Inland Arificial Limb & Brace, Inc.

Your Premier Choice for Prosthetics and Orthotics Services

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:

1. 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.
2. That certifying physician must document that the patient has one or more of the following qualifying conditions:
   a. Foot deformity
   b. Current or previous foot ulceration
   c. Current or previous pre-ulcerative calluses
   d. Previous partial amputation of one or both feet or complete amputation of one foot
   e. Peripheral neuropathy with evidence of callus formation
   f. 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.

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 Therapeutic Shoes for Persons with Diabetes Local Coverage Determination and Policy Article.

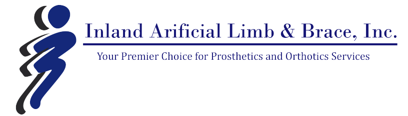
Suppliers may ask you to provide the medical documentation described above on a routine basis in order to assure that Medicare will pay for these items and that your patient will not be held financially liable. Providing this documentation is in compliance with the HIPPA Privacy Rule. No specific authorization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

Wilfred Mamuya, MD, PhD
Medical Director, DME MAC, Jurisdiction A
Noridian Healthcare Solutions

Peter J. Gurk, MD, CPE, CHCQM
Medical Director, DME MAC, Jurisdiction D
Noridian Healthcare Solutions

Physician Notes on Qualifying Condition(s) for Therapeutic Shoes PLEASE FAX TO 951.734-1538 As required by Medicare, save in patient chart.



Patient Name: ______________________ **Date of Birth:** ______________

Treatment Plan

Start Date: ______________ Duration of DM: ______________

Plan of Care

☐ Diet ☐ Meds ☐ Oral ☐ Injection

Diabetes Type: ☐ Type I, Controllled ☐ Type II, Controlled ☐ Type I, Uncontrolled ☐ Type II, Uncontrolled

Name of MD/DO Supervising DM*: ______________________ **Date of Last FBS:** ______________

(Please sign Certifying Physician Acknowledgment below)

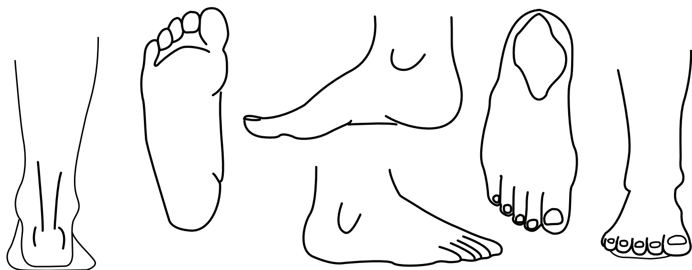
Physical Exam:

Neurological (Use Y or N)

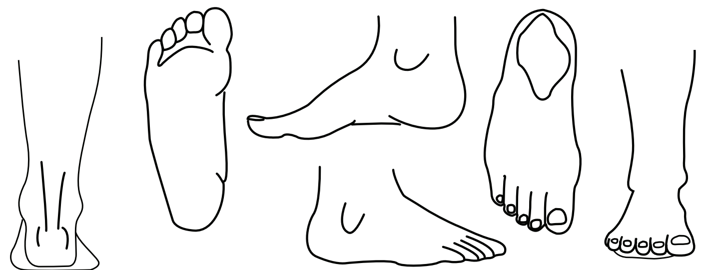
	Right	Left
Loss of Vibration Perception		
Loss of Protective Sensation		

Vascular (Circle appropriate level)

		Right	Left
Dorsalis Pedis	(3 = normal)	0 1 2 3 4	0 1 2 3 4
Posterior Tibial	(3 = normal)	0 1 2 3 4	0 1 2 3 4



Right



Left

Note any calluses, bunions, swelling, redness, deformities or amputations using the symbol key below:

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

*** Certifying Physician Acknowledgment:**

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.

Please fax this back to us with the attached Statement of Certifying Physician for Therapeutic Shoes and Prescription for Therapeutic Shoes and Inserts and keep original in your patient's chart. Thank you.

