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XTERN Compliance Packet

This Packet has 10 Pages to insure proper documentation and DME compliance.

Pages:

1) XTERN Compliance Packet and Checklist
2) Biomechanical Evaluation (page 1)
3) Biomechanical Evaluation (page 2)
4) Tests and Gait Evaluation
5) Document of Medical Necessity Custom Molded XTERN
6) Prescription (Rx) Custom Molded XTERN
7) XTERN Order Form
8) Proof of Delivery
9) Medicare DMEPOS Supplier Standards
10) Dispensing Documentation Custom Molded XTERN

Below is a check list to ensure all items are completed

To be completed by physician:

Biomechanical Evaluation for Patient Medical Record

- Medical necessity documents ☐

Medical Necessity Form

- Supports AFO usage qualification ☐
- Evaluates necessity for prefabrication device ☐
- Demonstrates necessity for custom fitting ☐
- Support for selection code(s) ☐

Prescription

- Patient name (printed) ☐
- Item Description ☐
  - R L B/L
- Diagnosis ☐
- Clinician name (printed) ☐
- Clinician signature ☐
- Date ☐

To be given to patient:

Proof of Delivery (provide copy to patient)

- Patient name (printed) ☐
- Patient address ☐
- Item description ☐
- Item code(s): ☐
- Patient signature ☐
- Delivery date

DMEPOS Supplier Standards ☐

To be completed by supplier/clinician

Dispensing Chart Notes

- Orthosis type ☐
- Demonstrates fitting ☐
- Document patient satisfaction ☐

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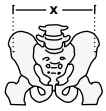
Biomechanical Evaluation (page 1)

Lower Extremity Data

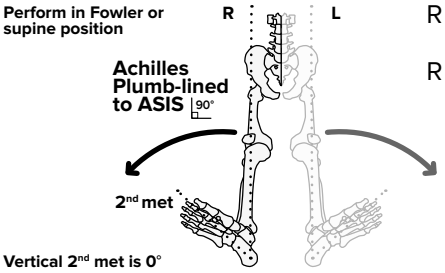
1. ASIS Width (cm)



14 15 16 17 18 19 20 21 **22** **23** 24 25 **26** **27** 28 29 30 31 32 33 34 35

Average male — Average female

2. External Hip Excursion



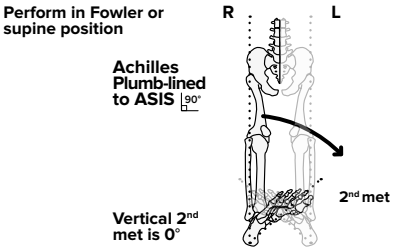
R Quality of motion: Tight | Normal | Loose

R
0° 2° 4° 6° 8° 10° 12° 14° 16° 18°
20° 22° 24° 26° 28° 30° 32° 34° 36° 38°
40° 42° 44° **46°** **48°** 50° 52° 54° 56° 58°
60° 62° 64° 66° 68° 70° 72° 74° 76° 78°
80° 82° 84° 86° 88° 80° 82° 84° 86° 88°
90° 92° 94° 96° 98° 100° 102° 104°

L Quality of motion: Tight | Normal | Loose

L
0° 2° 4° 6° 8° 10° 12° 14° 16° 18°
20° 22° 24° 26° 28° 30° 32° 34° 36° 38°
40° 42° 44° **46°** **48°** 50° 52° 54° 56° 58°
60° 62° 64° 66° 68° 70° 72° 74° 76° 78°
80° 82° 84° 86° 88° 80° 82° 84° 86° 88°
90° 92° 94° 96° 98° 100° 102° 104°

3. Internal Hip Excursion



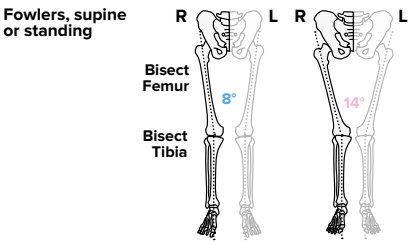
R Quality of motion: Tight | Normal | Loose

