DOCUMENTATION OVERVIEW

CERTIFYING PHYSICIAN	PRESCRIBING PHYSICIAN	SUPPLIER
Role		
Responsible for diagnosing and treating the beneficiary's diabetic systemic condition through a comprehensive plan of care	Performs foot exam and writes the Prescription/Detailed Written Order for therapeutic shoes and inserts	Furnishes the shoes and/or inserts to the beneficiary and bills Medicare
Who		

• Doctor of Medicine (MD)
• Doctor of Osteopathy (DO)
• *If practicing "Incident to" an MD/DO*
  • Nurse Practitioner (NP)
  • Physician Assistant (PA)
	• Doctor of Medicine (MD)
	• Doctor of Osteopathy (DO)
	• Physician's Assistant (PA)
	• Nurse Practitioner (NP)
	• Clinical Nurse Specialist (CNS)
	• Podiatrist (DPM)
		• Pedorthist (CPED)
		• Orthotist (CO)
		• Prosthetist (CP)
		• Prosthetist/Orthotist (CPO)
		• Other qualified individual

Documentation		
1. Diabetes Management Exam Note • Documents diabetes management through plan of care • Within 6 months of delivery • If completed by NP/PA, MD/DO will also need to sign and acknowledge agreement 2. Statement of Certifying Physician • Within 3 months of delivery of shoes and inserts • If completed by NP/PA, MD/DO will also need to sign and acknowledge agreement	3. Diabetic Foot Exam • If not completed by MD/DO, MD/DO must sign-off and indicate agreement by other PRESCRIBING PHYSICIAN • NP/PA practicing "incident to" can sign acknowledgement but MD/DO must also do so • Within 6 months of delivery 4. Prescription for Therapeutic Shoes and Inserts • Standard Written Order	5. Patient Evaluation and Shoe Selection 6. Proof of Delivery/Warranty/Break In and Care Instructions 7. Medicare Supplier Standards 8. Dispensing Note • a) Prefabricated Heat Moldable Inserts • b) Custom Fabricated Inserts • c) Customs and Toe Filler

*NP/PA (practicing "Incident to") and/or MD/DO can be both the CERTIFYING PHYSICIAN and PRESCRIBING PHYSICIAN

*If the NP/PA is practicing "incident to" a supervising MD/DO, they can sign and author the Diabetes Management Exam Note, Statement of Certifying Physician and/or Diabetic Foot Exam documents; however, the MD/DO will also need to sign those documents

*DPM can be both the PRESCRIBING PHYSICIAN and SUPPLIER, but cannot be the CERTIFYING PHYSICIAN

DOCUMENT PACK SUMMARY

Prior to Dispensing

- ☐ 0. Cover Letter: Fax to MD/DO and/or NP/PA managing the Patient's diabetes.
- ☐ 1. Diabetes Management Exam Note: Must be from MD/DO and/or NP/PA who signs the *Statement of Certifying Physician*. If authored/signed/dated by the NP/PA, the MD/DO must also sign and date.
- ☐ 2. Statement of Certifying Physician: Fax to MD/DO and/or NP/PA. Must be signed by MD/DO and dated after *Diabetic Foot Exam*. If signed by NP/PA, the MD/DO must also sign.
- ☐ 3. Diabetic Foot Exam: May be included in the *Diabetes Management Exam Note* by MD/DO/NP/PA. Otherwise it's performed, signed and dated by MD/DO/NP/PA/CNS/DPM, and then agreed with, signed and dated by the MD/DO who signed the *Statement of Certifying Physician*.
- ☐ 4. Prescription for Therapeutic Shoes and Inserts (Detail Written Order): Written by MD/DO/NP/PA/CNS/DPM. Must be signed and dated by MD/DO/NP/PA/CNS/DPM who performed the *Diabetic Foot Exam* identifying the qualifying conditions.
- ☐ 5. In-Person Evaluation and Shoe Selection: Performed by the Supplier, in-person with the patient, when shoes are selected.

