

Letter of Medical Necessity / Assignment of Benefits

Items Provided to Patient by MedVantage: Intermittent Pneumatic Compression Device and All Accessories

Please Apply
Patient ID Sticker
Here

Please Apply
SCD or DME Product Sticker or
Take-Home System Bar Code Sticker Here.

AT-HOME DVT Prevention System

1.) Proof Of Delivery, Assignment of Benefits (AOB) and Authorization to Release Information:

I understand that signing this form acknowledges the items indicated above were delivered to me. I understand that signing this form authorizes MedVantage and/or billing affiliates (BA) to submit claims directly on my behalf to my insurance carrier(s) or other health or medical plans. I also understand that signing this form assigns to MedVantage (BA) my right to payment of any and all healthcare or medical benefits for the items described above. This means MedVantage (BA) will receive direct payment for these items. I understand that signing this form authorizes MedVantage (BA) to acquire from the surgery center, and to release to my insurance carrier(s) and any other of my health or medical plans, any information necessary to process this or a related medical claim. I agree MedVantage (BA) may contact me for any additional information necessary to process this claim. I understand that after my surgery I will receive an Explanation of Benefits (EOB) document from my health insurance company which explains how the insurance company processed a claim for products / services by MedVantage (BA). Further, I understand that the EOB is not a bill or invoice, and I have read and understand the information on the back of this form. I agree should I have questions regarding the applicable EOB that I am to call MedVantage (BA) and not the surgery center or physician for information. If I receive a check from my insurance carrier for this service, I agree to endorse and forward on to MedVantage or its designated affiliate at 2134 S Richards St, Salt Lake City, UT 84115.

X

Signature of Patient / Responsible Patient Representative _____

Date _____

<p>1 Point Risk Factors</p> <ul style="list-style-type: none"> <input type="checkbox"/> Age 41-60 years <input type="checkbox"/> Minor Surgery planned <input type="checkbox"/> History of prior Major Surgery <input type="checkbox"/> Varicose Veins <input type="checkbox"/> History of inflammatory bowel disease <input type="checkbox"/> Swollen legs (current) <input type="checkbox"/> Obesity (BMI > 25) <input type="checkbox"/> Acute Myocardial Infarction (<1 month) <input type="checkbox"/> Congestive Heart Failure (< 1 month) <input type="checkbox"/> Sepsis (<1 month) <input type="checkbox"/> Serious lung disease, including Pneumonia (< 1 month) <input type="checkbox"/> Abnormal Pulmonary Function (COPD) <input type="checkbox"/> Medical patient currently at bed rest <input type="checkbox"/> Leg Plaster Cast or Brace <input type="checkbox"/> Use of Tourniquet <input type="checkbox"/> General Anesthesia (>30 minutes) <input type="checkbox"/> Oral Contraceptive or Hormone Replacement Therapy <input type="checkbox"/> Pregnancy or Postpartum (< 1 month) <input type="checkbox"/> History of unexplained stillborn infant, recurrent spontaneous abortion (=3), premature birth with toxemia or growth-restricted infant 	<p>2 Point Risk Factors</p> <ul style="list-style-type: none"> <input type="checkbox"/> Age 61-74 years <input type="checkbox"/> Major Surgery (> 45 minutes) <input type="checkbox"/> Arthroscopic Surgery <input type="checkbox"/> Laparoscopic Surgery (> 45 minutes) <input type="checkbox"/> Previous Malignancy <input type="checkbox"/> Central Venous Access <input type="checkbox"/> Morbid Obesity (BMI > 40) <p>3 Point Risk Factors</p> <ul style="list-style-type: none"> <input type="checkbox"/> Age 75 years and over <input type="checkbox"/> Major Surgery lasting 2-3 hours <input type="checkbox"/> BMI > 50 (Venous Stasis Syndrome) <input type="checkbox"/> History of SVT, DVT/PE <input type="checkbox"/> Family History of DVT/PE <input type="checkbox"/> Present Cancer or Chemotherapy <input type="checkbox"/> Positive Factor V Leiden <input type="checkbox"/> Positive Prothrombin 20210A <input type="checkbox"/> Elevated Serum Homocysteine <input type="checkbox"/> Positive Lupus Anticoagulant <input type="checkbox"/> Elevated Anticardiolipin Antibodies <input type="checkbox"/> Heparin-induced Thrombocytopenia (HIT) <input type="checkbox"/> Other Thrombophilia 	<p>5 Point Risk Factors</p> <ul style="list-style-type: none"> <input type="checkbox"/> Elective Major Lower Extremity Arthroplasty <input type="checkbox"/> Hip, Pelvis or Fracture (< 1 month) <input type="checkbox"/> Stroke (< 1 month) <input type="checkbox"/> Multiple Trauma <input type="checkbox"/> Acute Spinal Cord Injury (Paralysis) (< 1 month) <input type="checkbox"/> Major Surgery lasting over 3 hours <p>Surgical Risk Factors</p> <ul style="list-style-type: none"> <input type="checkbox"/> Revision Surgery <input type="checkbox"/> Extensive Surgical Dissection <input type="checkbox"/> Previous Major Bleeding <input type="checkbox"/> Difficult-to-Control Bleeding During Current Operative Procedure <p>TOTAL RISK FACTOR SCORE: <input style="width: 50px;" type="text"/></p> <p><input type="checkbox"/> High Risk: 3+ Points</p> <p><input type="checkbox"/> Moderate Risk: 2 Points</p> <p>Length of Need: _____ (Unit)</p>
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Due to this patient's risk for developing deep vein thrombosis, I am prescribing mechanical DVT prophylaxis because of the following:

- My patient has been prescribed antibiotics, NSAIDs or other medication documented by pharmaceutical manufacturers to have contraindications with anticoagulants, causing major interactions including but not limited to allergic skin reactions and excess bleeding
- My patient has been prescribed mechanical prophylaxis AND anticoagulants because of their level of risk.

American Journal of Medicine, Feb. 2012, Allergy, 2006 Dec; 61 (12) 1432-40, Cochrane Database of Systematic Reviews 2008, Issue 4, Epocrates.com

Please Write ICD-10 Codes Here: X _____ X _____ X _____ X _____

2.) Letter of Medical Necessity / Physician Order

Deep Vein Thrombosis (DVT) is a significant risk factor for patients undergoing surgery and immobilized patients. Prevention of DVT is more effective than treatment and an important aspect of patient care before, during and after surgery. I have assessed this patient's risk of developing DVT due to age, type of surgery, patient and family medical history, and other documented factors that may increase the risk of DVT. My assessment indicates the use of mechanical thromboprophylaxis by pneumatic compression device and segmental gradient pressure pneumatic appliances. It is my opinion this is medically necessary and reasonable in accordance with accepted standards of practice and appropriate treatment of this patient.

X

Physician Signature (OR ATTACH COPY OF SIGNED PHYSICIAN ORDER). Please do not stamp _____

Printed Name / NPI# _____

Date _____