle is less than 25 degrees but has rapidly progressed at least 5 degrees at the 4- to 6-month follow-up appointment

◯ To avoid a major surgery by either stopping curve progression altogether or at least preventing it from reaching 40 or 50 degrees

◯ To apply corrective forces on the spine to release load on the concave (inner) part of the curve and increase load on the convex (outer) part of the curve

◯ **Option 1 – Scoliosis BRACE SURGICAL PRE-DELIVERY**:(select one or all that apply for patient)

◯ To reduce pain by restricting mobility to the trunk.
◯ To facilitate healing following an injury to the **spine or related soft tissue** (circle one)
◯ To otherwise support **weak spinal muscles OR deformed spine** (circle one)

◯ **Option 2 - LSO BRACE SURGICAL POST-DELIVERY** Pt requires brace:

◯ To facilitate healing following an injury to the **spine or related soft tissue** (circle one)

◯ **Option 3 - LSO BRACE NON SURGICAL** Pt requires brace:

◯ To reduce pain by restricting mobility to the trunk.
◯ To facilitate healing following an injury to the **spine or related soft tissue** (circle one)
◯ To otherwise support **weak spinal muscles OR deformed spine** (circle one)

Type of Brace/Manufacturer issued to patient: _____ Qty:_____
Date of Order: _____ Patient Start Date: _____
Length of Need: (check **one**) ◯ 99 months/lifetime ◯ Rental ◯ Other duration_____

X_____ Date_____
Physician Signature (NO STAMP)

This information will become part of the dictation and permanent clinical record of the above patient.