

4246 Electric Rd. Roanoke, VA. 24018
**Phone:** (540) 904-7823 **Fax:** (540) 904-7826
[www.footcompanion.com](http://www.footcompanion.com) | info@footcompanion.com

Dear Doctor,

Your patient recently had a diabetic foot screening that indicated probable increased risk for ulceration. If so, Medicare may provide coverage for a pair of protective shoes. Please use the accompanying forms, as required by Medicare, when evaluating the patient in order to document diabetes management and qualifying conditions, if present.

Also attached is a letter from Paul J. Hughes, MD, Medicare Senior Medical Director, et al. that describes the medical doctor’s responsibility under the Therapeutic Shoe Program.

Ulcerative foot risk assessment may qualify as a billable visit.

Please complete the following forms, as indicated, and fax them to (540) 904-7826:

• Physician Notes on Qualifying Condition(s)

• Statement of Certifying Physician for Therapeutic Shoes

• Prescription for Diabetic Shoes and Inserts

Your cooperation is very much appreciated. If you have any questions or need additional information, please contact us at (540) 904-7823.

Sincerely,

Sim Alli, Certified Pedorthist
Clinical Services Manager
Foot Companion

**Please Fax to (540) 904-7826**

*Please fax this back with attached “Statement of Certifying Physician” and “Prescription for Therapeutic Shoes” and keep original in your patient’s chart.*

# Physician Notes on Qualifying Condition(s) for Therapeutic Shoes

* + Please complete ALL Steps as indicated. • As required by Medicare, save in patients chart.

**Name of Person to contact if there are any questions:** Patient Name: HICN: Date of Evaluation **Diabetes Management:** *(Required to support discussion of diabetes management.)*

**Plan of Care:** Diet Oral Meds Injection Pump Treatment Plan: Start date:

Duration of DM: Date of Last FBS:

**Physical Exam** - Please refer to the findings when noting secondary risk factor(s) on “Statement of Certifying Physician”

**Diagnosis code** - Coding Tip: Please refer to this exam when completing Statement of Certifying Physician.

**Vascular Right Left Neurological (LOPS) Right Left**

|  |  |  |
| --- | --- | --- |
| Dorsalis Pedis | normal diminished | normal diminished |
| Posterior Tibial | normal diminished | normal diminished |
| Capillary Refill Time | < 3 sec. > 3 sec | < 3 sec. > 3 sec |
| Edema Present | yes no | yes no |
| Other |  |  |

|  |  |  |
| --- | --- | --- |
| Vibration perception (tuning fork) | normaldiminished | normaldiminished |
| Loss of Protective Sensation (LOPS) | toes metsheel | toesmets heel |
| DTR | normaldiminished | normaldiminished |
| Sharp/Dull | yes no | yes no |

**Please indicate** bunions, swelling, redness, deformities, amputation or wounds using the symbol key below

**Right**

**Left**

Callus **C** | Bunion **B** | Swelling **S** | Redness **R** | Deformity **D** | Hammer/Claw Toe **HC** | Amputation **A** | Wound **W**

**Condition**

Diabetes mellitus without complications

Diabetes mellitus with diabetic polyneuropathy

Diabetes mellitus with diabetic peripheral angiopathy without gangrene

Diabetes mellitus with foot ulcer

**\* Certifying Physician Acknowledgment**

**Type 1 Diabetes**

E10.9 E10.42 E10.51

E10.621

**Type 2 Diabetes**

E11.9 E11.42 E11.51

E11.621

I am the MD/DO supervising the patient under a comprehensive plan of care for Diabetes Mellitus.

I have personally conducted this foot examination or have authorized an eligible prescriber to conduct this exam on my behalf and agree with the findings. I have incorporated this exam as part of my medical records. Part of the comprehensive plan of care for this patient includes therapeutic shoes and insoles.

Physician Signature:

*(Stamped signature nor date not allowable)*

Physician Name (Printed):

Date:

Physician NPI # :

*Shoes must be fit within 6 months of date of appointment for diabetes management.*

**Please Fax to (540) 904-7826**

*Please fax this back with the attached “Prescription” and “Physician Notes on Qualifying Conditions” and keep original in your patient’s chart.*

# Statement of Certifying Physician for Therapeutic Shoes

#### Name of Person to contact if there are any questions:

Patient Name: HICN: Date of Birth:

Please indicate all risk factors for diabetic foot ulcerations.

**When completing and signing this form, please make certain that the following checked condition(s) are the same as you indicated on the Physican Notes on Qualifying Condition(s).**

I certify that all the following statements are true:

1. The patient has diabetes mellitus.
2. This patient has one or more of the following conditions (indicate all that apply)

Foot Deformity

History of partial or complete amputation of the foot

History of preulcerative callus

History of previous foot ulceration

Peripheral neuropathy with evidence of callus formation

Poor circulation/PAD

**Acknowledgment Statement:**

I am treating this patient’s diabetes under a comprehensive plan of care. This patient requires diabetic shoes and heat-molded or custom-molded inserts to help prevent ulcers and further complications.

**Physician Signature:**

*(Stamped signature nor date not allowable)*

#### Physician Name (Printed):

*Must be the MD or DO who is treating the patient’s diabetes*

#### Physician Address:

**Date: Physician NPI #: Physician Phone:**

*\*Note: Shoes must be fit within 90 days of when Certifying Statement signed.*

**Form 3 of 3**

**Please Fax to (540) 904-7826**

**Prescription for Therapeutic Shoes and Inserts**

#### Name of Person to contact if there are any questions:

Patient Name: HICN: Date of Birth:

Quantity (Please check) HCPCS Code Description

1 A5500 Diabetic Depth Shoes, pair

3 2 1 A5512 Prefabricated inserts pairs -multiple density , direct formed, molded to foot with external

heat source (i.e. heat gun). Medicare allows up to three pairs of inserts per year.

