SEATTLE
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Specialty Out-Patient Referral Request Checklist
Ankle Foot Orthoses (AFOs)

Please include **all documentation** requested to ensure timely patient scheduling and access to the requested medical device. Please note that the clinical notes MUST be documented in the official visit/chart notes from an in-person visit within the last 6 months. Insurance does NOT recognize a letter of medical necessity (LMN) as sufficient documentation.

- ☐ **Patient Demographics**
  - Face sheet with demographics including date of birth, address, and phone number
  - Insurance information
- ☐ **Prescription**
  - Patient's Name
  - Date of prescription
  - Referring provider's full name, NPI and signature (wet signature preferred)
  - Diagnosis and diagnosis code in ICD-10 format
  - Type of requested device including general description, custom fit indication
- ☐ **Recent and reliant clinical notes**
  - **Off-the-shelf (OTS) AFOs:**
    - ☐ Patient is ambulatory (or, if not currently ambulatory, the plan to progress the patient to ambulation);
    - ☐ Patient has a weakness or deformity of the foot and ankle
    - ☐ Patient requires stabilization of the foot and ankle for medical reasons
    - ☐ Patient has the potential to benefit functionally from the use of a device
  - **Custom fabricated AFOs** require the above AND:
    The **physician must also document AND DISCUSS at least one of the following:
    - ☐ The condition necessitating the orthosis is expected to be permanent or of longstanding duration (more than 6 months); **or,**
    - ☐ There is a need to control the knee, ankle or foot in more than one plane; **or**,
    - ☐ The beneficiary has a documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury; **or**,
    - ☐ The beneficiary has a healing fracture which lacks normal anatomical integrity or anthropometric proportions.
  - **Replacement AFOs:**
    The **physician must also document AND DISCUSS the reason for replacement.

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Specialty Out-Patient Referral Request Checklist
Knee Orthoses (KOs)

Please include **all documentation** requested to ensure timely patient scheduling and access to the requested medical device. Please note that the clinical notes MUST be documented in the official visit/chart notes from an in-person visit within the last 6 months. Insurance does NOT recognize a letter of medical necessity (LMN) as sufficient documentation.

- ☐ **Patient Demographics**
  - Face sheet with demographics including date of birth, address, and phone number
  - Insurance information
- ☐ **Prescription**
  - Patient's Name
  - Date of prescription
  - Referring provider's full name, NPI and signature (wet signature preferred)
  - Diagnosis and diagnosis code in ICD-10 format
  - Type of requested device including general description, custom fit indication
- ☐ **Recent and reliant clinical notes**
  - Diagnosis codes must be specific, the most common including:
    - ☐ Osteoarthritis
    - ☐ Hemiplegia or paraplegia
    - ☐ Rheumatoid arthritis
    - ☐ Fracture of femur, tibia, and/or fibula
    - ☐ Meniscus tear or injury
    - ☐ Presence of artificial knee
  - Chart notes must document and discuss in detail:
    - ☐ Patient is ambulatory, **and**
    - ☐ Patient requires a knee orthosis, **and**
    - ☐ Recent injury or surgical procedure, cause and symptom of injury or surgery must be documented, **and**
    - ☐ Knee instability with joint laxity, description of the joint laxity (ex: varus/vaglus instability, etc.)
  - **Replacement KOs:**
    - ☐ **The **physician must also document AND DISCUSS** the reason for replacement

******Chronic knee pain alone will not be sufficient for insurance to cover knee braces******

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Specialty Out-Patient Referral Request Checklist
Knee-Ankle-Foot Orthoses (KAFOs) and Hip Orthoses

Please include **all documentation** requested to ensure timely patient scheduling and access to the requested medical device. Please note that the clinical notes MUST be documented in the official visit/chart notes from an in-person visit within the last 6 months. Insurance does NOT recognize a letter of medical necessity (LMN) as sufficient documentation.

- ☐ **Patient Demographics**
  - Face sheet with demographics including date of birth, address, and phone number
  - Insurance information
- ☐ **Prescription**
  - Patient's Name
  - Date of prescription
  - Referring provider's full name, NPI and signature (wet signature preferred)
  - Diagnosis and diagnosis code in ICD-10 format
  - Type of requested device including general description, custom fit indication
- ☐ **Recent and reliant clinical notes**
  - Knee-Ankle-Foot-Orthoses (KAFO)
    - ☐ The physician must document the following:
      - Patient is ambulatory (or, if not currently ambulatory, the plan to progress the patient to ambulation); **and**
      - Patient has a weakness or deformity of the foot and ankle; **and**
      - Patient requires stabilization of the knee, foot, and ankle for medical reasons; **and**
      - Patient has the potential to benefit functionally from the use of a KAFO; **and**
      - Patient requires additional knee stability; **and**
      - Why a prefabricated device will not work, and a custom device is required.
    - ☐ **AND** one of the following:
      - The condition necessitating the orthosis is expected to be permanent or of longstanding duration (more than 6 months); **or**,
      - There is a need to control the knee, ankle, or foot in more than one plane; **or**,
      - The beneficiary has a documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury; **or**,
      - The beneficiary has a healing fracture which lacks normal anatomical integrity or anthropometric proportions.
    - ☐ **Replacement KAFOs:**
      - **The **physician must also document AND DISCUSS** the reason for replacement.
  - Hip Orthoses
    - ☐ Hip Abduction Brace: Patient requires hip orthosis to prevent hip dislocation
    - ☐ Hip Flexion Assist Device: Patient requires hip orthosis and has weakness of hip flexors