R
0° 2° 4° 6° 8° 10° 12° 14° 16° 18°
20° 22° 24° 26° 28° 30° 32° 34° 36° 38°
40° 42° 44° **46°** **48°** 50° 52° 54° 56° 58°
60° 62° 64° 66° 68° 70° 72° 74° 76° 78°
80° 82° 84° 86° 88° 80° 82° 84° 86° 88°
90° 92° 94° 96° 98° 100° 102°

L Quality of motion: Tight | Normal | Loose

L
0° 2° 4° 6° 8° 10° 12° 14° 16° 18°
20° 22° 24° 26° 28° 30° 32° 34° 36° 38°
40° 42° 44° **46°** **48°** 50° 52° 54° 56° 58°
60° 62° 64° 66° 68° 70° 72° 74° 76° 78°
80° 82° 84° 86° 88° 80° 82° 84° 86° 88°
90° 92° 94° 96° 98° 100° 102°

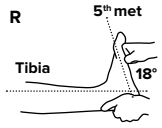
4. Genu Valgum/Varum



R
-8° -6° -4° -2° 0° 2° 4° 6° **8°** **10°**
12° **14°** 16° 18° 20° 22° 24° 26°

L
-8° -6° -4° -2° 0° 2° 4° 6° **8°** **10°**
12° **14°** 16° 18° 20° 22° 24° 26°

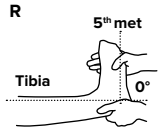
5. Foot Dorsiflexion Excursion



Dorsiflexion

R
0° 2° 4° 6° 8° 10° 12° 14° 16° **18°**
20° 22° 24° 26° 28° 30°

L
0° 2° 4° 6° 8° 10° 12° 14° 16° **18°**
20° 22° 24° 26° 28° 30°



Inverted Dorsiflexion

R
0° 2° 4° 6° 8° 10° 12° 14° 16° **18°**
20° 22° 24° 26° 28° 30°

L
0° 2° 4° 6° 8° 10° 12° 14° 16° **18°**
20° 22° 24° 26° 28° 30°

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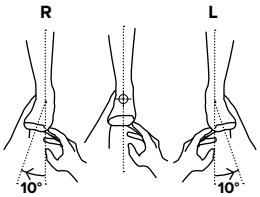
Biomechanical Evaluation (page 2)

6. Subtalar Joint Eversion Excursion

Achilles plumb-lined to ASIS 90°



R Quality of motion: Tight | Normal | Loose

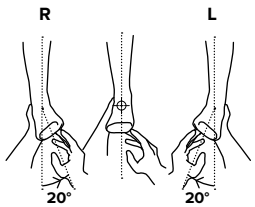
R: -6° | -4° | -2° | 0° | 2° | 4° | 6° | 8° | **10°** | 12° | 14° | 16° | 18° | 20° | 22° | 24° | 26° | 28° | 30° | 32° | 34° | 36° | 38° | 40° | 42° | 44° | 46° | 48° | 50° | 52°

L Quality of motion: Tight | Normal | Loose

L: -6° | -4° | -2° | 0° | 2° | 4° | 6° | 8° | **10°** | 12° | 14° | 16° | 18° | 20° | 22° | 24° | 26° | 28° | 30° | 32° | 34° | 36° | 38° | 40° | 42° | 44° | 46° | 48° | 50° | 52°

7. Subtalar Joint Inversion Excursion

Achilles plumb-lined to ASIS 90°



R Quality of motion: Tight | Normal | Loose

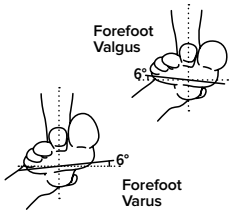
R: -6° | -4° | -2° | 0° | 2° | 4° | 6° | 8° | **10°** | 12° | 14° | 16° | 18° | 20° | 22° | 24° | 26° | 28° | 30° | 32° | 34° | 36° | 38° | 40° | 42° | 44° | 46° | 48° | 50° | 52°

