BlueCross BlueShield of North Carolina

Use for Blue Medicare HMO/PPO Plans

Ankle Foot Orthosis (AFO) or Knee Ankle Foot Orthosis (KAFO) Prior Authorization (PA) Request Form

(Incomplete Form May Delay Processing)

Provider Information		Member Information
Ordering Physician Name:	NPI #:	Member Name:
Office Phone#: Office Fax#:	Contact Name:	Member ID #:
Vendor Name:	NPI #:	Member's Date of Birth:
Vendor Phone #: Vendor Fax #:	Contact Name:	Member's Phone #:
ICD-10 Code(s):		

Please answer questions below

HCPCS code(s) (REQUIRED): _____

Please provide the following information:

1. What is the date of delivery/purchase? _ _/_ _/_ _ _ _
2. Why is the support device needed?
   _____
   _____
   _____
   _____
3. If the request is for a **spring loaded orthotic device or static progressive stretch device**, please answer the following:
   a. Has the member failed conventional treatment for restoring joint motion? (ex. exercise or Physical Therapy)? ☐ Yes ☐ No
4. If the request is for a **custom AFO/KAFO not used for ambulation (L4396, L4397)**, please answer the following:
   a. Is there plantar flexion contracture of the ankle with dorsiflexion or passive range of motion testing of at least 10 degrees? ☐ Yes ☐ No
   b. Is there reasonable expectation of the ability to correct the contracture? ☐ Yes ☐ No
   c. Does the contracture interfere or is it expected to interfere significantly with the member's functional abilities? ☐ Yes ☐ No
   d. Is the member participating in a physical therapy program, and is the orthotic a component of the program which includes active stretching of the involved muscle and/or tendons? ☐ Yes ☐ No
   e. Does the member have plantar fasciitis? ☐ Yes ☐ No
5. If the request is for **AFOs/KAFOs used during ambulation (L1900, L1902-L1990, L2106-L2116, L4350, L4360, L4361, L4386, L4387, L4631)**, please answer the following:
   a. Does the member have weakness or deformity of the foot and ankle? ☐ Yes ☐ No
   b. Does the member require stabilization? ☐ Yes ☐ No
   c. Does the member have potential to benefit functionally? ☐ Yes ☐ No

BlueCross BlueShield of North Carolina

Use for Blue Medicare HMO/PPO Plans

Ankle Foot Orthosis (AFO) or Knee Ankle Foot Orthosis (KAFO) Prior Authorization (PA) Request Form

(Incomplete Form May Delay Processing)

6. If the request is for **KAFOs used during ambulation (L2000-L2038, L2126-L2136, L4370)**, please answer the following:

   a. Does the member have weakness or deformity of the foot and ankle? ☐ Yes ☐ No
   b. Does the member require stabilization? ☐ Yes ☐ No
   c. Does the member have potential to benefit functionally? ☐ Yes ☐ No
   d. Does the member require additional knee stability? ☐ Yes ☐ No

7. If the **AFOs/KAFO is custom fabricated**, please answer the following:

   a. Could the member not be fitted for a prefabricated AFO? ☐ Yes ☐ No
   b. Is the condition requiring the orthosis expected to be permanent (>6 months)? ☐ Yes ☐ No
   c. Does the ankle, knee or foot need to be controlled in more than one plane? ☐ Yes ☐ No
   d. Does the member have documented neurological, circulatory, or orthopedic compromise requiring customization to prevent tissue damage? ☐ Yes ☐ No
   e. Does the member have a healing fracture that is not in normal anatomical position? ☐ Yes ☐ No

8. If the request is for a **concentric adjustable torsion mechanism (L2999)**, please answer the following:

   a. Is there a need to assist knee joint extension and ankle joint plantar flexion or dorsiflexion? ☐ Yes ☐ No
   b. Is there a coexisting joint contracture? ☐ Yes ☐ No

9. If the request is for **concentric adjustable torsion style mechanisms (E1810 and/or E1815)**, please answer the following:

   a. Does the member have contractures? ☐ Yes ☐ No

I certify that I have appropriate authority to request an organization determination for the item(s) indicated on this request. I further certify that the patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time in order to verify this information.

Signature:_____ Date: _____

Please Return Completed Form to:
Fax 1-336-794-1556
For questions, please call Care Management at 1-888-296-9790.

Blue Cross and Blue Shield of North Carolina is an HMO/PPO plan with a Medicare contract. Enrollment in Blue Cross and Blue Shield of North Carolina depends on contract renewal.