Dispensing Documents

- ☐ 6. Proof of Delivery/Warranty/Break In and Care Instructions: Signed by the patient. Copy given to the patient and the original is saved in the patient's chart.
- ☐ 7. Medicare Supplier Standards: Copy is given to the patient.
- ☐ 8. Dispensing Note: SOAP note written and signed by the qualified fitter delivering the shoes and inserts.

Additional Documents

- ☐ Invoice/Packing slip: Save in patient's chart to show proof of purchase.
- ☐ ABN: When indicated.

General Information	
Date:	

Provider Information	
Full Name:	SOLUTIONS ORTHOCARE GROUP, LLC
Phone Number:	803.781.1269
Fax Number:	877.218.8969

Patient Information	
Full Name:	
MBI:	
Date of Birth:	
Address:	

Primary Care Information	
Full Name:	
NPI:	
Address:	

Order Information	
Shoe Qty: (Pairs)	1
Insert Qty: (Pairs)	3

Submit and Print

Date:

Patient Name:

MBI#:

Dear Dr. ,

Your patient, , recently received a preliminary diabetic foot evaluation which indicated that they have a significant risk of developing diabetes related foot complications and may qualify for footwear and inserts under the Medicare Therapeutic Shoe Bill.

To qualify for Medicare reimbursement, a patient's Primary Care Physician/Practitioner (MD/DO and/or NP/PA) is required to certify that the patient meets one or more of the qualifying conditions listed on the *Statement of Certifying Physician* (included).

To satisfy this requirement, we ask you to please send the patient's most recent *Diabetes Management Exam Notes* (**1**) and complete and return the attached forms (**2 and 3**):

1. Diabetes Management Exam Note (Including Foot Exam)

- Within last 6 months
- Signed and dated by **MD/DO and/or NP/PA**
  - If authored and signed by NP/PA, the supervising MD/DO will also need to sign
- Foot findings must support items checked on the *Statement of Certifying Physician*

2. Statement of Certifying Physician

- Complete, Sign, and Date by **MD/DO and/or NP/PA**
  - If signed by NP/PA, the supervising MD/DO will also need to sign

3. Prescription for Diabetic Shoes and Inserts

- Complete, Sign, and Date

Please fax the completed forms back to us at 877.218.8969 and place a copy of this information in the patient's chart. Your cooperation is very much appreciated. If you have any questions or need additional information, please contact us at –

803.781.1269

Sincerely,

PLEASE FAX TO: 877.218.8969

STATEMENT OF CERTIFYING PHYSICIAN FOR THERAPEUTIC SHOES AND INSERTS

Patient Name:		MBI#:		DOB:	

Please complete this Statement of Certifying Physician for the patient listed above so that we may provide them with therapeutic shoes and inserts.

To qualify for Medicare reimbursement, it is required that the Primary Care Physician certify that the patient meets one or more of the conditions listed below.

I certify that all of the following statements are true:

1. This patient has diabetes mellitus.
   - ☐ Type I ICD-10 Code(s): _____
   - ☐ Type II ICD-10 Code(s): _____
2. This patient has one or more of the following conditions (indicate all that apply):
   - ☐ History of partial or complete amputation of the foot
   - ☐ History of previous foot ulceration
   - ☐ History of pre-ulcerative callus
   - ☐ Peripheral neuropathy with evidence of callus formation
   - ☐ Foot deformity
   - ☐ Poor circulation

   Please make certain these condition(s) are consistent with and supported by clinical findings noted in the patient's Diabetes Management Exam Notes
3. I am treating this patient under a comprehensive plan of care for diabetes.
4. This patient needs special shoes to help prevent complications resulting from diabetes.

Primary Care Signature: (NP/PA and/or MD/DO)		Date:	
Physician Name: (Printed)		NPI:	
Physician Address:			

This form **may only be completed and signed by a NP/PA and/or MD/DO. If completed and signed by NP/PA, the supervising MD/DO will also need to sign in acknowledgement. No stamped signatures permitted.*

Please fax back the completed form along with the exam note from the patient's chart supporting what's noted above. The original should be saved in the patient's chart.

