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