Compliance Documentation Pack
Thermoplastic AFOs - Precasting Packet

To be completed by physician:

- Biomechanical Evaluation Form (Medical Record Information)
  - Documents medical necessity

- Document of Medical Necessity
  - Justifies qualification for use of AFO
  - Details reason for prefabricated versus custom device
  - Justifies level of fitting (off-the-shelf versus custom-fitted)
  - Justifies code(s) selected

- Prescription
  - Description of the items
  - Patient Name
  - Physician’s printed name
  - Diagnosis
  - Physician’s signature (no stamps allowed)
  - Date (no stamps allowed)
  - Indication if right and / or left limb affected

To be given to Patient:

- Proof of Delivery
  - Patient Printed Name
  - Date of delivery
  - Item Description
  - Item Code(s)
  - Patient Signature
  - Patient Address

DMEPOS Supplier Standards

To be completed by Supplier / Physician:

- Dispensing Chart Notes
  - Type of orthosis
  - Describes method of fitting
  - Documents patient satisfaction
  * Confirms delivery of Supplier Standards
Biomechanical Evaluation Form

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Complaint:</td>
<td></td>
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<tr>
<td>History of problem:</td>
<td></td>
</tr>
<tr>
<td>Nature of discomfort/pain</td>
<td></td>
</tr>
<tr>
<td>Location (anatomic)</td>
<td></td>
</tr>
<tr>
<td>Duration</td>
<td></td>
</tr>
<tr>
<td>Onset</td>
<td></td>
</tr>
<tr>
<td>Course</td>
<td></td>
</tr>
<tr>
<td>Aggravating and/or alleviating factors</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Left</th>
<th>Stance Evaluation:</th>
<th>Right</th>
<th>Normative values:</th>
<th>Treatments and response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angle of gait</td>
<td></td>
<td>Base of gait</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tibial influence</td>
<td></td>
<td></td>
<td>0°-2° varus or valgus</td>
<td></td>
</tr>
<tr>
<td>Relaxed calcaneal stance position (RCSP)</td>
<td></td>
<td></td>
<td>0°</td>
<td></td>
</tr>
<tr>
<td>Neutral calcaneal stance position (NCSP)</td>
<td></td>
<td></td>
<td>0°</td>
<td></td>
</tr>
<tr>
<td>Non-Weight Bearing Evaluation:</td>
<td></td>
<td></td>
<td>Limb length</td>
<td></td>
</tr>
<tr>
<td>Hip sagittal plane:</td>
<td></td>
<td>Knee extended</td>
<td>Flexion 120°/extension 20°-30°</td>
<td></td>
</tr>
<tr>
<td>Hip transverse plane:</td>
<td></td>
<td>Knee flexed</td>
<td>Flexion 45°-60°/extension 20°-30°</td>
<td></td>
</tr>
<tr>
<td>Knee extended</td>
<td></td>
<td>Knee flexed</td>
<td>45° each direction</td>
<td></td>
</tr>
<tr>
<td>Knee flexed</td>
<td></td>
<td>Knee flexed</td>
<td>45° each direction</td>
<td></td>
</tr>
<tr>
<td>Hip frontal plane</td>
<td></td>
<td></td>
<td>45° each direction</td>
<td></td>
</tr>
<tr>
<td>Knee sagittal plane</td>
<td></td>
<td></td>
<td>45° each direction</td>
<td></td>
</tr>
<tr>
<td>Knee recurvatum</td>
<td></td>
<td></td>
<td>Absent</td>
<td></td>
</tr>
<tr>
<td>Ankle sagittal plane:</td>
<td></td>
<td>Knee extended</td>
<td>Dorsiflexion 10°/plantarflexion 40°-70°</td>
<td></td>
</tr>
<tr>
<td>Subtalar joint:</td>
<td></td>
<td>Knee flexed</td>
<td>Dorsiflexion 10°/plantarflexion 40°-70°</td>
<td></td>
</tr>
<tr>
<td>Inversion</td>
<td></td>
<td>20°</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eversion</td>
<td></td>
<td>10°</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midtarsal joint</td>
<td></td>
<td>0°</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1° ray range of motion</td>
<td></td>
<td>Dorsal &amp; plantar excursion 5mm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1° MTPJ range of motion</td>
<td></td>
<td>Dorsal 65° or &gt;unloaded/20°-40° loaded</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lesser MTPJ's</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other comments:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Muscle testing (extrinsics):**
- Invertors 5/5: normal strength
- Evertors 5/5: normal strength
- Dorsiflexors 5/5: normal strength
- Plantarflexors 5/5: normal strength

**Neurological testing:**
- Romberg= Balance intact
- Patellar reflex 2+ normal
- Achilles reflex 2+ normal
- Babinski No hallux extension
- Clonus Absent
- Protective sensation Present
- Gait Evaluation- |

**Gait Evaluation -**
- Gait pattern
- Comment on head/shoulders, spine, pelvis, sagittal/transverse/frontal plane, postural, etc.
- Footgear (size/width, wear pattern(s)) |
- Existing orthoses/type- |
- Weight- |
- Height- |

