Document of Medical Necessity:
Custom Molded Gauntlet Ankle Foot Orthotic

Patient Name: _____ HICN: _____ DOB: ___/___/___

Prognosis: Good **Duration of usage:** 12 Months **Circle Quantity:** (Bilateral) (Unilateral)

MBB (PDAC Verified)

- ☑ **L1940** Ankle foot orthosis, plastic or other material, custom fabricated
- ☑ **L2820** Addition to lower extremity orthosis, soft interface, below knee
- ☑ **L2330** Addition to lower extremity, lacer molded to patient model, for custom fabricated orthosis only

I hereby certify that Mr. / Ms. _____ _____ qualifies for and will benefit from the product designated above based on the following criteria (check all that apply):

- ☐ Partial or complete paralysis of one or more leg muscles.
- ☐ Significant weakness, ataxia or gait abnormality
- ☐ Significant impairment of gait due to pain or ankle / foot deformity.
- ☐ Instability in gait with recurrent sprains or falls.

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

- ☐ Improve mobility
- ☐ Improve lower extremity stability
- ☐ Decrease pain
- ☐ Decrease risk for fall

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. (Check 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

Additional Notes: _____

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 ankle foot orthosis is both reasonable and necessary in reference to accepted standards of medical practice in the treatment of the patient condition and rehabilitation.

Signature of Prescribing Physician: _____ Type I NPI: _____ Date: _____

Print Physician Name: _____

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.

safeStep™ PREVENTION PAYS

Rx: Moore Balance Brace (MBB)

Doctor Name: _____ Phone: _____

Patient Name: _____ HICN: _____ DOB: ___/___/___

Circle Quantity: (Bilateral) (Unilateral)

MBB (PDAC Verified)

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Dx: (check all that apply)

Fall Risk/Imbalance

- ☐ Muscle weakness (728.87)
- ☐ Ataxia, muscular incoordination (781.3)
- ☐ Gait abnormality/ staggering, ataxic (781.2)

DJD of Ankle and Rearfoot

- ☐ Osteoarthritis, Localized Primary Ankle & Foot (715.17)
- ☐ Arthropathy, unspecified, ankle and foot (716.97)
- ☐ Pain in joint, ankle, foot (719.47)

Lateral Ankle Instability

- ☐ Instability of Joint, Ankle & Foot (718.87)

Dropfoot

- ☐ Dropfoot (736.79)
- ☐ Hemiplegia (438.20)

Therapeutic Objectives: (check all that apply)

- ☐ Improve mobility
- ☐ Improve lower extremity stability
- ☐ Decrease pain
- ☐ Reduce risk of falls
- ☐ Facilitate muscular coordination and gait stability
- ☐ Reduce postural sway and increase ankle stability

Duration of usage: 12 Months

Signature of Prescribing Physician: _____ Type I NPI: _____ Date: _____

Print Physician Name: _____

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