AIM PLUS
MEDICAL SUPPLIES

Certificate of Medical Necessity of
Certifying Provider for Knee Orthosis

Please fax form with Provider's Signature to
866-496-7054

PATIENT INFORMATION

Name: _____ Date of Birth ____/____/_____
Primary Phone: _____ Secondary Phone: _____
Address: _____ City/State/Zip: _____
Primary Insurance: _____ ID#: _____
Secondary Insurance: _____ ID#: _____
Contact Person (If other than Patient): _____

It is my expert opinion that HCPCS Code ___ L1830 ___ L1833 ___ L1851 is medically necessary for the following reason(s). This prescription also acts as a Letter of Medical Necessity. (Check all that apply)

___ Beneficiary had a recent injury to or a surgical procedure on the knee(s) (L1830, L1833 or L1851) or
___ Patient is ambulatory. Knee instability has been documented by examination and objective description of joint laxity (e.g., varus/valgus instability, anterior/posterior drawer test). (L1851)

Please choose ICD-10 codes that apply: (Check all that apply)

___ M23.52 Chronic Instability of Knee, Left Knee ___ M23.51 Chronic Instability of Knee, Right Knee
___ M17.12 Unilateral Primary Osteoarthritis, LT Knee ___ M17.11 Unilateral Primary Osteoarthritis, RT Knee
___ M17.0 Bilateral Primary Osteoarthritis
___ M23.601 Other Spontaneous Disruption of Unspecified Ligament of RT Knee
___ M23.601 Other Spontaneous Disruption of Unspecified Ligament of LT Knee
___ M05.661 Rheumatoid Arthritis of RT Knee with Involvement of Other Organs
___ M05.761 Rheumatoid Arthritis of LT Knee with Involvement of Other Organs
___ M05.761 Rheumatoid Arthritis with Rheumatoid Factor of RT Knee Without Organ or Systems Involvement
___ M05.762 Rheumatoid Arthritis with Rheumatoid Factor of LT Knee Without Organ or Systems Involvement
___ S83.8X1A Sprain of Other Specified Parts of RT Knee, initial encounter
___ S83.8X2S Sprain of Other Specified Parts of LT Knee, Sequela
___ S83.194A Other Dislocation of RT Knee, Initial Encounter
___ S83.195S Other Dislocation of LT Knee, Initial Encounter
___ *Other _____ *For Other Relevant ICD 10 Codes, See
https://med.noridianmedicare.com/documents/2230703/7218263/Knee+Orthoses+LCD+and+PA
Duration: Patient has had this condition for a period of ____ month(s) ____ year(s). (Chronic = 3 months or more)
Estimated Length of Need ___ month(s) ____ 1-99 (99 = Lifetime)

Requested Product:

___ Min-Knee Hinged (L1833) S to 5X ___ Cross-Fit Universal Hinged (L1833) U
___ TM Wrap-Around Hinged (L1833) S to 4X ___ F.M. Hinged (L1833) S to 2X
___ Advanced Hinged Range of Motion (L1833) U ___ Panther Unloader Knee Brace (L1851) U
___ Cobra Unloader (L1851) U ___ ACL Knee Brace (L1851) S to 2X
___Premium Sized Knee Immobilizer (L1830) S to 2X ___ Tri-Panel Knee Immobilizer (L1830) U
___Quickie Knee Immobilizer (L1830) U

Please indicate: ___ Right (RT) ___ Left (LT) ___Both
Requested Size: ___S ___M ___L ___ XL ___2X ___ 3X ___ 4X ___5X ___Universal (U)

This patient is being treated under a comprehensive plan of care. I, the undersigned, certify that above prescribed is both reasonable and necessary in reference to accepted standards of medical practice in the treatment of the patient's condition and/or rehabilitation. I certify that the patient's medical records reflect the need for the item and will be made available upon request.

Provider Name (Print): _____ Provider NPI# _____
Provider Phone Number: _____ Provider Fax: _____
Provider Signature: _____ **Date**: _____