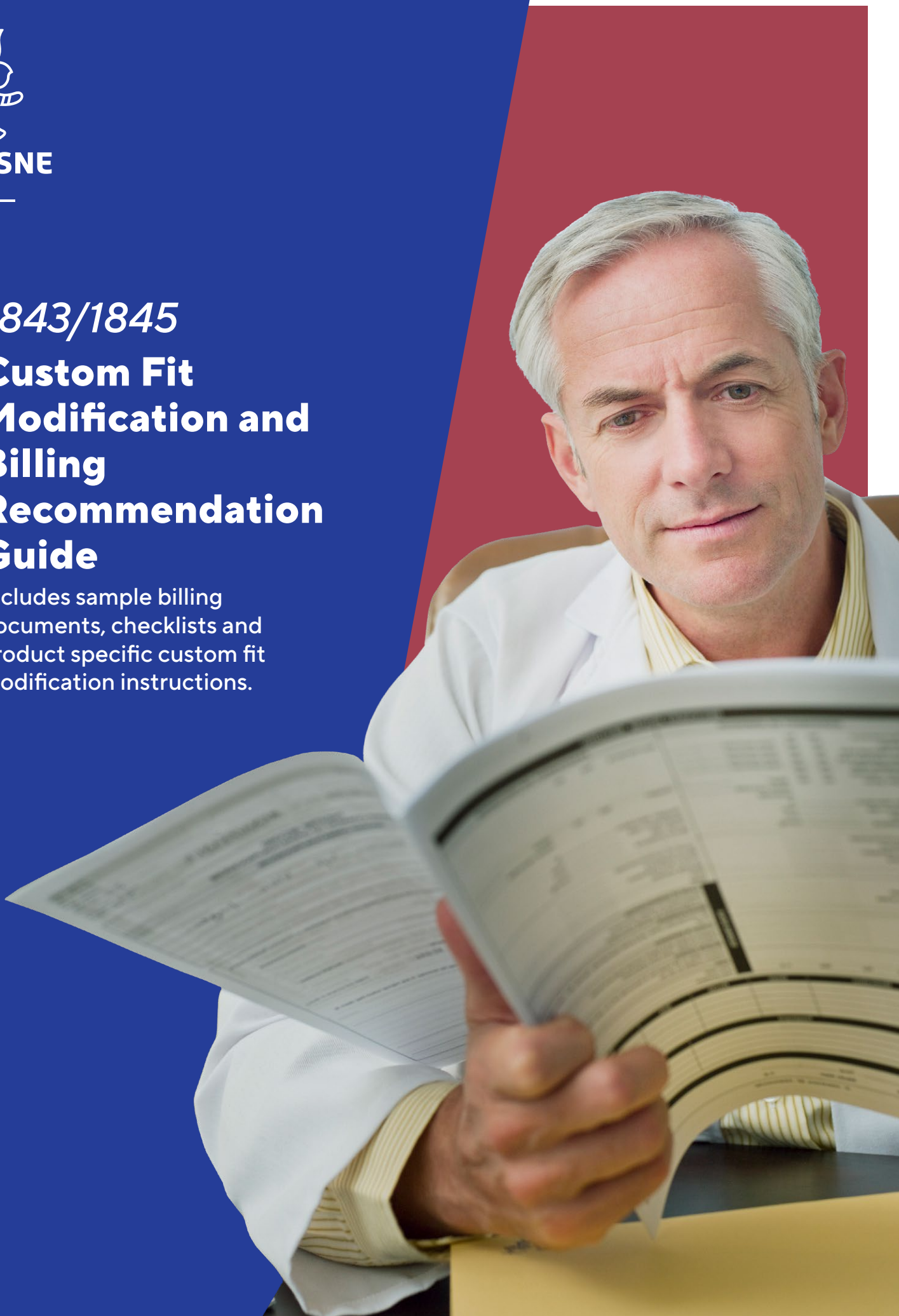
THUASNE

1843/1845

Custom Fit Modification and Billing Recommendation Guide

Includes sample billing documents, checklists and product specific custom fit modification instructions.



Modifications & Billing Guidelines

INDEX

Page

Why L1845?

A three-measurement custom fit for patients with billing support for providers

Measurements

The use of the knee M-L width, thigh circumference (6" above knee center) and calf circumference (6" below knee center) captures your patient's unique morphology, ensuring a custom fitted brace.

Modification and Documentation

Shells are hand bent to match the patient's measurements and accommodate any additional special requests (i.e. relief for prominent fibula head, adapting to disproportionate anatomy etc.) Using specifically calibrated tools, Thuasne USA ensures a proper fit and function of components. These modifications are documented for ease of billing and sent to the provider.

Built by Experts

Trained professionals with years of experience bend and square the devices. Each technician has received specialized training in the fabrication of the orthosis and all modifications made take place under the supervision of a Certified Prosthetist/Orthotist (CPO).

OA Knee Bracing
Checklist For Medicare Billing

Off the Shelf (OTS) codes are used to bill the brace when there is "minimal self-adjustment" at the time of fitting.

- ☐ Thuasne USA , OTS, Action Reliever L1851
- ☐ Thuasne USA , OTS, Dynamic Reliever L1851
- ☐ Thuasne USA , OTS, Reliever One L1851
- ☐ Thuasne USA , OTS, UniReliever L1851
- ☐ Thuasne USA , OTS, Rebel Reliever L1852

Custom-fit codes are used when there are substantial modifications made to achieve an individualized fit of the item. The substantial modifications must be documented and performed by a certified orthotist or an individual who has equivalent specialized training.

