CMN for Knee Orthotic Support

Patient Name: ____ Patient DOB: ___________________________

Medicare # ____ Patient Phone: __________________________

Treating Physician: ____

Physician Address: ____

Physician Phone: _________________________________ Physician Fax: __________________________________

INSTRUCTIONS: The above named patient has requested that you fill out this order form. Please complete *entire* form and fax to the number below. Per Medicare guidelines we are required to obtain **progress notes** along with this **signed RX** and **qualifying diagnosis code(s)** for product sought by your patient. Please make sure the supporting documentation is faxed to validate **medical necessity** in order to facilitate your patients' request. Unfortunately, without these necessary documents we will not be able to supply the product requested by your patient.

Item(s) to be ordered:

______ **L1833: Knee Orthosis, adjustable knee joints, positional orthosis, rigid support, prefabricated off the shelf**

______ **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 (Circle One)

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
____ 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)

BY SIGNING BELOW, I AUTHORIZE the use of this document as a legal prescription and I certify that the above prescribed equipment is medically necessary and reasonable, and is consistent with the current standards of medical practice and treatment of this patient's condition. I will maintain an original, signed copy of this physician order in my medical records and make it available to Medicare, their authorized agents, or other insurer, if required. ***** Medical justification must be documented in the patient's medical record *****

Physicians Signature: ________________________ NPI# __________________Date: _________

Please FAX this order to: 704-821-7777

Questions Call: Mobility & More 704-821-7777

REF ID