Required Physician Documentation for Therapeutic Diabetic Footwear

Below is a checklist of required physician documentation for therapeutic diabetic footwear. This information must be obtained by the **Certifying Physician,** which is the **MD** or **DO** managing the patient's diabetes. Medicare does not consider any other medical professional, such as a DPM, as a Certifying Physician.

Please note that signature stamps and date stamps are not accepted by Medicare.

1. **Prescription/CMN for Therapeutic Diabetic Footwear Form** (attached) ☐

   Checklist:

   ☐ All sections of this form must be completed and the form must be signed and dated by the Certifying Physician.

   ☐ This form must be completed in conjunction with a face-to-face physician office visit with the Certifying Physician.

   Please note that the physician office visit must occur within 90 days prior to completing the form and within 6 months of delivery of the therapeutic diabetic footwear.

2. **Medical records from the office visit with the Certifying Physician** ☐

   Checklist:

   ☐ Details on the patient's previous, current, and future diabetic treatment plan.

   ☐ Detailed information about the condition that qualifies the patient for coverage; **specifically documentation supporting each item that is circled on #2 of the Therapeutic Diabetic Footwear Form**.

   Please note that, if applicable, specific details on amputation, deformity, and locations of ulcerations and calluses need to be noted in the medical records.

3. **Annual Comprehensive Diabetes Foot Exam Form** (attached) ☐

   Checklist:

   ☐ Must be signed and dated by the Certifying Physician.

   ☐ *May* include additional signatures of other medical professionals involved in the patient's care plan.

Due to Medicare's strict guidelines on therapeutic diabetic footwear, all the information above must be provided to Bio-Tech Prosthetics & Orthotic before items are dispensed.

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Prescription/CMN for Therapeutic Diabetic Footwear

Patient Name: _____ Date of Birth: _____

Diagnosis (ICD-10 E08 – E13) _____

Date of last OV Diabetes management addressed: _____
Must be within 90 days prior to signing CMN

I certify that all of the following statements are true:

1. This patient has diabetes mellitus.
2. This patient has one or more of the following conditions. **(Circle all that apply)**
   - A.) History of partial or complete amputation of the foot
   - B.) History of previous foot ulceration
   - C.) History of pre-ulcerative callus
   - D.) Peripheral neuropathy with evidence of callus formation
   - E.) Foot deformity
   - F.) Poor circulation
3. I am treating this patient under a comprehensive plan of care for his/her diabetes.
4. This patient needs special shoes (depth or custom-molded shoes) because of his/her diabetes.

Items to be supplied: **(Select all that apply)**

- ☐ A5500 Diabetic depth shoes (2 each) and A5513 Diabetic custom inserts (6 each)
- ☐ A5501 Custom molded shoes (2 each) and A5513 Diabetic custom inserts (4 each)
- ☐ A5503 Diabetic rocker sole shoe modification
- ☐ A5504 Diabetic wedge shoe modification
- ☐ A5507 Diabetic shoe modification other: _____
- ☐ L5000 Partial foot

Physician Signature: _____ Date: _____
Signature must be completed by an M.D. or D.O.

Physician name **(printed):** _____ NPI: _____

Physician address: _____

Date of orthotic in-person evaluation/order start date: _____

Annual Comprehensive Diabetes Foot Exam Form

Patient Name _____ DOB: _____

I. Presence of Diabetes Complications
1. Check all that apply.
- ☐ Peripheral Neuropathy
- ☐ Nephropathy
- ☐ Retinopathy
- ☐ Peripheral Vascular Disease
- ☐ Cardiovascular Disease
- ☐ Amputation *(Specify date, side, and level)*

Current ulcer or history of a foot ulcer? Y___ N___

For Sections II & III, fill in the blanks with "Y" or "N" or with an "R," "L," or "B" for positive findings on the right, left, or both feet.

II. Current History

1. Is there pain in the calf muscles when walking that is relieved by rest? Y___ N___
2. Any change in the foot since the last evaluation? Y ___ N___
3. Any shoe problems? Y___ N___
4. Any blood or discharge on socks or hose? Y___ N___
5. Smoking history? Y___N___
6. Most recent hemoglobin A1c result _____% _____ *date*

III. Foot Exam

1. Skin, Hair, and Nail Condition
   Is the skin thin, fragile, shiny and hairless? Y ___ N___
   Are the nails thick, too long, ingrown, or infected with fungal disease? Y ___ N___

Measure, draw in, and label the patient's skin condition, using the key and the foot diagram below.
C=Callus U=Ulcer PU=Pre-Ulcer
F=Fissure M=Maceration R=Redness
S=Swelling W=Warmth D=Dryness

2. Note Musculoskeletal Deformities
   - ☐ Toe deformities
   - ☐ Bunions (Hallus Valgus)
   - ☐ Charcot foot
   - ☐ Foot drop
   - ☐ Prominent Metatarsal Heads
3. Pedal Pulses Fill in the blanks with a "P" or an "A" to indicate present or absent.
   Posterior tibial Left_____ Right_____
   Dorsalis pedis Left_____ Right_____

4. Sensory Foot Exam *Label sensory level with a "+" in the five circled areas of the foot if the patient can feel the 5.07 (10-gram) Semmes-Weinstein nylon monofilament and "-" if the patient cannot feel the filament.*

Notes

Right Foot

Left Foot

Notes

Label and reproduce for your practice

IV. Risk Categorization *Check appropriate box.*

☐ Low Risk Patient	☐ High Risk Patient
All of the following:	One or more of the following:
☐ Intact protective sensation	☐ Loss of protective sensation
☐ Pedal pulses present	☐ Absent pedal pulses
☐ No deformity	☐ Foot deformity
☐ No prior foot ulcer	☐ History of foot ulcer
☐ No amputation	☐ Prior amputation

V. Footwear Assessment *Indicate yes or no.*
1. Does the patient wear appropriate shoes? Y___ N ___
2. Does the patient need inserts? Y ___ N ___
3. Should corrective footwear be prescribed? Y ___ N ___

VI. Education *Indicate yes or no.*
1. Has the patient had prior foot care education? Y __N__
2. Can the patient demonstrate appropriate foot care? Y__N__
3. Does the patient need smoking cessation counseling? Y__N__
4. Does the patient need education about HbA1c or other diabetes self-care? Y__N__

VII. Management Plan *Check all that apply.*

1. Self-management education:
   Provide patient education for preventive foot care. Date: _____
   Provide or refer for smoking cessation counseling. Date: _____
   Provide patient education about HbA1c or other aspect of self-care. Date: _____
2. Diagnostic studies:
   - ☐ Vascular Laboratory
   - ☐ Hemoglobin A1c (at least twice per year)
   - ☐ Other: _____
3. Footwear recommendations:
   - ☐ None
   - ☐ Athletic shoes
   - ☐ Accommodative inserts
   - ☐ Custom shoes
   - ☐ Depth shoes
4. Refer to:
   - ☐ Primary Care Provider
   - ☐ Diabetes Educator
   - ☐ Podiatrist
   - ☐ RN Foot Specialist
   - ☐ Pedorthist
   - ☐ Orthotist
   - ☐ Endocrinologist
   - ☐ Vascular Surgeon
   - ☐ Foot Surgeon
   - ☐ Rehab. Specialist
   - ☐ Other: _____
5. Follow-up Care:
   Schedule follow-up visit. Date: _____

Certifying Physician Signature _____ (MD or DO only) Date _____

Certifying Physician Name (Printed) _____

Signature of Professional Performing Exam _____ Name (Printed) _____ Date _____

(If not Certifying Physician)