- ☐ Thuasne USA , Custom-Fit, Action Reliever L1843
- ☐ Thuasne USA , Custom-Fit, Dynamic Reliever L1843
- ☐ Thuasne USA , Custom-Fit, Reliever One L1843
- ☐ Thuasne USA , Custom-Fit, UniReliever L1843
- ☐ Thuasne USA , Custom-Fit, Rebel Reliever L1845

Coverage "May be covered when the following criteria is documented in the medical record:"

Patient is ambulatory

Knee joint laxity, documented by at least one of the following objective tests:

- Varus/valgus instability with stress testing,
- anterior/posterior drawer test,
- Pivot/shift test,
- Internal/external tibial rotation

Functional instability, as reported by patient

- "Knee gives away" during ADLs
- "Knee buckles and gives away"

Modifiers - All Knee Orthoses claims require the following modifiers:

- KX - Requirements specified in the medical policy have been met
- LT - Left side and/or
- RT - Right side

Suspension Sleeve - HCPCS L2397 - A suspension sleeve may be billed separately as a component

Reasonable Useful Lifetime - L1851/L1843- have a three year Reasonable Useful Lifetime, according to Medicare

Sample Medical Record Documentation:

PATIENT is a AGE year old MALE/FEMALE who presents with SYMPTOMS. HE/SHE is experiencing increased sensation of the knee "giving away" during normal activities. HE/SHE reports experiencing SYMPTOMS for LENGTH OF TIME. In the past, NAME OF PATIENT has tried LIST OF OTHER TREATMENTS. HE/SHE is currently taking LIST OF MEDICATIONS.

PATIENT ambulates with GAIT (antalgic/guarded/flexed knee/limited range of motion, varus or valgus thrust/unstable). Upon examination, the knee appears incongruent due to OA disease. There is obvious symptomatic instability as evidenced by:

- varus/valgus instability with stress testing,
- anterior/posterior drawer test,
- pivot/shift test,
- internal/external tibial rotation

PATIENT will benefit from the use of an off-loader brace, which maximizes stability and support for knee osteoarthritis. The brace will assist in correcting alignment, providing stability to the knee, and decreasing the chances of injury from a fall.

Clinic Name
Address
City, State, Zip
Ph: (000) 000-0000 Fx: (000) 000-0000

Sample; Clinical Application for Custom Fit Knee brace

Patient Name: _____
Product fitted: ❑L1832 ❑L1843 ❑L1845

Medical Necessity:

- ❑ Deformity of the leg or knee;
- ❑ Disproportionate Size of thigh and calf
- ❑ Minimal muscle mass upon which to suspend an orthosis
- ❑ Facilitate healing following a surgical procedure to the Knee or related ligament instabilities

Need for Custom-fitting:

❑Thigh to calf ratio/disparity ❑ Obesity ❑ Multi-ligament level injury/surgery

❑ Knee deformity ❑ Compromised cognitive/physical ability ❑Other_____

Additional notes: _____

_____

❑ **Substantial modifications required to meet above medical necessity and need for custom fitting:**

Gross Modifications:

❑Brace assembled/modified to fit patient circumference:

_____" Thigh; _____" Calf

Measurement of the knee;

_____" Knee M-L

Brace/component Modifications:

	Proximal	Distal	Anterior	Posterior	
Assembled	❑	❑	❑	❑	Purpose: _____
Trimmed	❑	❑	❑	❑	_____
Bent	❑	❑	❑	❑	_____
Molded	❑	❑	❑	❑	

Accessories/Other Modifications:

Description _____

Purpose _____

❑Assembled and angulated brace/support components to accommodate:

❑Deformity of the leg or knee ❑Thigh to Calf ratio/disparity ❑Minimal muscle mass

Patient Education:

❑Donning and doffing

❑Proper application to maximize compression and support

❑Proper location inferior/superior

Signature: _____ Date: ____ / ____ / ____

Sample Letter of Medical Necessity
L1843/ 1845 Custom Fit OA Knee Bracing

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Custom Fit L1843/ 1845
OA Knee Bracing :
Sample Letter of Medical Necessity

Date:
Patient:
Date of Birth:
Prescribing Physician:
Medical Diagnoses & ICD-10 Codes:

NAME OF PATIENT is a AGE year old MALE/ FEMALE who presents with SYMPTOMS. HE/SHE is experiencing increased pain in the knee due to osteoarthritis, the patient is ambulatory. HE/SHE states that they are experiencing SYMPTOMS for DURATION OF TIME. In the past, NAME OF PATIENT has tried LIST OF OTHER TREATMENTS. HE/SHE is currently taking LIST OF MEDICATIONS.

Examination:
NAME OF PATIENT is APPEARING patient. Patient ambulates with GAIT (antalgic/ guarded/ flexed knee/ limited range of motion, varus or valgus thrust/ unstable). Upon examination, HE/SHE has SWELLING (erythema, swelling, bruising, and discoloration), PALPATION/ LOCATION of PAIN, AROM/PROM*, +/- CREPITUS, Laxity/ Tissue instability Grade 1-3 Ant/Post Drawer, Grade 1-3 Lachmans, Grade 1-3 a varus/ valgus stress test, Varus/ Valgus malalignment, Patellofemoral ROM/+/-Apprehension Test, +/- McMurray's Test.

Diagnostics:
Xray/MRI findings include:
Joint space narrowing in the MEDIAL/ LATERAL Compartment
Joint space narrowing
Subchondral sclerosis
Subchondral cysts
Periarticular osteophytes
Joint subluxation

Diagnosis:
715.16 Osteoarthrosis localized primary involving lower leg

NAME OF PATIENT will benefit from the use of an off-loading brace, which maximizes stability and support for knee osteoarthritis.
At this time, a custom-fit off-loading brace is required for the knee due to Deformity of the leg or knee; OR Size of thigh and calf; OR Minimal muscle mass upon which to suspend an orthosis. The custom-fit device is required versus a prefabricated device due to REASON FOR CUSTOM-FIT. NAME OF PATIENT will require the use of the orthosis for an extended time. The custom-fit orthoses is required in an attempt to alleviate the need for surgery.

