PHYSICIAN PRESCRIPTION AND STATEMENT OF MEDICAL NECESSITY
KNEE BRACING

Patient Name:	SSN:
Primary ICD-9/Narrative Diagnosis:	Date of Service:
Description of Equipment Prescribed (**required**)**:**	
Affected knee **(circle one)**: RT LT BILATERAL	

Describe below why this patient needs a knee brace <u>AND</u> circle <u>ALL</u> conditions that apply:

- RHEUMATOID ARTHRITIS (714.0 – 714.4)
- OSTEOARTHRITIS (715.16, 715.26, 715.36, 715.96)
- MENISCAL CARTILAGE DERANGEMENT (717.0 – 717.5)
- CHRONDROMALACIA OF PATELLA (717.7)
- KNEE LIGAMENTOUS DISRUPTION (717.81 – 717.9)
- RUPTURE OF TENDON, NONTRAUMATIC-QUADRICEPS TENDON (727.65)
- PATHOLOGIC FRACTURE OF FEMUR (733.15)
- PATHOLOGIC FRACTURE OF TIBIA OR FIBULA (733.16)
- ASEPTIC NECROSIS OF OTHER BONE SITES (733.49)
- STRESS FRACTURE OF TIBIA OR FIBULA (733.93)
- CONGENITAL DEFORMITY OF KNEE (JOINT) (755.64)
- FRACTURE OF FEMUR – LOWER END (821.20 – 821.39)
- FRACTURE OF PATELLA (822.0 – 822.1)
- FRACTURE OF TIBIA AND/OR FIBULA – UPPER END (823.00 – 823.42)
- KNEE INSTABILITY (718.86)
- TEAR OF MEDIAL CARTILAGE OR MENISCUS OF KNEE – OTHER DISLOCATION OF KNEE (836.0 – 836.69)
- SPRAIN AND STRAIN OF THE LATERAL COLLATERAL LIGAMENT OF THE KNEE (844.0)
- SPRAIN AND STRAIN OF THE MEDIAL COLLATERAL LIGAMENT OF KNEE (844.1)
- SPRAIN AND STRAIN OF THE CRUCIATE LIGAMENT OF KNEE (844.2)
- FAILED TOTAL KNEE ARTHROPLASTY (996.40 – 996.49)
- INFECTION AND INFLAMMMATION REACTION DUE TO INTERNAL JOINT PROSTHESIS (996.66, V43.65)
- OTHER COMPLICATION OF INTERNAL PROSTHETIC DEVICE, IMPLANT AND GRAFT DUE TO INTERNAL JOINT PROSTHESIS (996.77, V43.65)
- MULTIPLE SCLEROSIS (340)
- HEMIPLEGIA (342.90)
- INFANTILE CEREBRAL PALSY, UNSPECIFIED (344.1)
- PARAPLEGIA OF BOTH LOWER LIMBS (344.1)
- MONONEURITIS OF LOWER LIMB, UNSPECIFIED (355.0, 355.2)

Describe here why this patient requires a knee brace <u>and</u> attach <u>all</u> supporting clinical documentation.
FOR HCPCS CODES **L1830** OR **L1832**, DESCRIBE WHY THIS PATIENT REQUIRES A BRACE WITH **RANGE OF MOTION LIMITATIONS**.
FOR HCPCS CODES **L1843**, **L1845**, OR **L1846** DESCRIBE ANY **KNEE INSTABILITY**.

In addition to the above information, if you are prescribing a Custom Brace, please provide rationale as to why a custom brace is necessary and a prefabricated brace will not meet the patient's needs. Please also circle the appropriate condition(s) listed below.

For CUSTOM BRACES, circle <u>ALL</u> the conditions that exist:

- DEFORMITY OF THE LEG OR KNEE THAT PRECLUDES FITTING WITH A PREFABRICATED ORTHOSIS
- DISPROPORTIONATE SIZE OF THIGH AND CALF OR ATYPICAL THIGH AND CALF DIMENSIONS DUE TO OBESITY (BODY MASS INDEX GREATER THAN OR EQUAL TO 30 KG/M^2)
- MINIMAL MUSCLE MASS UPON WHICH TO SUSPEND AN ORTHOSIS
- DOCUMENTED NEUROLOGICAL, CIRCULATORY, OR CUTANEOUS STATUS THAT PRECLUDES A PREFABRICATED ORTHOSIS
- INTIMATE FIT IS REQUIRED FOR LIGAMENT PROTECTION OR OFF-LOADING INDICATION

By my signature, I am prescribing the item listed above. In my judgment, the above-prescribed item is medically indicated and necessary, and consistent with current accepted standards of medical practice and treatment of this patient's physical condition.

Physician Signature (no signature stamps)			Date:
Physician Printed Name:			
Street Address:			
City:	State:	Zip Code:	NPI#:

A COPY OF THIS DOCUMENT SHOULD BE RETAINED BY THE PHYSICIAN IN THE PATIENT'S MEDICAL RECORD