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Specialty Out-Patient Referral Request Checklist
Spinal and Upper-Extremity Orthoses

Please include **all documentation** requested to ensure timely patient scheduling and access to the requested medical device. Please note that the clinical notes MUST be documented in the official visit/chart notes from an in-person visit within the last 6 months. Insurance does NOT recognize a letter of medical necessity (LMN) as sufficient documentation.

- ☐ **Patient Demographics**
  - Face sheet with demographics including date of birth, address, and phone number
  - Insurance information
- ☐ **Prescription**
  - Patient's Name
  - Date of prescription
  - Referring provider's full name, NPI and signature (wet signature preferred)
  - Diagnosis and diagnosis code in ICD-10 format
  - Type of requested device including general description, custom fit indication
- ☐ **Recent and reliant clinical notes**
  - **Spinal orthoses**
    - ☐ The physician must document AND DISCUSS the following:
      - Patient requires an LSO, CO, or TLSO
    - ☐ The physician must also document AND DISCUSS at least one of the following:
      - The orthosis is medically necessary to reduce pain by restricting mobility of the trunk; **or**
      - The orthosis is medically necessary to facilitate healing following an injury to the spine or related soft tissues; **or**
      - The orthosis is medically necessary to facilitate healing following a surgical procedure on the spine or related soft tissues; **or**
      - The orthosis is medically necessary to otherwise support weak spinal muscles and/or a deformed spine.
    - ☐ IF CUSTOM BRACE IS REQUIRED:
      - The **physician must also document AND DISCUSS** the following:
        - Detailed documentation in the treating physician's records to a support the medical necessity of custom fabricated rather than a prefabricated orthosis
    - ☐ **Replacement Spinal Orthoses:**
      - **The **physician must also document AND DISCUSS** the reason for replacement
  - **Upper extremity fracture orthoses**
    - ☐ The physician must document AND DISCUSS the following:
      - Patient has an upper extremity fracture; **and**
      - Patient requires stabilization

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Specialty Out-Patient Referral Request Checklist
Repairs and/or Adjustments

Please include **all documentation** requested to ensure timely patient scheduling and access to the requested medical device. Please note that the clinical notes MUST be documented in the official visit/chart notes from an in-person visit within the last 12 months. Insurance does NOT recognize a letter of medical necessity (LMN) as sufficient documentation.

- ☐ **Patient Demographics**
  - Face sheet with demographics including date of birth, address, and phone number
  - Insurance information
- ☐ **Private Insurance**
  - Recent/reliant clinical notes
    - ☐ Patient has and uses a prosthetic or orthotic device
  - Prescription for repair/adjustment items
    - ☐ Patient's Name
    - ☐ Date of prescription
    - ☐ Referring provider's full name, NPI and signature (wet signature preferred)
    - ☐ Diagnosis and diagnosis code in ICD-10 format
    - ☐ Adjustment/repair indicated
- ☐ **Medicare/Medicaid**
  - Recent/reliant clinical notes
    - ☐ Patient has and uses a prosthetic or orthotic device

If the patient requires a NEW device rather than adjustments or repairs, more documentation is required. Please call 206-328-4276 to inquire about requirements for new devices

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Specialty Out-Patient Referral Request Checklist
Consumables

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- ☐ **Patient Demographics**
  - Face sheet with demographics including date of birth, address, and phone number
  - Insurance information
- ☐ **Prescription**
  - Patient's Name
  - Date of prescription
  - Referring provider's full name, NPI and signature (wet signature preferred)
  - Diagnosis and diagnosis code in ICD-10 format
  - Consumable items indicated, and type if known
- ☐ **Recent and reliant clinical notes**
  - **Prosthetic patients**
    - ☐ Patient uses a prosthesis
  - **Orthotic patients**
    - ☐ Patient has and uses a brace or orthotic (and what type)

If the patient requires a NEW device rather than just consumables, more documentation is required. Please call 206-328-4276 to inquire about requirements for new devices

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Specialty Out-Patient Referral Request Checklist
Diabetic Shoes and Inserts

Please include **all documentation** requested to ensure timely patient scheduling and access to the requested medical device. Please note that the clinical notes MUST be documented in the official visit/chart notes from an in-person visit within the last 6 months. Insurance does NOT recognize a letter of medical necessity (LMN) as sufficient documentation.