L Quality of motion: Tight | Normal | Loose

L: -6° | -4° | -2° | 0° | 2° | 4° | 6° | 8° | **10°** | 12° | 14° | 16° | 18° | 20° | 22° | 24° | 26° | 28° | 30° | 32° | 34° | 36° | 38° | 40° | 42° | 44° | 46° | 48° | 50° | 52°

8. Metatarsal Head Mean Alignment

Achilles plumb-lined to ASIS 90°



Heel, 5th, 1st are Plantigrade (0°) ☐

Valgus

R: 2° | 4° | 6° | 8° | 10° | 12° | 14° | 16° | 18°

Varus

R: **2°** | 4° | 6° | 8° | 10° | 12° | 14° | 16° | 18° | 20° | 22° | 24° | 26°

Heel, 5th, 1st are Plantigrade (0°) ☐

Valgus

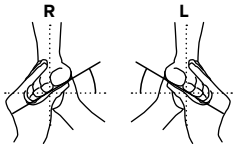
L: 2° | 4° | 6° | 8° | 10° | 12° | 14° | 16° | 18°

Varus

L: **2°** | 4° | 6° | 8° | 10° | 12° | 14° | 16° | 18° | 20° | 22° | 24° | 26°

9. Midfoot Flexibility Test

Achilles plumb-lined to ASIS 90°

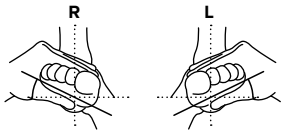


R: 0° - 10° | 11° - 20° | 21° - 30° | **31° - 40°** | **41° - 50°** | **51° - 60°** | 61° - 70° | 71° - 80° | 81° - 90° | 91° - 100°

L: 0° - 10° | 11° - 20° | 21° - 30° | **31° - 40°** | **41° - 50°** | **51° - 60°** | 61° - 70° | 71° - 80° | 81° - 90° | 91° - 100°

9. Reverse Midfoot Flexibility Test

Achilles plumb-lined to ASIS 90°



R: 0° - 10° | **11° - 20°** | **21° - 30°** | **31° - 40°** | 41° - 50° | 51° - 60° | 61° - 70° | 71° - 80° | 81° - 90° | 91° - 100°

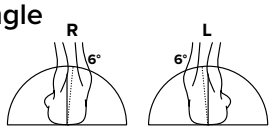
L: 0° - 10° | **11° - 20°** | **21° - 30°** | **31° - 40°** | 41° - 50° | 51° - 60° | 61° - 70° | 71° - 80° | 81° - 90° | 91° - 100°

10. Weight-bearing Foot Anatomical Structure

R: Severe PC | Moderate PC | **Normal** | Severe PP | Moderate PP

L: Severe PC | Moderate PC | **Normal** | Severe PP | Moderate PP

11. Kevin's Angle



R: -6° | -4° | -2° | 0° | 2° | **4°** | 6° | 8° | 10° | 12°

L: -6° | -4° | -2° | 0° | 2° | **4°** | 6° | 8° | 10° | 12°

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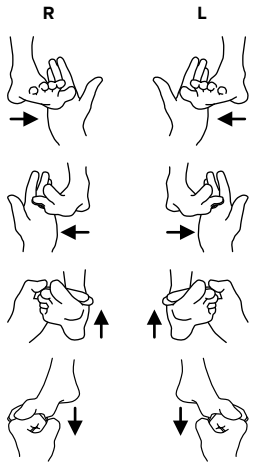
Tests and Gait Evaluation