PLEASE FAX TO: 877.218.8969

PRESCRIPTION FOR THERAPEUTIC SHOES AND INSERTS

Patient Name:		MBI#:		DOB:	

Other (Quantity/HCPCS Code):

A5500 2 UNITS DIABETIC SHOES

A5514 6 UNITS CUSTOM DIABETIC ORTHOTICS

Therapeutic Objectives:

☐ Prevent Ulceration and other pedal complications

☐ Distribute weight, balance, and plantar pressure

Duration of Usage: 12 Months

Physician Signature:		Date:	
Physician Name: (Printed)		NPI:	
Physician Address:			

**Please ensure this form is completed only by a DPM, MD, DO, PA, NP or CNS. No stamped signatures permitted.*

IN-PERSON EVALUATION AND SHOE SELECTION

Patient Name:		MBI#:		DOB:	

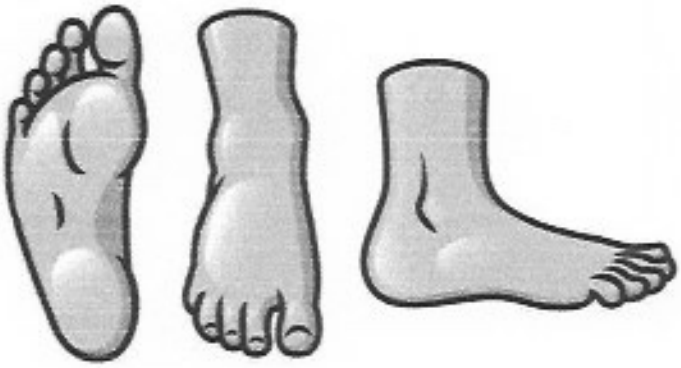
Does the patient have Diabetes? ☐ Yes ☐ No

Does the patient have Medicare as their primary insurance? ☐ Yes ☐ No

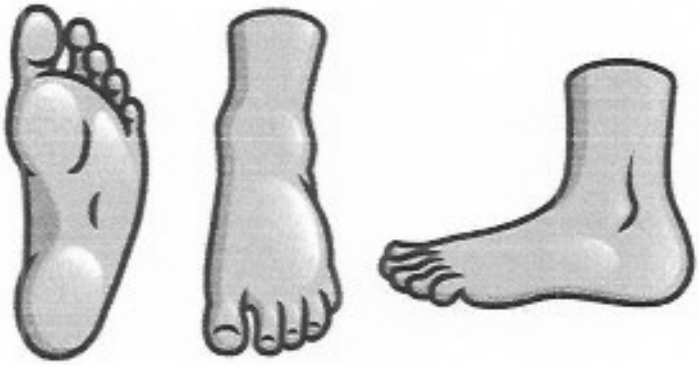
Had the patient received shoes under the Medicare Therapeutic Shoe Program this calendar year? ☐ Yes ☐ No

Assessment

RIGHT FOOT



LEFT FOOT



Note deformities on the images above using the symbol key below:

A: Amputation **B**: Bunions **C**: Callus **H**: Hammer Toes **R**: Redness **S**: Swelling **W**: Wound/Ulcer

Amputation:	☐ Left ☐ Right	Cognitive Awareness:	☐ Normal ☐ Abnormal
Bunions:	☐ Left ☐ Right	Fat Pads:	☐ Normal ☐ Abnormal
Callus:	☐ Left ☐ Right	Foot Color:	☐ Normal ☐ Abnormal
Hammer Toes:	☐ Left ☐ Right	Range of Motion:	☐ Normal ☐ Abnormal
Redness:	☐ Left ☐ Right	Skin Temperature:	☐ Normal ☐ Abnormal
Swelling:	☐ Left ☐ Right	Skin Integrity:	☐ Normal ☐ Abnormal
Wound/Ulcer:	☐ Left ☐ Right		

	Foot Measurements	
	Left	Right
Heel to toe		
Heel to Ball		
Width		

Other (Quantity/HCPCS Code):

A5500 2 UNITS DIABETIC SHOES

A5514 6 UNITS CUSTOM DIABETIC ORTHOTICS

Shoe Fitter Signature:		Shoe Fitter Name: (Printed)		Date:	