**Biomechanical assessment:**
- Treatment plan: |

Enter assistant name Enter date of exam
Signature of assistant Signature of physician

The Medicare Program Integrity Manual, states that “For any DMEPOS item to be covered by Medicare, the patient’s medical record contains sufficient documentation of the patient’s medical condition to substantiate the necessity for the type and quantity of the items ordered.”
Document of Medical Necessity: Thermoplastic AFO

Patient Name: _______________________________________   HICN: __________________________

Prognosis: Good   Duration of usage: 12 Months   Quantity: ☐ Bilateral   ☐ Unilateral

I certify that Mr. / Ms. ____________________________________________ qualifies for and will benefit from an ankle foot orthosis used during ambulation based on meeting all of the following criteria. The patient is:

• Ambulatory, and
• Has weakness or deformity of the foot and ankle, and
• Requires stabilization for medical reasons, and
• Has the potential to benefit functionally

The patient's medical record contains sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity of the items ordered.

The goal of this therapy: (indicate all that apply)

☐ Improve mobility
☐ Improve lower extremity stability
☐ Decrease pain
☐ Facilitate soft tissue healing
☐ Facilitate immobilization, healing and treatment of an injury

Necessity of Ankle Foot Orthotic molded to patient model:

A custom (vs. prefabricated) ankle foot orthosis has been prescribed based on the following criteria which are specific to the condition of this patient. (indicate all that apply)

☐ The patient could not be fit with a prefabricated AFO
☐ The condition necessitating the orthosis is expected to be permanent or of longstanding duration (more than 6 months)
☐ There is need to control the ankle or foot in more than one plane
☐ The patient has a documented neurological, circulatory, or orthopedic condition that requires custom fabrication over a model to prevent tissue injury
☐ The patient has a healing fracture that lacks normal anatomical integrity or anthropometric proportions

I hereby certify that the ankle foot orthotic described above is a rigid or semi-rigid device which is used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body. It is designed to provide support and counterforce on the limb or body part that is being braced. In my opinion, the custom molded thermoplastic AFO is both reasonable and necessary according to accepted standards of medical practice in the treatment of the patient's condition and rehabilitation.

Signature of Prescribing Physician: _______________________________   Type I NPI: _____________   Date: _____/_____/______

Printed Name of Prescribing Physician _______________________________   Phone: __________________________
Rx: Thermoplastic AFO

Doctor Name: _______________________________ Patient Name: _______________________________

Prognosis: Good  Duration of usage: 12 Months

Product Information (Check brand and model, circle base code and addition(s)):

☐ Arizona Optima Brace, Standard, Restricted
  R  L  L1970 An articulated molded plastic orthosis with ankle joints that allow for free motion of the ankle, (dorsi-plantar flexion), custom molded from a model of the patient, custom fabricated, includes casting and cast preparation.
  R  L  L2820 Addition to lower extremity orthosis, soft interface for molded plastic below knee section.

☐ Arizona Thermoplastic AFO - Articulated, Dorsi-Assist
  R  L  L1970 Articulated molded plastic orthosis with ankle joints, custom molded from a model of the patient, includes casting and cast preparation.
  R  L  L2210 Addition to lower extremity, dorsi-flexion assist (plantarflexion resist), each joint.

☐ Arizona Thermoplastic AFO - Articulated
  R  L  L1970 An articulated molded plastic orthosis with ankle joints that allow for free motion of the ankle, (dorsi-plantar flexion), custom molded from a model of the patient, custom fabricated, includes casting and cast preparation.
  R  L  L1960 A molded plastic ankle foot orthosis, posterior solid ankle trim lines, custom molded from a model of the patient, custom fabricated, includes casting and cast preparation.

☐ Arizona Thermoplastic AFO
  R  L  L1970 An articulated molded plastic orthosis with ankle joints that allow for free motion of the ankle, (dorsi-plantar flexion), custom molded from a model of the patient, custom fabricated, includes casting and cast preparation.
  R  L  L1907 Ankle orthosis, supramalleolar, with straps, with or without pads, custom fabricated.

DX: (indicate all that apply) - Corresponds to Biomechanical Examination Form

Adult Acquired Flat Foot (PTTD)
- Flat foot (pes planus) (acquired)
  - right (M21.41)  □ left (M21.42)
  - Spontaneous rupture of other tendons, ankle and foot
    - right (M66.871)  □ left (M66.872)
  - Disorder of ligament, ankle
    - right (M24.271)  □ left (M24.272)
  - Disorder of ligament, foot
    - right (M24.274)  □ left (M24.275)
  - Other acquired deformities of feet
    - right (M21.6X1)  □ left (M21.6X2)

DJD of ankle and rearfoot
- Primary osteoarthritis, ankle and foot
  - right (M19.071)  □ left (M19.072)
  - Pain in ankle and joints of foot
    - right (M25.571)  □ left (M25.572)
  - Pain in lower leg
    - right (M79.661)  □ left (M79.662)
  - Pain in foot
    - right (M79.671)  □ left (M79.672)
  - Other specified congenital deformities of feet
    - (Q66.89)