EXPECTED IMPROVEMENT INCLUDES:
Significant improvement in pain, stiffness, and physical function; preventing or reducing degenerative changes in the knee; allowing the patient to return to reasonable activities which may help them maintain a healthy weight; preserving the long-term viability of the knee; and increased resistance to injury from valgus, varus, rotational or anterior-posterior translation forces.
This brace has been clinically proven to improve patient's function and decrease pain medication usage and anti-inflammatory (NSAIDs) usage that can have negative GI side effects.
I am prescribing a clinically appropriate orthotic appliance that adheres to accepted medical standards and practices in the treatment of this condition, and is part of the medically necessary treatment for the NAME OF PATIENT well-being. If further assistance or questions are needed, please do not hesitate to contact me.

Regards,
Physician Name
Date

Custom Fit OA Knee Bracing:
OA Example Chart Notes

Custom Fit L1843/1845
OA Knee Bracing:
Example Chart Notes

Jane Smith is a 57 year old female who presents with left knee pain and swelling. She has been diagnosed with OA of the left knee and her physician, Dr. Jeffrey Greenbaum, has prescribed a Thuasne USA Action Reliever custom-fit knee brace.
The custom-fit brace has required several modifications to appropriately fit and treat Mrs. Smith. The thigh and calf shells has been heat molded to contour and distribute pressure to adjust for Mrs. Smith valgus knee. The flexion and extension control has been set to limit range of motion. The off-loading force system has been sized and custom-fit to Mrs. Smith left leg for optimal dosing and relief.
Mrs. Smith has been instructed on the proper use and maintenance of the brace. She is extremely satisfied with the comfort and fit.

Signature————
John Doe, CFO

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Custom Fit OA Knee Bracing:
Appeal Checklist

Tips & Suggestions to Patients: What to do if insurance denies your Custom-Fit OA Knee Brace. You the patient can be the best advocate for your own health needs. Work with your clinician to appeal the denial by following these suggested steps that insure a successful claim.

1) Determine the reason for denial

- Call the Customer Service Department. Have record number or ID ready
- Request written explanation of the reason for denial
- Request copies of the clinical policies/ documents used to determine denial
- Request name of person who reviewed file
- Request information on the Appeal process and time frames

2) Prepare the Appeal

- Write an appeal letter
- Obtain letter of medical necessity from your clinician
- Obtain supporting notes/ letters from your physician and other healthcare providers involved in your care
- Notify your employer's HR dept (or HR dept of source of your insurance) that the insurance company has denied your knee brace claim and inform them how this impacts you and your ability to perform physical tasks.

3) File the Appeal

- Meet all deadlines established by the insurance company
- Request your appeal be reviewed by a bracing expert
- Keep detailed copies of everything you send to the insurance

4) Second Appeal, if necessary

If your insurance company continues to deny the claim after your first appeal, you will be notified of the next step in the appeal process. After you gather facts, set a strategy. You may want to start by seeking help from one of the many non-profit and for-profit entities that offer assistance. Many states have health insurance consumer advocates, the advocacy group Families USA offers a list of state resources.

Key resources:

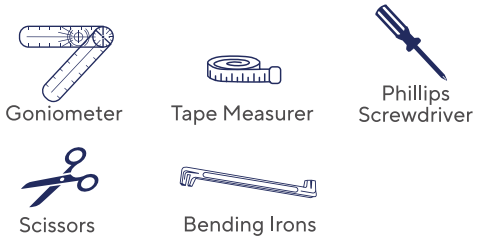
Patient Advocate Foundation: Non-profit organization that health-insurance appeals for free.

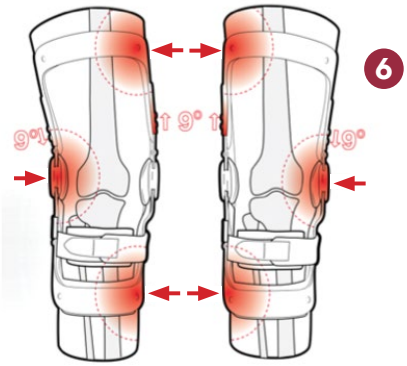
The office of Medicare Ombudsman (OMO) Helps with complaints, grievances, and information requests.

1-800-MEDICARE (800-633-4227)

Rebel Reliever –L1845
Custom Fit Modification Guide

TOOLS NEEDED





1. Contoured Tibia Shell promotes rotation control & anterior/posterior control
2. Widen/ narrow the fit at the knee joint with multiple thickness condyle pads for personalized comfort and intimate fit.
3. Positioning and orientation of the exclusive Synergistic Suspension Strap (posterior proximal calf strap) enhances suspension.
4. Adjustment of range of motion with extension/ flexion control stops.
5. Adjust the Medial/Lateral LoadShifter(s) to increase or decrease the amount of varus or valgus force applied
6. Adjust the Medial/ Lateral Loadshifter(s) so uprights can be set to specific height range or angulation to distribute pressure accordingly.
7. Thuasne USA's 3-measurement Assembly-Guarantees Custom Fit.

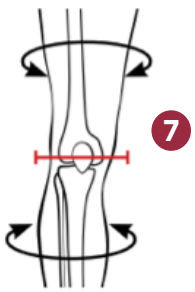
Custom Fit Measurement Data

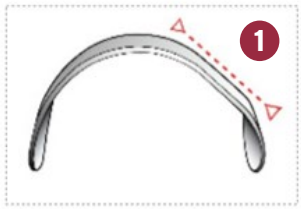
These measurements are required to fabricate a custom fit knee brace and to ensure accuracy at the time of fitting.