Physician Signature: ______________________ **Date:** ______________

Physician Name (Printed): ______________________ Physician NPI #: ______________

Note: Shoes must be dispensed within 6 months from when diabetes care discussed by Certifying Physician with patient.

PLEASE FAX TO 951.734-1538

Statement of Certifying Physician for Therapeutic Shoes

PLEASE FAX TO 951.134-1538

Patient Name: ____________________ **HICN:** ____________________

When completing and signing this form, please make certain that the following checked condition(s) are the same as your determined diagnosis indicated on the Physician Notes on Qualifying Condition.

I certify that all of the following are true:

Diabetes Type:

- ☐ Type II, Controlled
- ☐ Type I, Controlled
- ☐ Type II, Uncontrolled
- ☐ Type I, Uncontrolled

Primary diagnosis:

- ☐ Diabetes with neurological manifestations
- ☐ Diabetes with peripheral circulatory disorder
- ☐ Diabetes without neurovascular manifestations and with structural deformity

Foot Deformity

- ☐ Arthropathy associated with neurological disorders
- ☐ Bunion
- ☐ Claw toe
- ☐ Hallux rigidus
- ☐ Hallux valgus
- ☐ Hammer toe
- ☐ Unspecified deformity of ankle and foot, acquired
- ☐ Unspecified acquired deformity of toe

History of partial or complete amputation of the foot

- ☐ Lower limb amputation, foot
- ☐ Lower limb amputation, great toe
- ☐ Lower limb amputation, lesser toe(s)

History of preulcerative callus

- ☐ History of pre-ulcerative callus

History of previous foot ulceration

- ☐ Ulcer of heel and midfoot
- ☐ Ulcer other part of foot

Peripheral neuropathy with evidence of callus formation

- ☐ Neuropathy in diabetes

Poor circulation/PAD

- ☐ Atherosclerosis of the extremities with intermittent claudication
- ☐ Atherosclerosis of the extremities with ulceration
- ☐ Atherosclerosis of the extremities, unspecified
- ☐ Peripheral angiopathy
- ☐ Peripheral vascular disease unspecified

Acknowledgement Statement:

I am managing and 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: ____________________ **Date:** ____________________

Physician Name (Printed): ____________________ Physician NPI #: ____________________

Must be the MD or DO who is actively treating the patient's diabetes.

Physician Address: ____________________ Physician Phone: ____________________

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Note: Shoes must be dispensed within 3 months of date Certifying Statement signed by physician.

PLEASE FAX TO 951.734.1538

Prescription for Therapeutic Shoes and Inserts
PLEASE FAX TO 951.734.1538

Patient Name: ______________________________ **HICN:** ____________ **Date of Birth:** ______________

Prescriber Name: ______________________________ **Prescriber Phone:** ______________________

Quantity (Please check)	**HCPC 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

Primary Diagnosis Code: ____ ____ ____.____ ____

Please confirm that the entered Diagnosis Codes match your charting documentation.

Diabetes, without complications	**Diabetes with neurological manifestations**	**Diabetes with peripheral circulatory disorders**
E11.9 Type II controlled	**E11.40 Type II controlled**	**E11.51 Type II controlled**
E10.9 Type I controlled	**E10.40 Type I controlled**	**E10.51 Type I controlled**
E11.65 Type II uncontrolled	**E11.65 Type II uncontrolled**	**E11.65 Type II uncontrolled**
E10.65 Type I uncontrolled	**E10.65 Type I uncontrolled**	**E10.65 Type I uncontrolled**

Duration of usage: 12 Months

Prescriber Signature: ____ **Date:** ______________

Prescriber Name (Printed): ______________________________ Prescriber NPI #: ________________

Must be the MD, DO or other eligible prescriber who is actively treating patient's diabetes (e.g. PA, Licensed Nurse Practitioner, Clinical Nurse Specialist, DPM)