HEALTHCARE ASSOCIATES in Medicine, P.C.

IMS Experts

Email: imsexpertsintake@att.net
Fax (817)473-1839

Physician Detail Written Order (RX) and Letter of Medical Necessity (LMN)

PATIENT NAME:		**ICD-10 DX:**	
DOB:		**Additional DX:**	
PHYSICIAN:		**HCPC Code:**	
PHYSICIAN PH #:	**(718)448-3210**	**NPI:**	

Insurance: ☐ **Commercial** ☐ **Medicare** ☐ **Workers Compensation** ☐ **No Fault Liability**

PRE-FABRICATED ANKLE/ FOOT ORTHOSES: Pt requires Ankle/Foot brace (select the following)

Ankle-foot Orthoses (HCPCS codes L1900, L1902-L1990, L2106-L2116, L4350, L4361, L4387 and L4631) are covered for ambulatory beneficiaries when medical necessity criteria are met:

☐ Require stabilization for medical reasons, and have the potential to benefit functionally
☐ Correct ankle joint position during gait caused by weak muscles
☐ Decrease strain on deformed joints of the hindfoot and ankle

HCPCS Code:

☐ **L1902 - Game Day Ankle Brace** ☐ **L1902 - Target Ankle Wrap** ☐ **L1902 - Universal Plantar Fasciitis Support**
☐ **L1902 - Lace Up Ankle Brace** ☐ **L1906 - Hinged Ankle Brace** ☐ **L4350 Ankle Stirrup**
☐ **L1930 - Foot Drop Splint** ☐ **L4398 - Soft Foot Drop Brace** ☐ **L3260 - Med-Surg Shoe** ☐ **L3100 – Bunion Splint**
☐ **L4361 - Pneumatic Walking boot** ☐ **L4387 - Walking boot, non-pneumatic** ☐ **L4387 - ROM Walker**

An L4396 or L4397 (Static or dynamic positioning ankle-foot orthosis) is covered if either all of criteria 1 - 4 or criterion 5 is met:

☐ Plantar flexion contracture of the with dorsiflexion on passive range of motion testing of at least 10 degrees (i.e., a nonfixed contracture); and,
☐ Reasonable expectation of the ability to correct the contracture; and,
☐ Contracture is interfering or expected to interfere significantly with the beneficiary's functional abilities; and,
☐ Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons.
☐ The beneficiary has plantar fasciitis.

HCPCS Code:

☐ **L4397 - Plantar Fasciitis Soft Boot** ☐ **L4397 - Posterior Night Splint**

Length of Need: (check **one**) ☐ 99 months/lifetime ☐ Rental ☐ Other Duration _____

X_____ Date_____
Physician Signature (NO STAMP)

This information will become part of the dictation and permanent clinical record of the above patient.