Southern Mobility and Medical
DME/POS ACHC Accredited For DME/Orthotics Equipment
Pharmacy Permit # 01024 ACHC # 1866 NPI # 1922035567
Authorized Medicare, BCBS Provider
Phone: 1-800-681-8831 Fax: 1-877-611-3500

General Insurance Guidelines for a Knee Orthotic

(for Medicare)

Dear Physician,

If your patient suffers from chronic knee pain that interferes with their daily ADL's and would benefit from an orthotic in lieu of additional pain medications or surgery, please complete the following at the patient's next face to face exam.

- Fully complete the CMN form document **and**
- Mark in the upcoming exam notes:
  a. please address that the patient has chronic knee conditions and pain
  b. note the medical conditions related to the knee issues
  c. list other treatments that have been attempted (medication, surgery, PT, etc) and why they were each were not successful
  d. note that a knee brace is part of your plan of care.

FAX to: 1-877-611-3500 or call 1-800-681-8831 with any questions.

PHYSICIAN NAME:_____
Address:_____
City, State, ZIP Code:_____
Phone:_____

Patient Name:_____ DOB:_____

Physicians Order / CMN: Knee Orthosis

_X_L1833**:** Knee Orthosis, adjustable knee joints, positional orthosis, rigid support, prefabricated off the shelf

_X_L2397**:** Addition to lower extremity orthosis, suspension sleeve. Adds comfort and reduces possibility of skin irritation

Indications for Use • Mild sprains of the medial or lateral collateral ligaments. • Mild injuries of the menisci. • Patellar retinaculum injuries. • Mild instabilities. • Post-op knee rehabilitation.

For: Left Knee____, Right Knee____, Both Knees___

Mark all ICD-10 codes that are documented in progress notes and justify need:

___M1710 Unilateral Primary OA, Unspecified Knee
___M233205 Unspecified Medial Meniscus
___M2240 Chondromalacia Patellae
___M2350 Chronic Instability of Knee
___S82009A Unspecified Fracture of Patella
___S82009A Unspecified Fracture of Patella
___S83219A Bucket Tear of Medial Meniscus
___M069 RA, Unspecified

Justification(s): Check all that apply.

____To reduce pain by restricting mobility of the knee; **or**

____To facilitate healing following an injury to the knee or related soft tissues; ***or***

____ To facilitate healing following a surgical procedure on the knee or related soft tissue; ***or***
____otherwise support weak knee

Estimated Length of Need (# of months) _____ ***99=lifetime***

Physician's Name_____ NPI#_____

Physician's Signature_____Date_____
(no stamps please)

Fax to: 1-877-611-3500