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WorryFreeDME

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

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Biomechanical Evaluation Form

Patient Name:	
Chief Complaint:	
History of problem:	
Nature of discomfort/pain	
Location (anatomic)	
Duration	
Onset	
Course	
Aggravating and/or alleviating factors	

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

Save in patient's chart



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 patients 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: _____

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WorryFreeDME

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.

Arizona Thermoplastic AFO

- 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

AZ CROW Walker™

- R L **L4631** A bivalved custom molded plastic orthosis, with a removable custom arch support, soft interface, and a rocker bottom walking sole. For patients with Charcot.

Split Upright 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 **L2820** Addition to lower extremity orthosis, soft interface for molded plastic below knee section

Split Upright AFO, Dorsi-Assist

- 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 **L2210** Addition to lower extremity, dorsi-flexion assist (plantarflexion resist), each joint.
- R L **L2820** Addition to lower extremity orthosis, soft interface for molded plastic below knee section

Supramalleolar Orthosis

- 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 (M24.275c)
- Other acquired deformities of foot
 - right (M21.6X1) left (M21.6X2)

DJD of ankle and rearfoot

- Primary osteoarthritis, ankle and foot
 - right (M19.071) c left (M19.072)
- Pain in ankle and joints of foot
 - right (M25.571) c 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 (I69.951)
 - affecting left dominant side (I69.952)
 - affecting right non-dominant side (I69.953)
 - affecting left non-dominant side (I69.954)

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 (M76.811) 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

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.

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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: ____/____/____
(Must be current with CMS)

Prescribing Physician Printed Name: _____

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Ship to address:
4825 East Ingram St.
Mesa, AZ 85205
Fax: 480.222.1599

Dispense Date: _____
Work Order #: _____

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

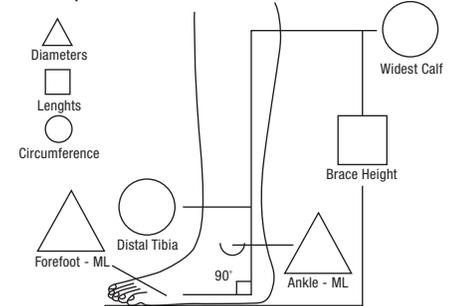
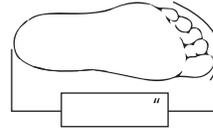


- AZ CROW Walker™
- Color:** Black White

- 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: _____ Shoe Size: _____ Gender: M F
Dx: _____ D.O.B: _____

Shipping and Billing Information:

Bill to my account:
 Arizona SafeStep Account # _____

Practitioner: _____
Email: _____
PO#: _____
Facility Name: _____
Phone: _____
Fax: _____
Ship to address: _____
Bill 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: _____

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