



Instruction for Ordering Diabetic Shoes and Inserts

1. Complete "Statement of Certifying Physician"

confirming the patient meets Medicare criteria they have diabetes and one of the six qualifying conditions listed on the statement.

2. Complete the "Prescription for Diabetic Shoes and Inserts"

3. Provide a copy of your patient visit notes showing

1. Diagnosis of the qualifying condition and
2. treatment of the patient's diabetes

FAX ALL OR SEND WITH PATIENT TO

❖ ***1005 N Kingshighway Ste. 12 Cape Girardeau, MO 63701***

PH 573-803-2390 FAX 573-803-1247

❖ ***780 N Main St. Sikeston, MO 63801***

PH 573-475-8570 FAX 573-475-8590

❖ ***519 N Main St. Perryville, MO 63775***

PH 573-768-3243 FAX 573-768-3630

Diabetic Shoes/Inserts

the supplier prior to claim submission. If the supplier bills for an item without first receiving the completed order, the item will be denied as noncovered.

a Certifying Physician is defined as a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) who is responsible for diagnosing and treating the beneficiary's diabetic systemic condition through a comprehensive plan of care. The certifying physician may not be a podiatrist, physician assistant, nurse practitioner, or clinical nurse specialist.

The Prescribing Practitioner is the person who actually writes the order for the therapeutic shoe, modifications and inserts. This practitioner must be knowledgeable in the fitting of diabetic shoes and inserts. The prescribing practitioner may be a podiatrist, M.D., D.O., physician assistant, nurse practitioner, or clinical nurse specialist. The prescribing practitioner may be the supplier (i.e., the one who furnishes the footwear).

The Supplier is the person or entity that actually furnishes the shoe, modification, and/or insert to the beneficiary and that bills Medicare. The supplier may be a podiatrist, pedorthist, orthotist, prosthetist or other qualified individual. The Prescribing Practitioner may be the supplier. The Certifying Physician may only be the supplier if the certifying physician is practicing in a defined rural area or a defined health professional shortage area.

Therapeutic shoes, inserts and/or modifications to therapeutic shoes are covered if all of the following criteria are met:

See forms

1. The beneficiary has diabetes mellitus (Reference diagnosis code section below); and
2. The certifying physician has documented in the beneficiary's medical record one or more of the following conditions:
 - a. Previous amputation of the other foot, or part of either foot, or
 - b. History of previous foot ulceration of either foot, or
 - c. History of pre-ulcerative calluses of either foot, or
 - d. Peripheral neuropathy with evidence of callus formation of either foot, or
 - e. Foot deformity of either foot, or
 - f. Poor circulation in either foot; and
3. The certifying physician has certified that indications (1) and (2) are met and that he/she is treating the beneficiary under a comprehensive plan of care for his/her diabetes and that the beneficiary needs diabetic shoes. For claims with dates of service on or after 01/01/2011, the certifying physician must:
 - Have an in-person visit with the beneficiary during which diabetes management is addressed within 6 months prior to delivery of the shoes/inserts; and
 - Sign the certification statement (refer to the Policy Specific Documentation Requirements section below) on or after the date of the in-person visit and within 3 months prior to delivery of the shoes/inserts.
4. Prior to selecting the specific items that will be provided, the supplier must conduct and document an in-person evaluation of the beneficiary. (Refer to the Policy Specific Documentation Requirements section below.)
5. At the time of in-person delivery to the beneficiary of the items selected, the supplier must conduct an objective assessment of the fit of the shoe and inserts and document the results. A beneficiary's subjective statements regarding fit as the sole documentation of the in-person delivery does not meet this criterion.

If criteria 1-5 are not met, the therapeutic shoes, inserts and/or modifications will be denied as noncovered. When codes are billed without a KX modifier (see Policy Specific Documentation Requirements section below), they will be denied as noncovered.

In order to meet criterion 2, the certifying physician must either:

- i. Personally document one or more of criteria a – f in the medical record of an in-person visit within 6 months prior to delivery of the shoes/inserts and prior to or on the same day as signing the certification statement; or
- ii. Obtain, initial, date (prior to signing the certification statement), and indicate agreement with information from



Statement of Certifying Physician

Patient Name: _____ Gender: Male/Female

Patient Address: _____

Patient DOB: _____ Patient Phone: _____

HIC #: _____ Medicaid #: _____

Secondary Insurance: _____ Policy #: _____ Group#: _____

1.) This patient has diabetes mellitus:

_____ Type II (Dx: E11.9) _____ Type I (Dx: E10.9) _____ Other

2.) Qualifying Conditions: I have diagnosed and am including my notes showing that this patient has one or more of the following:

_____ History of partial or complete amputation of the foot (S98.019-S98.929) _____ RT _____ LT

_____ History of previous foot ulceration (L97.509-L98.499) _____ RT _____ LT

_____ History of pre-ulcerative callus (355.8) _____ RT _____ LT

_____ Peripheral neuropathy with evidence of callus information (G57.90) _____ RT _____ LT

_____ Foot deformity (M20.60-M21.969) _____ RT _____ LT

_____ Poor circulation (I99.8) _____ RT _____ LT

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

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

5.) This patient needs shoe inserts (heat molded or custom fabricated) because of his/her diabetes.

Physicians Signature: _____

Physicians Name Printed: _____

NPI#: _____ Date: _____

Physician's Phone#: _____ Fax #: _____

Address: _____

Medx Medical Equipment

1005 N Kingshighway STE 200 Cape Girardeau, MO 63701

Phone: 573-803-2390 Fax: 573-803-1247



Prescription for Diabetic Shoes and Inserts

Patient: _____

DOB: _____ Patient's Phone #: _____

1.) Type of shoes prescribed (check):

_____ Extra Depth (A5500) – 1 pair, unless otherwise noted

2.) Types of inserts prescribed (check one)

_____ Heat moldable (A5512) – 3 pairs, unless otherwise noted

_____ Custom Fabricated (A5513) – 3 pairs, unless otherwise noted

ICD Notes and/or Special Instructions:

*Note: Chart notes must reflect all of the statements and be within 6 months prior to signing the certifying statement.

Physician's Signature: _____

Physician's Name: _____

NPI#: _____ Date: _____

Physician's Phone: _____

Physician's Address: _____