_____ Circumference 6 inches above mid-patella

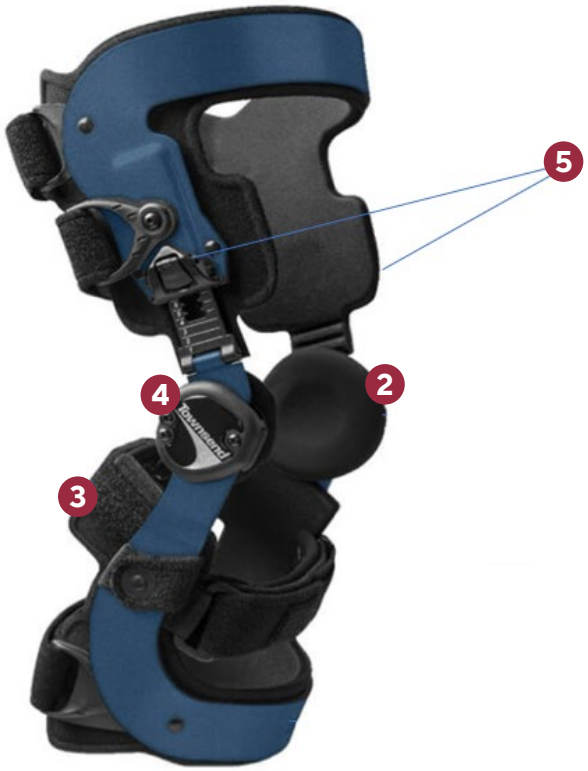
_____ Medial-Lateral Knee Width (not circumference) at knee center

_____ Circumference 6 inches below mid-patella





Contoured Tibia Shell



Rebel Series –L1845

(Rebel Pro, Rebel, Rebel Lite)

Custom Fit Modification Guide

TOOLS NEEDED


Goniometer


Tape Measurer


Phillips Screwdriver


Scissors


Bending Irons

1. Contoured Tibia Shell-Promotes Rotation Control &Anterior/ Posterior Control
2. Widen/ Narrow the fit at the knee joint with multiple thickness condyle pads for personalized comfort and intimate fit.
3. Positioning and orientation of the exclusive Synergistic Suspension Strap (posterior proximal calf strap) enhances suspension
4. Adjustment of range of motion with extension/ flexion control stops
5. 3-measurement Assembly-Guarantees Custom Fit

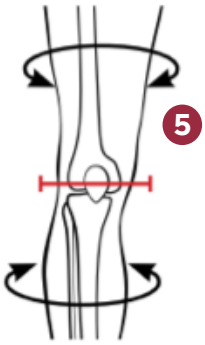
Custom Fit Measurement Data

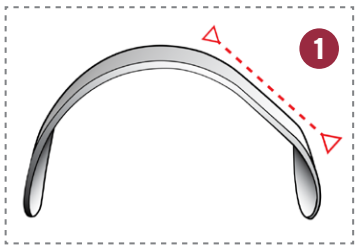
These measurements are required to fabricate a custom fit knee brace and to ensure accuracy at the time of fitting.

_____ Circumference 6 inches above mid-patella

_____ Medial-Lateral Knee Width (not circumference) at knee center

_____ Circumference 6 inches below mid-patella

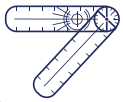




Contoured Tibia Shell

RelieverOne –L1843
UniReliever –L1843
Custom Fit Modification Guide

TOOLS NEEDED


Goniometer


Tape Measurer


Phillips Screwdriver


Scissors


Bending Irons

1. Contoured Tibia Shell-Promotes Rotation Control & Precise Intimate Fit
2. Positioning and orientation of the exclusive Synergistic Suspension Strap (posterior proximal calf strap) enhances suspension
3. Adjustment of range of motion at hinge with extension/ flexion control stops
4. Adjustable paddle for comfortable distribution of corrective force
5. 3-measurement Assembly-Guarantees Custom Fit

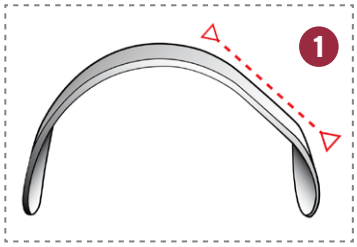
Custom-Fit Measurement Data

These measurements are required to fabricate a custom fit knee brace and to ensure accuracy at the time of fitting.

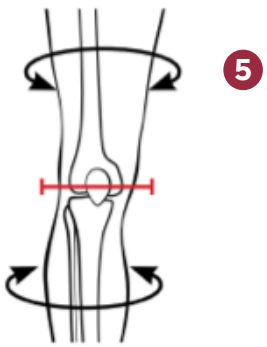
_____ Circumference 6 inches above mid-patella

_____ Medial-Lateral Knee Width (not circumference) at knee center

_____ Circumference 6 inches below mid-patella



Contoured Tibia Shell



RelieverOne

UniReliever

THUASNE

TOOLS NEEDED


Goniometer


Tape Measurer


Phillips Screwdriver


Scissors


Bending Irons


Heat Gun

Action Reliever –L1843
Custom Fit Modification Guide

1. Heat mold or trim thigh shell component to distribute pressure accordingly to varus/ valgus load applied
2. Heat mold or trim calf shell component to distribute pressure accordingly to varus/ valgus load applied
3. Cross strap system adjusted for optimal efficacy and off-loading dosing on patient
4. Positioning and orientation of the distal posterior strap enhances suspension

Dynamic Reliever –L1843
Custom Fit Modification Guide

1. Self-Contouring Nylon shells offered individually for assembly in clinic
2. Tool-less adjustable tibia shell bolster prevents brace rotation as correction is applied.
3. Positioning and orientation of the exclusive Synergistic Suspension Strap (posterior proximal calf strap) enhances suspension
4. Adjustment of range of motion at hinge with extension/ flexion control stops
5. Corrective dosing dial allows for comfortable distribution of corrective force
6. 3-measurement Assembly-Guarantees Custom Fit

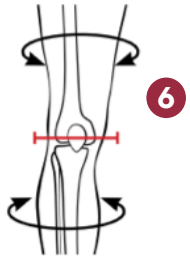
Custom Fit Measurement Data

These measurements are required to fabricate a custom-fit knee brace and to ensure accuracy at the time of fitting.

