**Documentation Checklist for AFOs and KAFOs (attach to chart)**

**From Physician Records**

<table>
<thead>
<tr>
<th>History of condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis and Diagnosis Code</td>
</tr>
<tr>
<td>Affected Side, Symptoms</td>
</tr>
<tr>
<td>Clinical course, therapeutic interventions and results</td>
</tr>
<tr>
<td>Prognosis</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Functional limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADLs and how impacted by deficit(s)</td>
</tr>
<tr>
<td>Diagnoses causing these symptoms</td>
</tr>
<tr>
<td>Other co-morbidities</td>
</tr>
<tr>
<td>Ambulatory assistance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Status/condition of the current orthosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason for replacement</td>
</tr>
<tr>
<td>If repair is needed: statement of continued medical need</td>
</tr>
<tr>
<td>Past experience with orthoses/braces and other failed treatments</td>
</tr>
</tbody>
</table>

| Physical examination                  |  
| Weight and height, weight loss/gain   |  
| Presence of deformity                 |  
| Document swelling, tenderness, contractures, or spasticity, joint laxity/stability, range of motion (ROM) |  

| Document that patient meets criteria for coverage |  
| Patient is ambulatory and                     |  
| For AFO: weakness/deformity of the foot and ankle or For KAFO weakness/deformity of the foot, ankle and knee and |  
| Requires stabilization of the foot and ankle (and knee for KAFO) due to a medical reason and |  
| Patient has potential to benefit functionally from an AFO/KAFO |  

**If brace will be custom fabricated, one of the following must also be documented:**

1. Permanent condition > 6 months
2. Patient could not fit prefabricated AFO/KAFO
3. Need to control knee, ankle, or foot in more than one plane
4. Documented neurological, circulatory, or orthopedic status requires custom fab over a model to prevent tissue injury
5. Healing fracture lacking normal anatomical integrity or anthropometric proportions

**If the brace is a stance control orthosis (SCO) the following must also be documented:**

- Medical need for a stance control orthosis and why patient cannot use a standard KAFO
- If electronic: Reason why patient cannot use a non-electronic stance control orthosis
- **Recommendation for type of orthosis and rationale for decision (brand name not required)**
- **Patient must be clearly identified on each page**

**Physician Signature Requirements**

- Physician Signature and Date on each chart note
- Notes are dated prior to delivery
- May be handwritten or electronic
- Each chart note includes printed name of physician or signature attestation attached

**Dispensing Order** (if delivered prior to DWO signed)

- Patient’s name
- Date of order
- Description of item (brand name not required)
- Printed name of signatory
- Signature (written order needs physician’s signature; verbal order needs signature of person taking the order)
- May be handwritten or electronic

**Detailed Written Order (DWO)**

- Start date of the order (from the dispensing order or the date prepared)
- Side of body, for each item being provided
- Sufficiently detailed description to identify the item(s) to be provided (e.g. narrative description, including brand name, model number for purchased components).

For items provided on periodic basis: include quantity, frequency of use & number of refills

- Patient’s name on each page

**Physician signature and date requirements on DWO**

- Signed and dated prior to billing
- Handwritten signature and date
- Printed name, credential, address, phone, NPI

**Compliance with State Law**

**Orthotist Records**

- History of orthosis being replaced, description of labor, and reason for replacement (loss, damage, significant change). Must still be medically necessary.
- Functional evaluation (must corroborate physician’s documentation)
- Recommendation for new orthosis: type/brand and fit (custom/custom fit/OTS), rationale –based on physician order
- Describe modifications (trim, bend, mold, assemble, etc.)
- If custom fabricated: Device must be individually made for patient over positive model and records should describe basic materials, labor and fitting.
- Dated chart note for each visit
- Patient name on each page
- Orthotist’s printed name & signature (suggest signature log)

**Proof of Delivery (POD)**

- Patient Name
- Address where item is delivered
- Quantity
- Affected side for each item
- Sufficiently detailed description to identify the item(s) delivered (e.g. narrative description, including brand name, model & serial number for purchased components or full HCPCS description if adequate)
- Handwritten signature
- Printed name of patient/designee & relationship
- Delivery date (or patient signature date)

**Beneficiary Authorization**

- Signed by patient prior to delivery

**Advance Beneficiary Notice (ABN)** (if required)

- Signed by patient prior to delivery

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