Foot Drop
- Foot Drop, acquired
  - right (M21.371)  □ left (M21.372)
- Hemiplegia
  - affecting right dominant side (69.951)
  - affecting left dominant side (69.952)
  - affecting right non-dominant side (69.953)
  - affecting left non-dominant side (69.954)

Lateral ankle instability
- Other specific joint derangements of ankle, not elsewhere classified
  - right (M24.871)  □ left (M24.872)
  - Other specific joint derangements of foot, not elsewhere classified
    - right (M24.874)  □ left (M24.875)
    - Sprain of ankle calcaneofibular ligament
      - right (S93.411)  □ left (S93.412)

Tendinitis
- Achilles tendinitis
  - right (M76.61)  □ left (M76.62)
- Anterior tibial syndrome
  - right (M76.81)  □ left (M76.812)
- Posterior tibial tendinitis
  - right (M76.821)  □ left (M76.822)
- Other synovitis and tenosynovitis, ankle and foot
  - right (M65.871)  □ left (M65.872)

Amputation
- Acquired absence of great toe
  - right (Z89.411)  □ left (Z89.412)
- Acquired absence of other toe(s)
  - right (Z89.421)  □ left (Z89.422)
- Acquired absence of foot
  - right (Z89.431)  □ left (Z89.432)
- Other
  - right (Z89.432)

Charcot
- Right ankle and foot
  - (M14.671)
- Left ankle and foot
  - (M14.672)

The codes contained herein are not the official position or endorsement of any organization or company. They are offered as a suggestion based upon input from previous customers. Each prescribing practitioner should contact his or her local carrier or Medicare office to verify billing codes, regulations and guidelines relevant to their geographic location.
Rx: Thermoplastic AFO (continued)

THERAPEUTIC OBJECTIVE(S): (indicate all that apply)

- [ ] Improve mobility
- [ ] Improve lower extremity stability
- [ ] Decrease pain
- [ ] Facilitate soft tissue healing
- [ ] Facilitate immobilization, healing and treatment of an injury

Signature of Prescribing Physician: ______________________________
Type I NPI: _______________
Order Date: ______/_______/_______

Prescribing Physician Printed Name: ______________________________

(Must be current with CMS)
Thermoplastic AFO Collection

- **Thermoplastic AFO**
  - Color: [ ] Black [ ] White
  - Trim Line: [ ] PLS [ ] Semi-Solid [ ] Solid
  - Plastic Type: [ ] Polypropylene 1/8 3/16 1/4
    [ ] Co-Polymer 1/8 3/16 1/4

- **Thermoplastic AFO - Articulated**
  - Color: [ ] Black [ ] White
  - Hinge: [ ] Tamarack [ ] Oklahoma [ ] Camber Axis
  - Tamarack Dorsi - Assist: Durometer - [ ] 75 [ ] 85
  - Plantar Stops: [ ] 90° stop, plastic buttress
    [ ] Adjustable Stop
    [ ] Posterior Spring Assist
  - Plastic Type: [ ] Polypropylene 1/8 3/16 1/4
    [ ] Co-Polymer 1/8 3/16 1/4

- **Arizona Optima Brace**
  - Color: [ ] Black
  - Hinge: [ ] Free Motion [ ] Restricted

- **Supra Malleolar Orthosis**
  - Color: [ ] Black [ ] White

- **Split Upright**
  - Color: [ ] Black
  - Hinge: [ ] Tamarack [ ] Oklahoma [ ] Camber Axis
  - Tamarack Dorsi - Assist: Durometer - [ ] 75 [ ] 85

- **AZ CROW Walker™**
  - Color: [ ] Black [ ] Neutral

Additions: [ ] Carbon Ankle Inserts [ ] Full Toe Plate
[ ] Foam lining: Plastazote 1/8 3/16 [ ] Foam lining: Aliplast 1/8 3/16

Measurements - please include for optimal fit:

- Indicate Location for Ulcer Reliefs
- **Patient Information:** [ ] Right Foot [ ] Left Foot [ ] Bilateral
  - Patient Name: _______________________________________
  - Height: _________ Weight: _________

Shipping and Billing Information:

- Bill to my account: [ ] Arizona [ ] SafeStep [ ] Langer
  Account # ______________________
  - Practitioner: ________________________________________
  - Email: ________________________________________
  - Facility Name: ______________________
  - Phone: ______________________
  - Fax: ______________________
  - Ship to address: ________________________________________

Shipping Options:

- [ ] Ground [ ] 3 Day Air [ ] 2 Day Air [ ] Overnight

Special Instructions: If you do not want the dorsi-plantar angle of the cast set to our recommendations, please choose:

- [ ] Leave cast exactly as is
- [ ] Correct Ankle Varus / Valgus

- [ ] Correct Forefoot to Neutral
- [ ] Other __________________

Remarks: ________________________________________________________