DWO for Ankle Supports/Bracing

FAX COMPLETED DWO, PATIENT DEMOGRAPHICS AND SUPPORTING MEDICAL NOTES TO 207-221-9622

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

- O M24.573 Contracture, unspecified ankle
- O M24.576 Contracture, unspecified foot
- O M72.2 Plantar fascial fibromatosis
- O M47.817 Spondylosis without myelopathy or radiculopathy, lumbosacral region
- O Other_____
(Any diagnosis that indicates the need for ankle/foot immobilization or foot drop)

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.