Extrinsic Muscle Testing



Invertors

R ☐ 0/5 ☐ 1/5 ☐ 2/5 ☐ 3/5 ☐ 4/5 ☐ 5/5 L ☐ 0/5 ☐ 1/5 ☐ 2/5 ☐ 3/5 ☐ 4/5 ☐ 5/5

Evertors

R ☐ 0/5 ☐ 1/5 ☐ 2/5 ☐ 3/5 ☐ 4/5 ☐ 5/5 L ☐ 0/5 ☐ 1/5 ☐ 2/5 ☐ 3/5 ☐ 4/5 ☐ 5/5

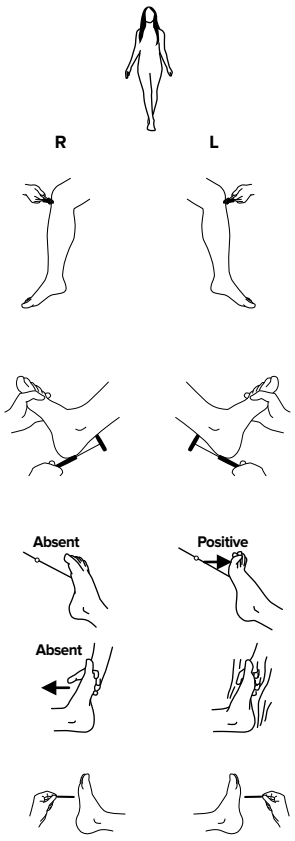
Dorsiflexors

R ☐ 0/5 ☐ 1/5 ☐ 2/5 ☐ 3/5 ☐ 4/5 ☐ 5/5 L ☐ 0/5 ☐ 1/5 ☐ 2/5 ☐ 3/5 ☐ 4/5 ☐ 5/5

Plantar Flexors

R ☐ 0/5 ☐ 1/5 ☐ 2/5 ☐ 3/5 ☐ 4/5 ☐ 5/5 L ☐ 0/5 ☐ 1/5 ☐ 2/5 ☐ 3/5 ☐ 4/5 ☐ 5/5

Neurological Testing



Romberg

R ☐ Balance intact ☐ Positive Romberg L ☐ Balance intact ☐ Positive Romberg

Patellar Reflex

R ☐ Absent despite reinforcement ☐ Present only with reinforcement ☐ Normal ☐ Increased but normal ☐ Markedly hyperactive, with clonus

L ☐ Absent despite reinforcement ☐ Present only with reinforcement ☐ Normal ☐ Increased but normal ☐ Markedly hyperactive, with clonus

Patellar Reflex

R ☐ Absent despite reinforcement ☐ Present only with reinforcement ☐ Normal ☐ Increased but normal ☐ Markedly hyperactive, with clonus

L ☐ Absent despite reinforcement ☐ Present only with reinforcement ☐ Normal ☐ Increased but normal ☐ Markedly hyperactive, with clonus

Babinski Sign

R ☐ Absent ☐ Positive L ☐ Absent ☐ Positive

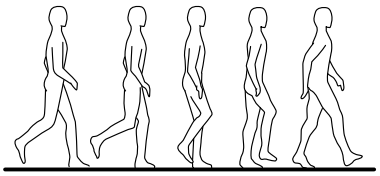
Ankle Clonus

R ☐ Absent ☐ Positive (5 beats or more) L ☐ Absent ☐ Positive (5 beats or more)

Protective Sensation (Semmes Weinstein)

R ☐ Absent ☐ Present L ☐ Absent ☐ Present

Gait Evaluation



Gait Pattern

R ☐ Normal ☐ Hemiplegic ☐ Spastic Diplegic ☐ Neuropathic ☐ Myopathic ☐ Parkinsonian ☐ Choreiform ☐ Ataxic (cerebellar) ☐ Sensory

L ☐ Normal ☐ Hemiplegic ☐ Spastic Diplegic ☐ Neuropathic ☐ Myopathic ☐ Parkinsonian ☐ Choreiform ☐ Ataxic (cerebellar) ☐ Sensory

Comment on head, shoulders, spinee, pelvis, sagittal/transverse/frontal posture, etc.