_____ Circumference 6 inches above mid-patella

_____ Medial-Lateral Knee Width (not circumference) at knee center

_____ Circumference 6 inches below mid-patella



MEDICARE REIMBURSEMENT AT A GLANCE

This document is intended to provide a brief overview of the process required to bill OA and functional knee orthoses. This guide is not a guarantee of payment. Please refer to the following link for all necessary information on how to bill for these knee orthoses. Local Coverage Determination/Article (LCD): Knee Orthosis

Coverage Requirements

- An OA or Functional knee orthosis is covered when it is ordered for one of the following indications:
  - Recent injury to or a surgical procedure on the knee(s)
  - The patient is ambulatory and has documented knee instability

Diagnosis Requirement

- A knee orthosis requires a diagnosis/condition specified in the Group 4 ICD-10 coding. For approved coding please refer to the above Knee Orthosis link.

Custom Fitted VS Off-The-Shelf Coding

- Off-the-Shelf requires minimal self-adjustment and can be done by beneficiary, caretaker, or supplier. Coding is L1851/L1852.
- Custom Fitted requires more than minimal self-adjustment, by a qualified practitioner, at the time of delivery, to provide an individualized fit. The orthosis must be trimmed, bent, molded (with or without heat). Coding is L1843/L1845.

Documentation Requirements

- When applicable, knee instability must be documented by examination of the beneficiary and an objective description of joint laxity must be documented in the medical record.
- The knee orthosis being dispensed must be documented within the notes
- If a custom-fit L-Code (L1843 or L1845) is selected, a detailed description of the modifications must be in the notes and available upon request.

Billing Requirements

- Appropriate modifiers are required for billing knee orthosis (extremity modifiers alone are not sufficient)
  - LT or RT
  - KX requirements specified in the medical policy have been met
  - GA ABN on file/waiver of liability issued
  - GZ ABN not on file/item expected to be denied as not medically necessary
  - EY No physician or other licensed healthcare provider order for this item or service

LINK TO LCD

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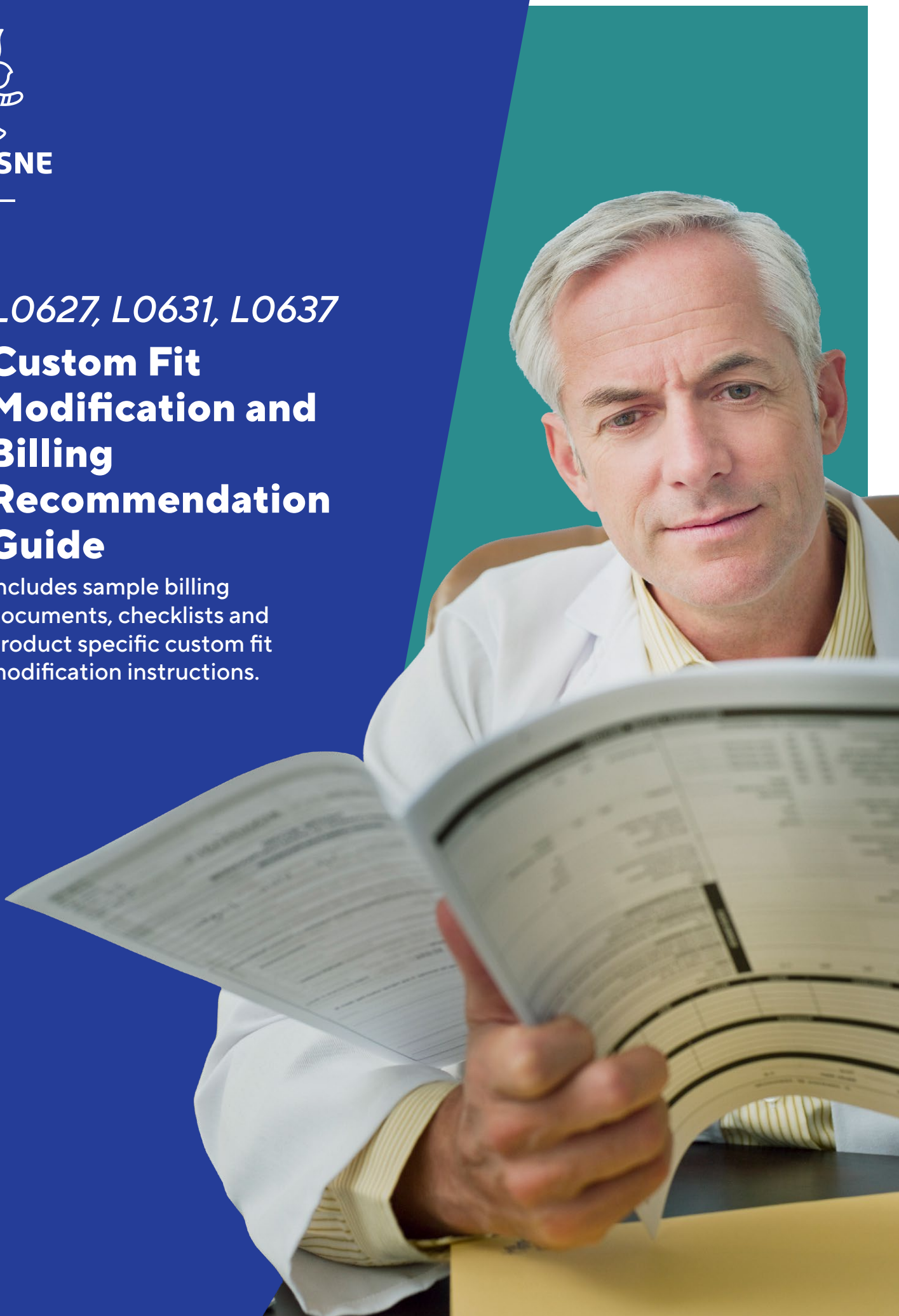
L0627, L0631, L0637

