

DME MAC Jurisdiction A

Therapeutic Shoes for Diabetics - Physician Documentation Requirements

Posted November 11, 2010 ([SPE](#))

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:

- 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.
- That certifying physician must document that the patient has one or more of the following qualifying conditions:
 - Foot deformity
 - Current or previous foot ulceration
 - Current or previous pre-ulcerative calluses
 - Previous partial amputation of one or both feet or complete amputation of one foot
 - Peripheral neuropathy with evidence of callus formation
 - 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.
4. **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 Local Coverage Determination and Policy Article titled *Therapeutic Shoes for Persons with Diabetes* on the NHIC Web site at <http://www.medicarenhic.com> viewed in the local coverage section of the Medicare Coverage Database at <http://www.cms.hhs.gov/mcd/search.asp>

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 HIPAA 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,

Paul J. Hughes, MD
NHIC DME MAC Jurisdiction A
Medical Director
75 William B. Terry Drive
Hingham, MA 02043



Simple Instructions for Receiving Therapeutic Footwear for Diabetics with your Medicare Insurance

Your shoes are important to your health. We are prepared to help you protect your feet from developing complications of foot problems and/or ulceration commonly associated with diabetes by providing you with fitted, diabetic footwear. In 2011, Medicare rules changed for receiving your benefit. Now, you must have four signed documents before we can expedite the process of your new shoes and inserts. You may either take this envelope to your physician(s) or direct them to www.bostonpedorthic.com/diabetes for the same information.

REQUIRED PAPERWORK

- Office visit note with your Certifying Physician (within six months)**

- Office visit note that details your qualifying complication**
 - Please see the attached MEDICARE LETTER TO PHYSICIANS
 - Qualifying complications include amputation, previous foot ulceration, pre-ulcerative callus, peripheral neuropathy with calluses, foot deformity, and/or poor circulation
 - This note can come from your primary care physician, or your podiatrist.
 - If your podiatrist generates the note, **then your certifying physician must sign it.**

- Prescription (sample attached)**
 - Your prescription may be written on the Doctor's pad or you may use the attached Prescription Form. It may be completed by either your MD or your podiatrist (DPM). **Please note that your prescription will expire after 90 days**

- Statement of Certifying Physician (SCP attached)** (signed by an MD or DO)
 - Take the attached Statement of Certifying Physician to the physician who is managing your diabetes (either a Medical Doctor, MD, or Doctor of Osteopathy, DO). Ask him/her to complete the SCP form in its entirety

617-787-8779

When you have all of your paperwork, call ahead for an appointment
.Boston Pedorthic. Reservoir Towers. 1929 Commonwealth Avenue, Brighton MA 02135

PRESCRIPTION FORM

Therapeutic Shoes for Persons with Diabetes and Complications (TSD)

Patient Name: _____ DOB _____

Dx	Rx
<p>1. Diagnosis: _____</p> <p>2. Secondary diagnosis, complication to Diabetes:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Lower limb amputation, foot (V49.73 & 755.38) <input type="checkbox"/> Lower limb amputation, great toe (V49.71 & 755.39) <input type="checkbox"/> Lower limb amputation, lesser toe(s) (V49.72 & 755.39) <input type="checkbox"/> Ulcer of heel and midfoot (707.14) <input type="checkbox"/> Ulcer other part of foot (707.15) <input type="checkbox"/> History of pre-ulcerative callus (707.9) <input type="checkbox"/> Polyneuropathy in diabetes (357.2) <u>and</u> History of pre-ulcerative callus (707.9) BOTH MUST BE DOCUMENTED <input type="checkbox"/> Claw toe (735.5) <input type="checkbox"/> Hammer toe (735.4) Other _____ <input type="checkbox"/> Hallux valgus (735.0) <input type="checkbox"/> Hallux rigidus (735.2) <input type="checkbox"/> Unspecified acquired deformity of toe (735.9) <input type="checkbox"/> Unspecified deformity of ankle and foot, acquired (736.70) <input type="checkbox"/> Charcot Arthropathy (713.5) <input type="checkbox"/> Atherosclerosis of the extremities, unspecified (440.20) <input type="checkbox"/> Atherosclerosis of the extremities with intermittent claudication (440.21) <input type="checkbox"/> Atherosclerosis of the extremities with ulceration (440.23) Peripheral vascular disease, unspecified (443.9) <input type="checkbox"/> Other (Specify): _____ _____ <p>3. Enclose detail substantiating the complication to diabetes (tests exams, inspections, findings, etc. that were used to come to the conclusion that the condition exists)</p>	<p>4. Prescription</p> <ul style="list-style-type: none"> <input type="checkbox"/> Depth Shoes (A5500) <ul style="list-style-type: none"> <input type="checkbox"/> Custom Molded Inserts (A5513) <input type="checkbox"/> Prefabricated, Heat Molded Inserts (A5512) <input type="checkbox"/> Custom Molded Shoes (A5501) & Custom Molded Inserts (A5513) <input type="checkbox"/> Custom Toe Filler (L5000) (Left Right) Qty of units per foot (circle one) : 3 2 1 <p><u>Modifications (may not be a covered benefit)</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Rigid Rocker Bottom Sole/Bar (A5503) <input type="checkbox"/> Sole/Heel Wedge) (A5504) <input type="checkbox"/> Metatarsal Bar (A5505) <input type="checkbox"/> Other Modifications (Medial Stabilizers, Lateral Stabilizers, etc.) (A5507) <p>_____ _____ _____</p>

Please fax Dx, Detail & Rx to (270) 747-8779

PRESCRIBING PHYSICIAN INFORMATION:

Physician Name (printed) _____

Physician Address _____

Physician Signature _____ Date _____

Physician NPI # _____

Physician Phone # _____

PATIENTS: PLEASE CALL AHEAD FOR AN APPOINTMENT 617-787-8779

Boston Pedorthic. 1929 Commonwealth Avenue, Brighton MA 02135. Tel 617-787-8779. Fax 270-747-8779

Statement of Certifying Physician (SCP) for Therapeutic Shoes

This document must be signed by the M.D. or D.O. managing the patient's systemic diabetic condition

Patient Name: _____ Patient Telephone: _____ Patient Date of Birth: _____

I certify that all of the following are true:

1. This is a patient with diabetes mellitus **ICD-9 Code:** _____ (ICD-9 diagnosis codes 249.00-250.93)

2. This patient has one or more of the following conditions: (**check 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

3. Detail about the above conditions is contained in attached clinical notes that I have prepared or that another clinician as prepared and I have reviewed, and signed and dated **upon the document**, indicating my agreement. **<PLEASE FAX OR MAIL>**

4. I have seen this patient within the last six months, as shown in a copy of notes of their visit. **<PLEASE FAX OR MAIL>**

5. I am treating this patient under a comprehensive plan of care for his or her diabetes.

6. This patient needs special shoes (depth or custom-molded shoes) and/or inserts because of his/her diabetes.

Certifying Physician Information

Physician Name (Printed) MD or DO (circle one) Physician Signature _____ Date _____ 2011

Physician Address Physician NPI # _____

Physician Phone # _____

Questions: Call (617) 787-8779 • Fax (270) 747-8779 • info@bostonpedorthic.com

Reservoir Towers, 1929 Commonwealth Avenue, Brighton, MA 02135

PATIENTS: PLEASE CALL AHEAD FOR AN APPOINTMENT

Please fax or mail 1) this completed form, 2) detail about complications to diabetes, 3) last visit notes to Boston Pedorthic or to your patient