**OR**

3 2 1 A5513 Custom-molded inserts - multiple, density, molded to model of patient’s foot.

Medicare allows up to three pairs of inserts per year.

**OR**

1 Left Partial Foot Filler (L5000) 3 Right Custom Inserts 1 Right Partial Foot Filler (L5000) 3 Left Custom Inserts

**Condition**

Diabetes mellitus without complications

Diabetes mellitus with diabetic polyneuropathy

Diabetes mellitus with diabetic peripheral angiopathy without gangrene

Diabetes mellitus with foot ulcer

**Type 1 Diabetes**

E10.9 E10.42 E10.51

E10.621

#### Type 2 Diabetes

E11.9 E11.42 E11.51

E11.621

Please confirm that the entered Diagnosis Code matches your charting documentation.

Duration of usage: 12 Months

**Prescriber Signature:**

*(Stamped signature nor date not allowable)*

**Prescriber Name** (Printed):

#### Date: Physician NPI #:

**Please fax this back with the attached “Statement of Certifying Physician for Therapeutic Shoes” and “Physician Notes on Qualifying Conditions” and keep original in your patient’s chart. Thank you.**

**November 2010**

#### Therapeutic Shoes for Diabetics – Physician Documentation Requirements

Dear Physician,

Medicare covers therapeutic shoes and inserts for persons with diabetes. This statutory benefit is limited to one pair of shoes and up to 3 pairs of inserts or shoe modifications per calendar year. However, in order for these items to be covered for your patient, the following criteria must be met:

* An M.D. or D.O. (termed the “certifying physician”) must be managing the patient’s diabetes under a comprehensive plan of care and must certify that the patient needs therapeutic shoes.
* That certifying physician must document that the patient has one or more of the following qualifying conditions:
* Foot deformity • Previous partial amputation of one or both feet or complete amputation of one foot
* Current or previous foot ulceration • Peripheral neuropathy with evidence of callus formation
* Current or previous pre-ulcerative calluses • Poor circulation

According to Medicare national policy, it is not sufficient for a podiatrist, physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS) to provide that documentation (although they are permitted to sign the order for the shoes and inserts) .The certifying physician must be an M.D. or D.O.

The following documentation is required in order for Medicare to pay for therapeutic shoes and inserts and must be provided by the physician to the supplier, if requested:

1. A detailed written order. This can be prepared by the supplier but must be signed and dated by you to indicate agreement.
2. A copy of an office visit note from your medical records that shows that you are managing the patient’s diabetes. This note should be within 6 months prior to delivery of the shoes and inserts.
3. Either (a) a copy of an office visit note from your medical records that describes one of the qualifying conditions or (b) an office visit note from another physician (e.g., podiatrist) or from a PA, NP, or CNS that describes one of the qualifying conditions .If option (b) is used, you must sign, date, and make a note on that document indicating your agreement and send that to the supplier.

The note documenting the qualifying condition(s) must be more detailed than the general descriptions that are listed above. It must describe (examples not all-inclusive):

* + The specific foot deformity (e.g., bunion, hammer toe, etc.); **or**
	+ The location of a foot ulcer or callus or a history of one these conditions; **or**
	+ The type of foot amputation; **or**
	+ Symptoms, signs, or tests supporting a diagnosis of peripheral neuropathy plus the presence of a callus; **or**
	+ The specifics about poor circulation in the feet – e.g., a diagnosis of venous or arterial insufficiency or symptoms, signs, or test documenting one of these diagnoses. A diagnosis of hypertension, coronary artery disease, or congestive heart failure or the presence of edema are not by themselves sufficient.
1. A certification form stating that the coverage criteria described above have been met .This form will be provided by the supplier but must be completed, signed, and dated by you after the visits described in #2 and 3 .If option 3(b) is used, that visit note must be signed prior to or at the same time as the completion of the certification form. **However, this form is not sufficient by itself to show that the coverage criteria have been met, but must be supported by other documents in your medical records – as noted in #2 and 3.**

New documentation is required yearly in order for Medicare to pay for replacement shoes and inserts.

Physicians can review the complete Local Coverage Determination and Policy Article titled Therapeutic Shoes for Persons with Diabetes on the NAS web site at [www.noridianmedicare.com/dme.](http://www.noridianmedicare.com/dme) It may also be viewed in the local coverage section of the Medicare Coverage Database at [www.cms.hhs.gov/mcd/search.asp.](http://www.cms.hhs.gov/mcd/search.asp)

Suppliers may ask you to provide the medical documentation described above on a routine basis in order to assure that Medicare will pay for these items and that your patient will not be held financially liable .Providing this documentation is in compliance with the HIPPA Privacy Rule. No specific authorization is required from your patient .Also note that you may not charge the supplier or the beneficiary to provide this information.

Please cooperate with the supplier so that they can provide the therapeutic shoes and inserts that are needed by your patient.

Sincerely,

Paul J. Hughes, M.D.

Medical Director, DME MAC, Jurisdiction A

Robert D. Hoover, Jr., MD, MPH, FACP Medical

Director, DME MAC, Jurisdiction C

Adrian M. Oleck, M.D.

Medical Director, DME MAC, Jurisdiction B

Richard W. Whitten, MD, MBA, FACP

Medical Director, DME MAC, Jurisdiction D