.....

.....

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Document of Medical Necessity Custom Molded XTERN

Patient Name: .....

HICN: .....

Prognosis: good

Duration of usage: 12 months

I certify that patient..... qualifies for and will benefit from an ankle foot orthosis used during ambulation based on meeting all of the following criteria.

The patient is:
- Ambulatory
- Has weakness or deformity of the foot and ankle
- Requires stabilization for medical reasons
- Has the potential to benefit functionally

Sufficient documentation of the medical condition found in the patient's medical record confirms the necessity for the type and quantity of items ordered.

Therapy Goals (mark all that apply):

- To improve mobility ☐
- To improve stability of lower extremity ☐
- Decrease pain ☐
- Aid healing soft tissue ☐
- Promote immobilization, healing and treatment of injury ☐

I hereby certify that an ankle foot orthotic described above is a semi-rigid or rigid device whose use is solely intended for the support of a weak or deformed limb or the restriction and/or elimination of motion in an injured and/or diseased part of the body. The AFO is designed to provide the appropriate stabilization, support and counterforces necessary for the limb or other extremity that requires bracing. All of the observations, physical exams, and documentation has provided me with enough sound evidence that it is my opinion that a custom molded ankle foot orthosis is both reasonable and necessary in reference to the accepted guidelines of medical practice in the treatment of the patient condition and rehabilitation.

Prescribing Clinician (printed name): .....

Signature of Prescribing Clinician: .....

Phone: ..... Type I NPI: .....

Date: ...../...../..... .
MM DD YYYY

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Tests and Gait Evaluation

Basic Information

Clinician Name: ..... Patient Name: .....
Prognosis: .....
Duration of usage: ..... Product Brand & Model: .....

Product Information (Mark all necessary codes and additions that apply)

XTERN AFO Collection

☐ **X100l - XTERN AFO (large)**
☐R ☐L L2270 (Accessory: ANKLE STABILISATION STRAP REIMBURSEMENT) - Addition to lower extremity, varus/valgus correction ('t') strap, padded/lined or malleolus pad

☐ **X100m - XTERN AFO (medium)**
☐R ☐L L2270 (Accessory: ANKLE STABILISATION STRAP REIMBURSEMENT) - Addition to lower extremity, varus/valgus correction ('t') strap, padded/lined or malleolus pad

☐ **X100s - XTERN AFO (small)**
☐R ☐L L2270 (Accessory: ANKLE STABILISATION STRAP REIMBURSEMENT) - Addition to lower extremity, varus/valgus correction ('t') strap, padded/lined or malleolus pad

☐ **X100p - XTERN AFO (pediatric)**
☐R ☐L L2270 (Accessory: ANKLE STABILISATION STRAP REIMBURSEMENT) - Addition to lower extremity, varus/valgus correction ('t') strap, padded/lined or malleolus pad

DX (Mark all that apply) Corresponds to Biomechanical Examination Form

Adult Acquired Flatfoot (PTTD)	Flat foot [pes planus] (acquired)	☐R M21.41	☐L M21.42
	Spontaneous rupture of other tendons, ankle and foot	☐R M66.871	☐L M66.872
	Disorder of ligament, ankle	☐R M24.271	☐L M24.272
	Disorder of ligament, foot	☐R M24.274	☐L M24.275
	Other acquired deformities of foot	☐R M21.6X1	☐L M21.6X2
Lateral Ankle Instability	Other specific joint derangements of ankle, not elsewhere classified	☐R M24.871	☐L M24.872
Amputation	Acquired absence of great toe	☐R Z89.411	☐L Z89.412
	Acquired absence of other toe(s)	☐R Z89.421	☐L Z89.422
	Acquired absence of foot	☐R Z89.431	☐L Z89.432
Foot Drop	Foot Drop, acquired	☐R M21.371	☐L M21.372
	Hemiplegia - affecting [right/left] dominant side	☐R I69.951	☐L I69.952
	Hemiplegia - affecting [right/left] non-dominant side	☐R I69.953	☐L I69.954
DJD of Ankle and Rearfoot	Primary osteoarthritis, ankle and foot	☐R M19.071	☐L M19.072
	Pain in ankle and joints of foot	☐R M25.571	☐L M25.572
	Pain in lower leg	☐R M79.661	☐L M79.662
	Pain in foot	☐R M79.671	☐L M79.672
	Other specified congenital deformities of feet	☐R Q66.89	
	Other		

