FAX: Documentation Request

Fax to Name	Fax from Name
Company	Company
Phone	Phone
Fax	Fax
Patient Date of Birth	No. of Pages

We have received a referral from your office to provide a _____ for the above patient. Please be advised that Medicare's documentation requirements state that payment for an orthosis is based solely on the information in the physician's records (not the Orthotist's). Therefore we need the following information from your medical records in order to be in compliance with Medicare and receive reimbursement. We appreciate your cooperation.

Criteria for Coverage: One of the following conditions must be objectively documented in the physician's medical record in order for a knee orthosis to be covered:

1. Ambulatory with weakness or deformity, requiring stabilization; or
2. Ambulatory with flexion or extension contractures; or
3. Recent injury to or a surgical procedure on the knee(s): or
4. Ambulatory with knee instability documented by examination of the beneficiary and objective description of joint laxity (e.g., varus/valgus instability, anterior/posterior Drawer test); or
5. Ambulatory with knee instability due to genu recurvatum - hyperextended knee.

For Custom Knee Orthosis: One of the following conditions must also be documented:

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

Please document the following:

- **History of Condition necessitating the Orthosis:** Diagnosis; Affected Side; Clinical Course; Therapeutic Interventions and Results; and Prognosis.
- **Functional Limitations:** Activities of Daily Living (ADL) and how impacted by deficit(s), Diagnoses causing these symptoms; other Co-morbidities.
- **Status/Condition of Current Orthosis (if applicable):** Describe the orthosis. Does it need to be repaired or replaced?
    - **Damage:** If damaged, please describe the incident.
    - **Repair:** If the device needs repair there needs to be a statement of continued medical need
    - **Wear and Tear:** Useful lifetime is 5 years, so it cannot be replaced for normal wear and tear before that.
    - **Patient's Condition:** If patient's condition has changed, describe why device is no longer appropriate (e.g. weight gain/loss, decreased stability, etc.).
- **Past Experience with Orthosis/Brace and other Failed Treatments**
- **Recent Physical Exam specific to the abnormality/deformity with objective assessment of the condition necessitating the brace:** Include (if applicable) presence of abnormality/deformity, swelling, tenderness, muscle spasm; objective assessment of joint laxity/stability; range of motion; weight, height, weight loss/gain; neurological; etc.
- **Recommendation for the new Orthosis/component(s):** Include the type of device (brand name not required), a statement that patient has the potential to benefit functionally with the device, and your rational for ordering it (based on the information above). *Each note must have your signature, date, printed name & credential; and each page should clearly identify the patient.*

Please fax the signed documents to: _____ at (_____)_____

Knee Brace Fax Request.03096