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 Private Insurances, such as BCBS, Humana, UHC, Aetna, Cigna)

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

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