



1809 E Indian Wells Lane
Draper, UT 84020-8301
801-450-6940
801-944-5910 fax

Detailed Written Order for L1832

Patient: _____ Date: _____

Based on the patient's history, examination and diagnosis below I'm prescribing:

- L1832 Knee Orthosis (KO), adjustable knee joints (unicentric or polycentric), positional Orthosis, rigid support, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

A custom fabricated Orthosis is covered when there is a documented physical characteristic which requires the use of a custom fabricated Orthosis instead of a prefabricated Orthosis. Examples of situations which meet the criterion for a custom fabricated Orthosis include, but are not limited to:

1. Deformity of the leg or knee;
2. Size of thigh and calf;
3. Minimal muscle mass upon which to suspend an Orthosis

Medical Necessity for Knee Brace

- To reduce knee pain by offloading pressure from compartmental knee arthritis
- To provide stability to a weakened knee during exercise
- To provide stability to a knee with ligamentous damage
- To correct for Genu Valgus/ Varus deformity of knee
- To provide support during walking
- To provide support during activities of daily living

Diagnosis for Knee Brace

- | | |
|--|--|
| <input type="checkbox"/> M17.0 Bilateral primary osteoarthritis of knee | <input type="checkbox"/> M21.062 Valgus deformity of left knee |
| <input type="checkbox"/> M17.11 Unilateral primary osteoarthritis, right knee | <input type="checkbox"/> M21.161 Varus deformity of right knee |
| <input type="checkbox"/> M17.12 Unilateral primary osteoarthritis, left knee | <input type="checkbox"/> M21.162 Varus deformity of left knee |
| <input type="checkbox"/> M17.2 Bilateral post-traumatic osteoarthritis of knee | <input type="checkbox"/> M22.2X1 Patellofemoral disorders, right knee |
| <input type="checkbox"/> M17.31 Unilateral post-traumatic osteoarthritis, right knee | <input type="checkbox"/> M22.2X2 Patellofemoral disorders, left knee |
| <input type="checkbox"/> M17.32 Unilateral post-traumatic osteoarthritis, left knee | <input type="checkbox"/> M22.3X1 Other derangements of patella, right knee |
| <input type="checkbox"/> M17.4 Other bilateral secondary osteoarthritis of knee | <input type="checkbox"/> M22.3X2 Other derangements of patella, left knee |
| <input type="checkbox"/> M17.9 Osteoarthritis of knee, unspecified | <input type="checkbox"/> M22.41 Chondromalacia patellae, right knee |
| <input type="checkbox"/> M21.061 Valgus deformity of right knee | <input type="checkbox"/> M22.42 Chondromalacia patellae, left knee |
| | <input type="checkbox"/> M22.8X1 Other disorders of patella, right knee |
| | <input type="checkbox"/> M22.8X2 Other disorders of patella, left knee |
| | <input type="checkbox"/> M23.51 Chronic instability of knee, right knee |
| | <input type="checkbox"/> M23.52 Chronic instability of knee, left knee |

I, the undersigned, confirm the order for the above-named patient. I also certify that the prescribed treatment is medically necessary for this patient's well-being. In my opinion, the prescribed treatment is both reasonable and necessary in reference to accepted standards of medical practice within the community in treatment of this patient's condition.

Prescriber's Signature: _____ Date: _____