Therapy Goal(s): (mark all that apply)

☐ To improve mobility
☐ Promote healing soft tissue
☐ Decrease pain
☐ To improve stability of lower extremity
☐ Treatment of injury

Clinician Information

Prescribing Clinician (printed name): .....
Signature of Prescribing Clinician: .....
Type I NPI: ..... Order Date: ...../...../..... MM DD YYYY

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XTERN Foot Drop AFO

Date MM...../DD...../YYYY.....
Rush production
3 days ☐ 4 days ☐

Clinician

Account Name/Number .....
Location .....
PO Number .....
Clinician .....
Contact me before processing ☐

Patient

First Name .....
Last Name .....
Gender: M ☐ F ☐ **DOB** MM...../DD...../YYYY.....
Height ..... **Weight** ..... **Shoe size** .....
Dx .....
Ship to Patient ☐
Street Address .....
City .....
State ..... Zip .....

Size (see chart)

Pediatric | Small | Medium | Large

Side

Right | Left | Bilateral

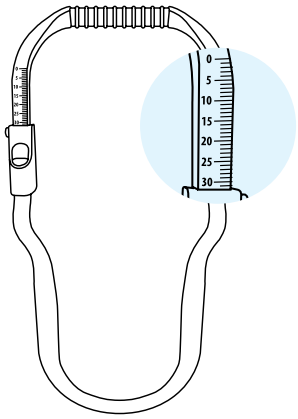
ORDER

XTERN AFO REIMBURSEMENT: L1951
OPTIONAL: L2820, L2270 (Accessory: ANKLE STABILISATION STRAP REIMBURSEMENT)
-Addition to lower extremity, varus/valgus correction ('t') strap, padded/lined or malleolus pad

1 REQUIRED

Front length: .....

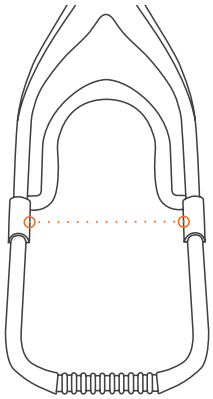
⚠ Always same numbers on both sides.



2 OPTIONAL

Total width:

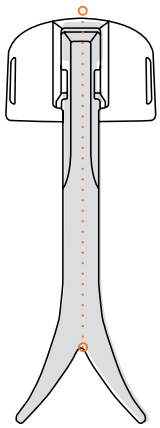
Same as trial-kit
.....mm narrower
..... mm wider



3 OPTIONAL

Calf height: ..... cm

Slide the calf band at the desired position on patient calf. On the back of the orthosis, measure the distance in centimeters between the "Y" intersection and the top of the plastic calf band.



Accessories and options (Extra charge for all items - see price list)

Varus/Valgus Ankle Stabilisation Strap .....

Extra Lace Clips (1pc) .....

Extra Zip Ties (20pcs) .....

Extra Calf Strap / Padding Kit .....

Extension Stopper Kit .....

Tactical Belt .....

ANKLE STABILISATION STRAP REIMBURSEMENT: L2270 - Addition to lower extremity, varus/valgus correction ('t') strap, padded/lined or malleolus pad

Visit the Kevin Orthopedic Institute YouTube Channel for Patient Assessment guidelines ▶

Use QR App and focus the camera on your phone on this code to take you directly to video tutorial.