Custom Fit Modification and Billing Recommendation Guide

Includes sample billing documents, checklists and product specific custom fit modification instructions.



THUASNE

Spinal Orthosis
Medicare Billing Guidelines

Overview

This document is intended to provide a brief overview of the process required to bill a Spinal Orthosis. This guide is not a guarantee of payment. Please refer to the link for all necessary information on how to bill for a Spinal Orthosis. Local Coverage Determination (LCD): Spinal Orthosis

Coverage/Diagnosis Requirements

- A Spinal Orthosis must be medically necessary when dispensed and necessary for the diagnosis or treatment of illness or injury or to improve the function of a malformed body member. A spinal orthosis is covered when it is ordered for one of the following indications:
  - Reduce pain by restricting mobility of the trunk; or
  - Facilitate healing following an injury to the spine or related soft tissue; or
  - Facilitate healing following a surgical procedure on the spine; or
  - Support weak spinal muscles and/or a deformed spine

Documentation Requirements

- To justify payment for DMEPOS items, suppliers must meet the following:
  - SWO (Standard Written Order)
  - Medical Record Information
  - Correct Coding
  - Proof of Delivery

Custom Fitted VS Off-The-Shelf Coding

- Off-the-Shelf requires minimal self-adjustment and can be done by beneficiary, caretaker, or supplier. Coding is L0642, L0648, L0650
- Custom Fitted requires more than minimal self-adjustment, by a qualified practitioner or individual with expertise, at the time of delivery, to provide an individualized fit. The orthosis must be trimmed, bent, molded (with or without heat). Coding is L0627, L0631, L0637

Billing Requirements

When providing these items suppliers must:

- Provide the product that is specified by the treating practitioner
- Be sure that the treating practitioner's medical record justifies the need for the type of product (i.e., Prefabricated versus Custom Fabricated)
- Only bill for the HCPCS code that accurately reflects both the type of orthosis and the appropriate level of fitting
- Have detailed documentation in supplier's records that justifies the code selected

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Sample Letter of Medical Necessity
Custom Fit Spinal Orthosis

Clinic Name
Address
City, State, Zip
Ph: (000) 000-0000 Fx: (000) 000-0000

RX, Pre-Auth & Medical Necessity Certification for LSO Braces - L0627/L0642, L0631/L0648, L0637/L0650 & TLSO - L0456/L0457

Patient Name: _____ DOB: _____ ID #: _____ Date: ____ / ____/ ____

Expected Benefits of/need for LSO/TLSO (check all appropriate)

- ❑ Reduce pain by restricting mobility of the trunk
- ❑ Facilitate healing following a surgical procedure to the spine or related soft tissues
- ❑ Facilitate healing following injury to the spine or related soft tissues
- ❑ Support weak spinal muscles and/or deformed spine

Diagnosis:

( ) 724.2	Low Back Pain	( ) 722.10	Disc Displacement w/o myelo
( ) 728.85	Muscle Spasm	( ) 722.73	Disc Displacement w/ myelo
( ) 728.4	Ligamentous Instability	( ) 722.52	Lumbar Disc Degeneration
( ) 781.92	Abnormal Posture	( ) 847.2	Lumbar Sprain/Strain
( ) 724.4	Lumbar/Thoracic neuritis/radiculitis	( ) 737.10	Kyphosis
( ) 738.4	Spondylolisthesis	( ) 724.1	Pain in Thoracic Spine
( ) 724.3	Sciatica	( ) 724.01	Spinal Stenosis of Thoracic region
( ) 724.9	Nerve Root Compression		
( ) Other:	_____		

Rx:

- ❑ Prefabricated custom-fitted device requiring substantial modifications by an individual with expertise and specialized training
- ❑ Prefabricated OTS device delivered with minimal self-adjustment

_____ L0627, LO sagitt rigid panel prefab	_____ L0642, LSO sag ri ant/pos pnl pre ots
_____ L0631, LSO sag-coro rigid frame pre	_____ L0648, LSO sag ri ant/pos pnl pre ots
_____ L0637, LSO sag-coronal panel prefab	_____ L0650, LSO sc ri ant/pos pnl pre ots
_____ L0456, TLSO flex prefab	_____ L0457, TLSO flex trnk sj-ss pre ots

Need for Custom-fitting:

❑ waist to hip ratio/disparity ❑ pendulous abdomen ❑ obesity ❑ short stature/torso ❑ hyper/hypo-lordosis ❑ multi-vertebral level injury/surgery ❑ accommodate post-surgical dressings ❑ scoliosis ❑ spinal deformity ❑ compromised cognitive/physical ability ❑ hyper-kyphosis ❑ Other _____

Additional notes: _____

_____

Duration of need: ❑ 12 Months ❑ Life ❑ PRN

Frequency of use: ❑ ___/times per day ❑ ___/hours ❑ ___/minutes ❑ ___/weeks ❑ ___/months

Prognosis: ❑ Fair ❑ Good ❑ Excellent

Utilizing accepted medical practice standards; the above-prescribed durable medical equipment is essential in the continuous treatment of the patient.

