MEDICAL LETTER OF NECESSITY

DATE: PATIENT: DATE OF BIRTH:

PRESCRIBING PHYSICIAN:

MEDICAL DIAGNOSES & ICD-9 CODES:

MEDICAL EQUIPMENT PRESCRIBED: RIGHT ☐ LEFT ☐

DATE OF ASSESSMENT/EVALUATION FOR BRACING:

HISTORY:

- Knee instability ☐
- Ligament insufficiency/deficiency ☐
- Reconstructed ligament ☐
- Articular defect repair ☐
- Avascular necrosis ☐
- Meniscal cartilage repair ☐
- Painful failed total knee arthroplasty ☐
- Painful high tibial osteotomy ☐
- Painful unicompartmental osteoarthritis ☐
- Tibial plateau fracture ☐
- Abnormal limb contour:
  - Valgus limb ☐
  - Varus limb ☐
  - Tibial varum ☐
  - Disproportionate thigh and calf ☐
  - Minimal muscle mass ☐
  - Patellofemoral joint space narrowing ☐
- Skin changes, such as:
  - Excessive redundant soft skin ☐
  - Thin skin with risk of breakdown (example: chronic steroid medication) ☐
- Severe osteoarthritis (grade III or IV) ☐
- Maximal off-loading of painful or repaired knee compartment:
  - Patient weight ☐
  - Significant pain ☐
- Severe instability as noted on physical examination of knee ☐
- Not surgery candidate ☐
- Post-Operative ☐

IMPROVEMENT EXPECTED INCLUDES:

Significant improvement in pain, stiffness, and physical function; preventing or reducing degenerative changes in the knee; allowing the patient to return to reasonable activities; preserving the long-term viability of the knee; and increased resistance to injury from valgus, varus, rotational or anterior-posterior translation forces.

I am prescribing a clinically appropriate orthotic appliance that adheres to accepted medical standards and practices in the treatment of this condition, and is a part of the medically necessary treatment for my patient's well being. If I can be of further assistance, please do not hesitate to contact me.

Sincerely,

Physician Date