Special Instructions (including multiple product orders): .....
.....
.....

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KevinRoot MEDICAL

Proof of Delivery - original in patient's chart, copy given to patient

Supplier Information

Supplier Name: .....

HICN:.....

Product Information (Mark all necessary codes and additions that apply)

XTERN AFO Collection

☐ **X100l - XTERN AFO (large)**

R L L2270 (Accessory: ANKLE STABILISATION STRAP REIMBURSEMENT) - Addition to lower extremity, varus/valgus correction ('t') strap, padded/lined or malleolus pad

☐ **X100m - XTERN AFO (medium)**

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☐ **X100s - XTERN AFO (small)**

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☐ **X100p - XTERN AFO (pediatric)**

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Usage Instructions:

This ankle foot orthosis has been dispensed to you to assist in immobilizing your foot and ankle. Any AFO requires a period of adjustment (usually two weeks) and it is best worn for one hour on the first day, with one additional hour added from the previous day. Please continue this process for two weeks. The device should only be removed as intended and instructed by your physician. If tightening of the brace should occur, you may be walking too frequently. It is recommended to get off your feet and elevate your foot until the tightness resolves. If tightness or uncomfortability continues, please contact the Kevin Orthopedic office immediately. If the device cracks or breaks, remove it promptly and do not wear again until you contacted our office immediately. Do not use a cracked or broken brace. The closures of the brace should be kept clean to ensure the device can be properly secured. Skin moisturizes and knee high socks can be used to prevent skin irritation.

Material failure warranty coverage:

Any hardware, plastic or metal components are covered at no-charge for up to 2 years. All soft materials are covered at no-charge for up to ninety days, including: material covers, Velcro straps, laces, and limb support pads.

I have read the posted Complaint Resolution Policy and have been provided a copy of the Medicare Supplier Standards. I certify that I have received the item(s) that have been indicated. The supplier has reviewed and provided me with written instructions of proper usage and care. I understand that improper care for this item(s) will result in a voided warranty. A voided warranty as a result of improper care could result in my responsibility for future repairs or replacements costs if my insurance policy will not cover those costs. The supplier has instructed me to call the office if any difficulties or problems with the device arise.

Patient Name (printed) ..... Patient Signature: .....

Patient Address: ..... **Delivery Date:** ...../...../..... MM DD YYYY

Provide a copy to patient

call us: 1-800-496-0987 www.kevinrootmedical.com
fax: 1-866-919-9268 hello@kevinrootmedical.com

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MEDICARE DMEPOS SUPPLIER STANDARDS

Note: This is an abbreviated version of the supplier standards every Medicare DMEPOS supplier must meet in order to obtain and retain their billing privileges. These standards, in their entirety, are listed in 42 C.F.R. 424.57(c).

1. A supplier must be in compliance with all applicable Federal and State licensure and regulatory requirements.
2. A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days.
3. A supplier must have an authorized individual (whose signature is binding) sign the enrollment application for billing privileges.
4. A supplier must fill orders from its own inventory, or contract with other companies for the purchase of items necessary to fill orders.

A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or any other Federal procurement or non-procurement programs.

