Rx: Moore Balance Brace (MBB)

Doctor Name: _____ Phone: _____

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

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

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: _____

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.

Print additional copies at SafeStep.net | **866.712.STEP (7837)**

Document of Medical Necessity:
Custom Molded Gauntlet Ankle Foot Orthotic

MBB
MOORE BALANCE BRACE

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.

Print additional copies at SafeStep.net | **866.712.STEP (7837)**

safestep™
PREVENTION PAYS

Dispensing Chart Notes:
Custom Molded Gauntlet Ankle Foot Orthotic

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

MBB
MOORE BALANCE BRACE

Dx: (check all that apply)

Fall Risk/Imbalance

- ☐ At Risk/History of Fall (V15.88)
- ☐ 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)

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

S) (Product name)_____ was dispensed and fit at this visit. Patient is ambulatory. There is instability with range of motion that requires stabilization. Due to the indicated diagnosis(s) and related symptoms this device is medically necessary as part of the overall treatment. The function of this device is to stabilize gait, improve postural balance/sway, provide stabilization in the ankle joint and to reduce the risk for fall. It is anticipated that the patient will benefit functionally with the use of this device. The custom device is utilized in an attempt to reduce the mortality/morbidity of falling.

O) Upon gait analysis, the device appeared to be fitting well and the patient states that the device is comfortable.

A) Good fit. The patient was able to apply properly and ambulate without distress.

P) The goals and function of this device were explained in detail to the patient. The patient was shown how to properly apply, wear, and care for the device. It was explained that the device will fit and function best in a lace-up shoe with a stiff heel counter and a wide base of support. When the device was dispensed, it was suitable for the patient's condition and not substandard. No guarantees were given. Precautions were reviewed. Written instructions, warranty information and a copy of DMEPOS Supplier Standards were provided. All questions were answered.

Additional Notes: _____

Supplier Signature: _____ **Date:** ___/___/___

Print Supplier 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.

Patient Receipt: Custom Molded Ankle Foot Orthotic

Doctor Name: _____ Phone: _____

Patient Name: _____ HICN: _____ DOB: ____/____/____

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

Instructions For Use:

Material failure warranty coverage:

- Hardware, plastic and metal components are covered at no-charge for six months.
- All soft materials: material covers, Velcro straps and limb support pads, are covered at no-charge up to ninety days.

You have been dispensed this custom molded ankle brace to stabilize your foot and ankle in order to prevents falls and imbalance. An AFO often requires a period of adjustment. It is best to wear it for one hour more each day and to continue this for two weeks. It should only be removed as specifically instructed. If the brace feels too tight, you may be walking too much. Get off your feet, loosen any straps and elevate your foot until the tightness resolves. If your symptoms do not resolve, please contact our office immediately. Should the device crack or break, remove it and do not use it again until you contact our office. Straps should be kept clean of clothing fabric to insure the device is properly secured to your extremity. Applying a skin moisturizer and wearing knee high socks will prevent your skin from irritation.

I understand the office's Complaint Resolution Policy and have been provided with a copy of the Medicare Supplier Standards. I certify that I have received the item(s) indicated. The supplier has reviewed the instructions for proper use and care and provided me with written instructions. I understand that failure to properly care for this item(s) will result in the warranty being voided. This could result in my responsibility for future repair or replacement costs if my insurance policy will not cover such costs. The supplier has instructed me to call the office if I have any difficulties or problems with the device.

Additional Notes: _____

Patient Signature: _____ Date: _____

Print Patient Name: _____

Patient Address: _____

_____

_____

Original in patient's chart, copy to patient

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.

Print additional copies at SafeStep.net | **866.712.STEP (7837)**