- ☐ **Patient Demographics**
  - Face sheet with demographics including date of birth, address, and phone number
  - Insurance information
  - Patient's PCP if not the referring provider
- ☐ **Prescription**
  - Patient's Name
  - Date of prescription
  - Referring provider's full name, NPI and signature (wet signature preferred)
  - Diagnosis and diagnosis code in ICD-10 format
  - Type of requested device including general description
- ☐ **Recent and reliant clinical notes**
  - **Documentation from any physician including DPM, ARNP, PA:**
    - ☐ Management of the patient's diabetes within past 6 months
    - ☐ Foot exam within the past 6 months
    - ☐ Treatment of the patient's condition(s) requires the use of diabetic footwear

    ***For DPM providers please provide the information for the patient's primary care or diabetic managing provider information including practitioners name, healthcare organization and phone number if available.**
  - **Documentation from MD or DO, or NP / ARNP under direct supervision of the MD:**
  - **Medicare and Medicaid patients**: Diabetic Verification Form - **Must be signed on or after the date of the in person-visit (See attached form)**
  - Chart Notes must discuss items checked on DVF - Must be from MD or DO or chart notes signed off by MD or DO
    - ☐ History of partial or complete amputation of the foot
    - ☐ Current or previous foot ulceration
    - ☐ Current or previous pre-ulcerative calluses
    - ☐ Peripheral neuropathy with evidence of callus formation
    - ☐ Foot deformity
    - ☐ Poor circulation

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Statement of Certifying Physician for Diabetic Shoes

Patient Name: _____

DOB: _____

I certify that all of the following statements are true:

1. This patient has diabetes mellitus.

2. This patient has one or more of the following conditions. (**Circle all that apply**):

    a) History of partial or complete amputation of the foot

    b) History of previous foot ulceration

    c) History of pre-ulcerative callus

    d) Peripheral neuropathy with evidence of callus formation

    e) Foot deformity

    f) Poor circulation

3. I am treating this patient under a comprehensive plan of care for his/her diabetes.

4. This patient needs special shoes (depth or custom-molded shoes) because of his/her diabetes.

Physician signature: _____

Date Signed: _____

Physician name (printed - **MUST BE AN M.D. OR D.O.**):

_____

Physician address:

_____

_____

Physician NPI: _____

Physician Phone: _____

Physician Fax: _____

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Specialty Out-Patient Referral Request Checklist
Prosthetics

Please include **all documentation** requested to ensure timely patient scheduling and access to the requested medical device. Please note that the clinical notes MUST be documented in the official visit/chart notes from an in-person visit within the last 6 months. Insurance does NOT recognize a letter of medical necessity (LMN) as sufficient documentation.

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- ☐ **Prescription**
  - Patient's Name
  - Date of prescription
  - Referring provider's full name, NPI and signature (wet signature preferred)
  - Diagnosis and diagnosis code in ICD-10 format
  - Type of requested device including general description
- ☐ **Recent and reliant clinical notes**
  - **All Prosthetics:**
    - ☐ Record of an amputation and what level it was
    - ☐ Medical necessity for prosthesis, without a less expensive alternative that will allow patient to perform required activity
    - ☐ Specific activities (including ADLs) that the patient is unable to perform without prosthesis, including activities performed prior to amputation
  - **Lower Limb:**
    - ☐ Patient is motivated to ambulate
    - ☐ Status of residual limb
    - ☐ Nature and extent of functional limitations (physical or mental)
    - ☐ Patient's realistic ambulation potential with prosthesis within a reasonable period of time
    - ☐ K-Level description and assessment (see attached form)
  - **Replacement Devices:**
    - ☐ **The **physician must also document AND DISCUSS** the reason for replacement

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K-Level Assessment- Prosthetics

Patient: _____ DOB:_____

I have conducted physical examination of this patient; and the following are my findings (check all that apply):

1. Is the patient able to safely transfer (with or without assistance)

Yes (Continue to question 2)
If No, does he/she has such potential? Yes (Continue to question 2)
No (STOP. This patient is K-0 and not a prosthetic candidate at the present time.

2. Is the patient able to ambulate on level surfaces with fixed cadence?

Yes (Continue to question 3)
If No, does he/she has such potential? Yes (Continue to question 3)
No (STOP. This patient has K-1 functional level)

3. Is the patient able to transverse most low level environmental barriers, such as curbs, stairs or uneven surfaces?

Yes (Continue to question 4)
If No, does he/she has such potential? Yes (Continue to question 4)
No (STOP. This patient has K-1 functional level)

4. Is the patient able to ambulate with variable cadence?

Yes (Continue to question 5)
If No, does he/she has such potential? Yes (Continue to question 5)
No (STOP. This patient has K-2 functional level)

5. Does the patient have the ability for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress or energy levels, typical of the prosthetic demands of the child, active adult or athlete?

Yes (STOP. This patient has K-4 functional level)
If No, does he/she has such potential? Yes (This patient has K-4 functional level)
No (STOP. This patient has K-3 functional level)

Additional comments: _____

Physician: _____ ; NPI: _____

Address:_____; Tel: _____
Signature: _____; Date:_____