5. A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental equipment.
6. A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable State law, and repair or replace free of charge Medicare covered items that are under warranty.
7. A supplier must maintain a physical facility on an appropriate site and must maintain a visible sign with posted hours of operation. The location must be accessible to the public and staffed during posted hours of business. The location must be at least 200 square feet and contain space for storing records.
8. A supplier must permit CMS or its agents to conduct on-site inspections to ascertain the supplier's compliance with these standards.
9. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The exclusive use of a beeper, answering machine, answering service or cell phone during posted business hours is prohibited.
10. A supplier must have comprehensive liability insurance in the amount of at least $300,000 that covers both the supplier's place of business and all customers and employees of the supplier. If the supplier manufactures its own items, this insurance must also cover product liability and completed operations.
11. A supplier is prohibited from direct solicitation to Medicare beneficiaries. For complete details on this prohibition see 42 CFR § 424.57 (c) (11).
12. A supplier is responsible for delivery of and must instruct beneficiaries on the use of Medicare covered items, and maintain proof of delivery and beneficiary instruction.
13. A supplier must answer questions and respond to complaints of beneficiaries, and maintain documentation of such contacts.
14. A supplier must maintain and replace at no charge or repair cost either directly, or through a service contract with another company, any Medicare-covered items it has rented to beneficiaries.
15. A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.
16. A supplier must disclose these standards to each beneficiary it supplies a Medicare-covered item.
17. A supplier must disclose any person having ownership, financial, or control interest in the supplier.
18. A supplier must not convey or reassign a supplier number; i.e., the supplier may not sell or allow another entity to use its Medicare billing number.
19. A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility.
20. Complaint records must include: the name, address, telephone number and health insurance claim number of the beneficiary, a summary of the complaint, and any actions taken to resolve it.
21. A supplier must agree to furnish CMS any information required by the Medicare statute and regulations.
22. All suppliers must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services, for which the supplier is accredited in order for the supplier to receive payment for those specific products and services (except for certain exempt pharmaceuticals).
23. All suppliers must notify their accreditation organization when a new DMEPOS location is opened.
24. All supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare.
25. All suppliers must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation.
26. A supplier must meet the surety bond requirements specified in 42 CFR § 424.57 (d).
27. A supplier must obtain oxygen from a state-licensed oxygen supplier.
28. A supplier must maintain ordering and referring documentation consistent with provisions found in 42 CFR § 424.516(f).
29. A supplier is prohibited from sharing a practice location with other Medicare providers and suppliers.
30. A supplier must remain open to the public for a minimum of 30 hours per week except physicians (as defined in section 1848(j) (3) of the Act) or physical and occupational therapists or a DMEPOS supplier working with custom made orthotics and prosthetics.

DMEPOS suppliers have the option to disclose the following statement to satisfy the requirement outlined in Supplier Standard 16 in lieu of providing a copy of the standards to the beneficiary. The products and/or services provided to you by (Kevin Orthopedic) are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g. honoring warranties and hours of operation). The full text of these standards can be obtained at http://www.ecfr.gov. Upon request we will furnish you a written copy of the standards.

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Dispensing Documentation Custom Molded XTERN

Patient Information

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HICN:.....

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Note:

S) At the time of the patient's visit, a custom fabricated AFO was dispensed and fitted. Although the patient is ambulatory, their condition and related symptoms deem that this medical device is necessary as part of their treatment. It is anticipated that this device will functionally benefit the patient. This custom device is appropriate and utilized in an attempt to avert surgery and because a prefabricated device is inappropriate for the patient's condition.

O) The device appears to fit well and comfortably on the patient during a gait analysis.

A) Regarding the good fit, the patient was able to wear properly and ambulate without concern or distress. This device's function is to assist motion and provide ankle joint stabilization.

P) The patient had received satisfactory information on the goals and functions of the device. Demonstrations of proper application, wear, and care for the device were shown to the patient. The patient was told that the device will function and can fit best externally on a variety of shoes, including: running shoes, lace and velcro-fastening shoes/boots, walking shoes/boots, safety work boots/shoes, dress shoes and sandals. The device was suitable for the patient's condition and not substandard when dispensed. The patient received no guarantees and reviewed all precautions. Written instructions, warranty information and a copy of DMEPOS Supplier standards were provided to the patient. All and any questions were answered.

Additional Notes:.....

Print Supplier Name:..... Supplier Signature: .....

Dispensing Date: ...../...../..... .
MM DD YYYY