LIFESTYLES
Orthotics & Prosthetics

15418 West Center Road
Omaha, NE 68144
Phone: 402-393-2354
Fax: 402-393-2509

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- ☐ Urgent
- ☐ For Review
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MESSAGE:

1) Please complete, sign & date the Therapeutic Shoe Form (including current ICD-10 code(s) for the patient's specific type of diabetes) attached.
2) Please also include office notes to support the diagnosis (i.e. diabetic foot exam).
****E11.9 (Type 2 diabetes mellitus without complications) IS NOT a qualifying diagnosis and Medicare <u>will not</u> cover the diabetic footwear/**

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Medicare Requirement for Physician Medical Documentation

Certifying Physician Documentation "Cheat Sheet" for Diabetic Therapeutic Footwear

Step 1- Starting prescription/referral to include:

- Description of item; i.e. "Diabetic shoes and inserts/modifications"
- Patient's full name
- Prescribing MD name (can be DPM, DO, NP, or PA if within scope of practice)
- Handwritten signature and date or electronic in EMR -- NO STAMPS

Step 2- Certifying Physician Medical Records

- MUST INCLUDE AND SPECIFY:
  - Patient has diabetes mellitus (**WITH** complications- ICD-10 E11.9 DOES NOT qualify) **AND**
  - Patient has one of the following:
    - Previous amputation of the other foot, or part of either foot, **OR**
    - History of previous foot ulceration of either foot, **OR**
    - History of pre-ulcerative callus on either foot, **OR**
    - Peripheral neuropathy with evidence of callus formation of either foot, **OR**
    - Foot deformity of either foot,
    - **AND** state that he/she is treating the patient under a comprehensive plan of care for his/her diabetes, **AND** specifically state that the "Patient NEEDS DIABETIC SHOES".

Suggested Sample Note:
"Patient has diabetes mellitus, and I am treating the patient in a comprehensive diabetes care plan. This patient requires special diabetic footwear with appropriate inserts/modifications due to (any one or combination of conditions listed above)."

Step 3- Lifestyles Orthotics & Prosthetics will provide a Detailed Written Order for your signature along with the Medicare required "Statement of Certifying Physician for Therapeutic Footwear". These documents include all CMS required information, including our narrative evaluation and plan. However, the documentation MUST be corroborated in your medical record/patient file.

Prior to providing ANY services OR devices to Medicare patients, Lifestyles Orthotics & Prosthetics **MUST RECEIVE ALL OF THE FOLLOWING**:

1. **Initial prescription/referral** for "Diabetic shoes/inserts"
2. Signed and dated copy of the **Physician Medical Record** which specifically includes the medical necessity identified in Step 2 above.
3. Signed and dated **Detailed Written Order**
4. Signed and dated **Statement of Certifying Physician For Therapeutic Footwear**

All records MUST have an original signature and date or meet electronic signature guidelines. We cannot accept ANY stamped prescriptions.

Thank you for your assistance.

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DIABETIC FOOTWEAR PRESCRIPTION FORM

NOTE: FOR COVERAGE BY MEDICARE UNDER THE THERAPEUTIC SHOES FOR DIABETICS PROGRAM, THIS PRESCRIPTION MUST BE ACCOMPANIED BY A SIGNED STATEMENT OF CERTIFYING PHYSICIAN (SCP). **THE SCP MUST BE SIGNED BY THE M.D. OR D.O. MANAGING THE PATIENT'S SYSTEMIC DIABETIC CONDITION.**
PLEASE NOTE: THIS FORM IS NOT COMPLETE UNTIL ICD-10 CODES HAVE BEEN ADDED TO CHECKED BOXES

Patient's Name: _____ Date of Birth:_____

Diabetic DX ICD-10 Code(s):_____

Start Date:_____ **(REQUIRED)**

Patient must have ONE of the following:
(CHECK ALL THAT APPLY- ICD-10 REQUIRED)