Physician's Signature: _____ Printed: _____

Tax ID#: _____ Date: ____ / ____/ ____

Clinic Name
Address
City, State, Zip
Ph: (000) 000-0000 Fx: (000) 000-0000

Clinical Application Record for Custom-Fit LSO and TLSO

Patient Name: _____

Product fitted: ❑L0627 ❑L0631 ❑L0637 ❑L0456

Medical Necessity:

❑Reduce pain by restricting mobility of the trunk
❑Facilitate healing following injury to the spine or related soft tissues
❑Facilitate healing following a surgical procedure to the spine or related soft tissues
❑Support weak spinal muscles and/or deformed spine

Need for Custom-fitting:

❑waist to hip ratio/disparity ❑pendulous abdomen ❑obesity ❑short stature/torso ❑hyper/hypo-lordosis
❑multi-vertebral level injury/surgery ❑accommodate post-surgical dressings ❑scoliosis ❑spinal deformity
❑compromised cognitive/physical ability ❑hyper-kyphosis ❑Other_____
Additional notes: _____
_____

❑ **Substantial modifications required to meet above medical necessity and need for custom fitting:**

Gross Modifications:

❑Brace assembled/modified to fit patient circumference:
_____" waist; _____" hip; _____" lower rib

Panel/component Modifications:

	Anterior	Lateral	Posterior	Thoracic	
Assembled	❑	❑	❑	❑	Purpose: _____
Trimmed	❑	❑	❑	❑	_____
Bent	❑	❑	❑	❑	_____
Molded	❑	❑	❑	❑	

Accessories/Other Modifications:

Description _____
Purpose _____
❑Assembled and angulated panel/belt components to accommodate:
❑Neutral waist ❑Waist to hip ratio/disparity ❑Pendulous abdomen ❑Scoliosis ❑Spinal deformity

Patient Education:

❑Donning and doffing
❑Proper application to maximize compression and support
❑Proper location inferior/superior

Signature: _____ Printed: _____

Date: ____ / ____ / ____

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Appeal Checklist
Custom Fit Spinal Orthosis

Tips & Suggestions to Patients: What to do if insurance denies your Custom-Fit Spinal orthosis. You the patient can be the best advocate for your own health needs. Work with your clinician to appeal the denial by following these suggested steps that insure a successful claim.

1) Determine the reason for denial

- Call the Customer Service Department. Have record number or ID ready
- Request written explanation of the reason for denial
- Request copies of the clinical policies/ documents used to determine denial
- Request name of person who reviewed file
- Request information on the Appeal process and time frames

2) Prepare the Appeal

- Write an appeal letter
- Obtain letter of medical necessity from your clinician
- Obtain supporting notes/ letters from your physician and other healthcare providers involved in your care
- Notify your employer's HR dept (or HR dept of source of your insurance) that the insurance company has denied your knee brace claim and inform them how this impacts you and your ability to perform physical tasks.

3) File the Appeal

- Meet all deadlines established by the insurance company
- Request your appeal be reviewed by a bracing expert
- Keep detailed copies of everything you send to the insurance

4) Second Appeal, if necessary

If your insurance company continues to deny the claim after your first appeal, you will be notified of the next step in the appeal process. After you gather facts, set a strategy. You may want to start by seeking help from one of the many non-profit and for-profit entities that offer assistance. Many states have health insurance consumer advocates, the advocacy group Families USA offers a list of state resources.

Key resources:

Patient Advocate Foundation: Non-profit organization that health-insurance appeals for free.

The office of Medicare Ombudsman (OMO) Helps with complaints, grievances, and information requests.

1-800-MEDICARE (800-633-4227)

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(Circle one)

Customizable LSO

DOCUMENTATION WORKSHEET

(RETAIN IN PATIENT RECORD)

Doctor: _____ Patient Name: _____

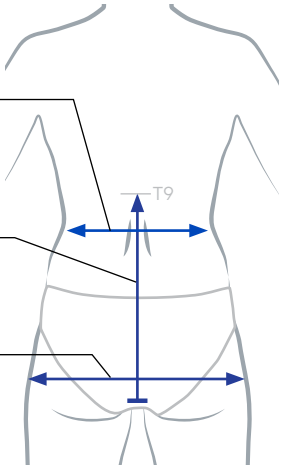
Fitter: _____ Patient #: _____

Date: _____ Follow-up Dates: _____

FOR USE WITH PRODUCTS MANUFACTURED BY THUASNE ONLY. THIS PRODUCT IS INTENDED FOR APPLICATION BY HEALTH CARE PRACTITIONERS AS DIRECTED BY A PHYSICIAN OR OTHER MEDICAL AUTHORITY. THIS IS A PREFABRICATED ORTHOSIS. IT IS INTENDED TO BE CUSTOMIZED TO AN INDIVIDUAL PATIENT. FOLLOW THE DIRECTIONS BELOW TO CUSTOMIZE.

