

DATE OF ORDER: _____

DATE OF LAST FACE TO FACE: _____

PATIENT INFORMATION

First Name _____ Last Name _____

Address _____ City _____ State _____ Zip _____ Phone _____

Date of Birth _____ Emergency Contact _____ Emergency Contact Phone _____

REFERRING PT OR CLINIC INFORMATION (if applicable)

Clinic Name _____ Therapist Name _____

Clinic Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____ Therapist Email _____

PRODUCT PRESCRIBED

AFO, Static (Non-Ambulation), Night Splint, Circle one or both: RT or LT

L4397 Static or dynamic ankle foot orthosis, including soft interface material, adjustable for fit, for positioning, may be used for minimal ambulation, prefabricated, OTS

AFO, Non-Static (used during ambulation), Circle one or both: RT or LT

L1902 - Ankle foot orthosis, ankle gauntlet, prefabricated, off-the-shelf

L1906 - Ankle foot orthosis, multiligamentus ankle support, prefabricated, OTS

Ankle Brace, Circle one or both: RT or LT

L1971 - Ankle foot orthosis, plastic or other material with ankle joint, prefabricated, includes fitting and adjustment

Pneumatic Walking Boot, Circle one or both: RT or LT

L4361 Walking boot, pneumatic and/or vacuum, with or without joints, with or without interface material, prefabricated, OTS

Non-Pneumatic Walking Boot, Circle one or both: RT or LT

L4387 (L4386) - Walking boot, non-pneumatic, with or without joints, with or without interface material, prefabricated, OTS

Other Ankle Brace _____ Circle one or both: RT or LT

DIAGNOSIS

M24.573 Contracture, unspecified ankle

M47.817 Spondylosis without myelopathy or radiculopathy, lumbosacral region

M24.576 Contracture, unspecified foot

Other _____
(Any diagnosis that indicates the need for ankle/foot immobilization or foot drop)

M72.2 Plantar fascial fibromatosis

PHYSICIAN INFORMATION (Must be MD, DO, NP or PA)
By signing and dating, I attest to prescribing the above mentioned item(s). In my professional opinion, the item(s) is both reasonable and necessary in reference to the current accepted standards of medical practice and treatment of this patient's condition. All other related treatments have been tried/considered and ruled out.

Physician Name _____ NPI# _____ Phone _____ Fax _____

Physician Address _____ City _____ State _____ Zip _____

Physician Signature _____ Date Signed _____

COVERAGE CRITERIA

Static (non-ambulation) AFO is covered if the following criteria are met:

Scenario A

1. Plantar flexion contracture of the ankle (ICD-9 diagnosis code 718.47) with dorsiflexion on passive range of motion testing of at least 10 degrees (i.e., a non-fixed contracture); **and**
2. Reasonable expectation of the ability to correct the contracture; **and**
3. Contracture is interfering or expected to interfere significantly with the patient's functional abilities; **and**
4. Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons.

Scenario B

The patient has plantar fasciitis (ICD-9 diagnosis code 728.71).

Non-static (used during ambulation) AFO is covered for patients: That have a weakness or deformity of the foot and ankle, who require stabilization for medical reasons, and have the potential to benefit functionally.