- ☐ Amputation of toes(s)
- ☐ Amputation of foot
- ☐ Ulcer of heel and midfoot
- ☐ Ulcer other part of foot, toes
- ☐ History of pre-ulcerative callus
- ☐ Hallux valgus, acquired
- ☐ Charcot Arthropathy
- ☐ Hallux rigidus
- ☐ Deformity of toe(s), acquired
- ☐ Claw toe, acquired
- ☐ Deformity of ankle and foot, acquired
- ☐ Hammer toe, acquired
- ☐ Polyneuropathy in diabetes AND history of pre-ulcerative callus ***Polyneuropathy alone does not meet criteria***

Covered Shoes, Inserts, and Modification

(Check all items you are prescribing for this patient)

- ☐ SHOES, Extra Depth, Custom Made (A5501) AND 2 pairs of custom fabricated inserts (A5513)
- ☐ SHOES, Extra Depth, Off-The-Shelf (A5500) - must include inserts - indicate inserts below

- ☐ INSERT, Prefabricated, Heat-Moldable (A5512)
- ☐ INSERT, Custom Fabricated (A5513)
- ☐ INSERT, Custom Partial Foot Toe Filler (L5000) please select which foot ☐ Left ☐ Right

*Prefabricated inserts have an average life of 4 months. For 12 months of protection, the patient should receive no less than 3 pairs of prefabricated inserts per year. Medicare allows up to 3 pairs of inserts per year.

Modifications to a shoe listed below must be a substitute for an insert

- ☐ Rigid Rocker Bottom Sole (A5503)
- ☐ Wedge, Sole, and/or Heel (A5504)
- ☐ Metatarsal Bar (A5505)
- ☐ Off-Set Heel(s) (A5506)
- ☐ Other (medial/lateral stabilizer, flare, etc) (A5507)

PRESCRIBING PHYSICIAN INFORMATION:

_____ _____
Physician Signature **Date**

_____

_____

_____ _____
Physician Name, Address & Phone Number (Printed Only) **Physician NPI#**

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STATEMENT OF CERTIFYING PHYSICIAN FOR THERAPEUTIC FOOTWEAR

NOTE: FOR COVERAGE BY MEDICARE UNDER THE THERAPEUTIC SHOES FOR DIABETICS PROGRAM, THIS DOCUMENT **MUST** BE SIGNED BY THE M.D. OR D.O. MANAGING THE PATIENT'S SYSTEMIC DIABETIC CONDITION AND THE STATEMENTS DOCUMENTED BELOW MUST BE DOCUMENTED IN THE PATIENT'S MEDICAL RECORD- WHICH WE MUST ALSO RECEIVE A COPY OF TO VERIFY THE ITEMS BELOW.
PLEASE NOTE: THIS FORM IS NOT COMPLETE UNLESS ICD-10 CODES HAVE BEEN ADDED TO CHECK BOXED

Patient's Name:_____ Date of Birth:_____

I certify that **ALL** of the following statements are true:

1. This patient has diabetes mellitus, ICD-10 Code(s):_____
2. This patient has one or more of the following conditions: (check all that apply)
   a. History of partial or complete amputation of the foot
      □ Amputation of toe(s)
      □ Amputation of foot
   b. History of previous foot ulceration
      □ Ulcer of heel and midfoot
      □ Ulcer of other part of foot, toes
   c. History of pre-ulcerative callus
      □ History of pre-ulcerative callus
   d. Peripheral neuropathy with evidence of callus formation
      □ Polyneuropathy in diabetes AND history of pre-ulcerative callus
      (Polyneuropathy alone does not meet criteria)
   e. Foot deformity
      □ Claw toe, acquired
      □ Hammer toe, acquired
      □ Deformity of toe(s), acquired
      □ Deformity of ankle and foot, acquired
      □ Charcot Arthropathy
      □ Hallux valgus, acquired
      □ Hallux rigidus
3. I am treating this patient under a comprehensive plan of care for his/her diabetes.
4. This patient needs special shoes (extra depth or custom-molded shoes) and/or inserts because of his/her diabetes.
5. With diabetic footwear, the patient's prognosis is _____.
6. The above information is documented in the patient's medical record, **as indicated in the attached addendum to clinical notes.**

PRESCRIBING PHYSICIAN INFORMATION:

_____ _____
Physician Signature **Date**

_____

_____

_____ _____
Physician Name, Address & Phone Number (Printed Only) **Physician NPI#**