REQUIRED TOOLS (Scissors, Heat Gun, Measuring Tape)

STEP 1 - MEASUREMENTS



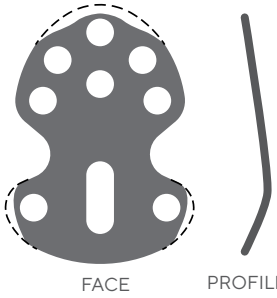
1. Waist Circumference = ☐
2. T9 to Sacrococcygeal Junction (L5-L1 for **627**) = ☐
3. Hip Circumference = ☐

TIME SPENT: _____

STEP 3- CUSTOMIZE BACK PANEL TO ANATOMY

A. Measure patient's lordosis then customize back panel to anatomy.

B. To customize back panel Remove the panel, heat, trim, and reassemble.



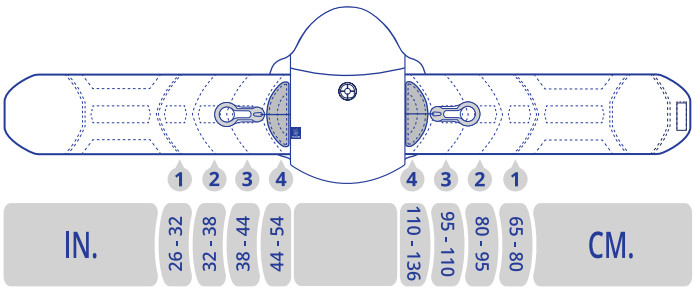
Patient's Lordosis Degree = ☐

Heat form to individual patient's anatomy and contour to create intimate fit for individual lordosis and soft tissue. Trim for individual patient's anatomy based on 3

TIME SPENT: _____

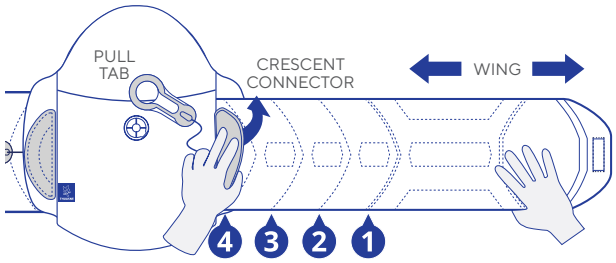
STEP 2- SIZING MODIFICATIONS

BRACE SIZING IS CRUCIAL FOR PROPER PERFORMANCE. Use the sizing guide below to custom fit patients anatomy.



A. Determine sizing (average of 1 and 2) = _____

TIME SPENT: _____



B. Adjust length

- Detach Pull Tab from wing.
- Lift Crescent Connector slide wing to numbered sizing arc.
- Press Down Crescent Connector to secure.
- Replace Pull Tab into ready position (see 7.1).
- Repeat on opposite wing.

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DOCUMENTATION WORKSHEET

(RETAIN IN PATIENT RECORD)

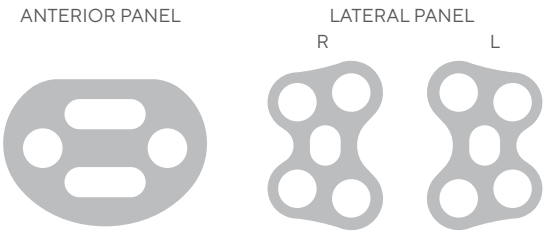
Doctor: _____ Patient Name: _____

Fitter: _____ Patient #: _____

Date: _____ Follow-up Dates: _____

STEP 4- MODIFYING RIGID PANELS

PERFORM MODIFICATIONS TO ANTERIOR AND LATERAL PANELS AS NECESSARY



Indicate trim lines and heat modifications

☐ **A.** Remove fabric cover to trim for smaller anatomies .

☐ **B.** Remove fabric cover to heat modify as necessary

TIME SPENT: _____

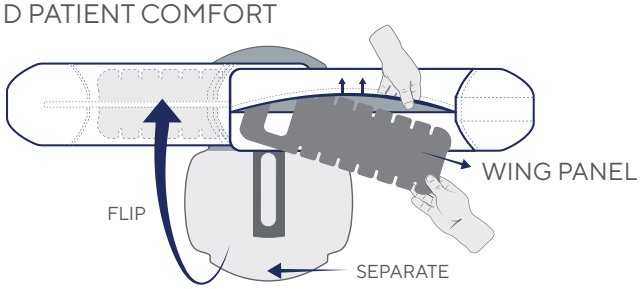
STEP 5 - MODIFYING WING INSERTS

MODIFYING FELT WING INSERTS IMPROVES ANATOMIC FIT AND PATIENT COMFORT

See product instruction manual for assistance accessing interior components.

A. Separate cover at base, flip-up wing assembly

B. Remove felt panel and modify as necessary



TIME SPENT: _____

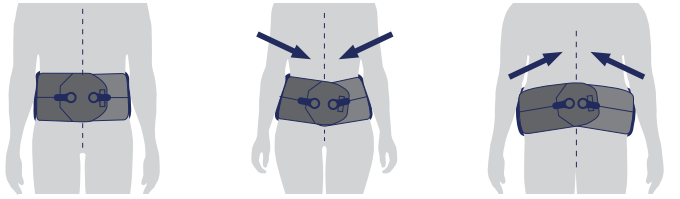
STEP 6 - BELT FIT

CUSTOMIZE ANTERIOR CLOSURE ANGULATION IN RELATION TO HIP DEVELOPMENT OR PENDULOUS ABDOMEN

Evaluate each patient for unique individual anatomy. Determine angulation for proper fit.

A. Release crescent connectors to enable wing angulation

B. Ensure anterior wings overlap at midline



☐ Neutral Alignment ☐ Inferior Angulation ☐ Superior Angulation

TIME SPENT: _____

STEP 7 - PATIENT EDUCATION

PROPER EDUCATION IS NEEDED FOR INDIVIDUAL TO MAINTAIN PROPER FIT THROUGHOUT TOTAL TIME OF USE.

Items to education patient on:

- ☐ Independent compression mechanics
- ☐ Don & Doffing
- ☐ Proper angulation to ensure circumference contact
- ☐ Proper brace positioning
- ☐ Proper care
- ☐ Follow up appointments

TIME SPENT: _____

CLINICAL JUSTIFICATION FOR CUSTOMIZING BRACE

TOTAL TIME TO CUSTOMIZE BRACE: _____