GUIDELINE FOR CLINICAL NOTES

Dear Certifying Physician,

Thank you for helping this patient to receive Diabetic Footwear. Medicare has required for years for you to fill out and submit the Statement of Certifying Physician. However, in June of 2010, Medicare increased the amount of paperwork they require from you.

Now, we must have clinical notes from you that support the four major portions of the Statement of Certifying Physician. If the clinical notes do not support the Statement of Certifying Physician then the statement is rendered void.

CLINICAL NOTES GUIDELINES:

1. Must **explicitly** certify that the patient has diabetes and assign a 5 digit ICD-10 tests, exams, findings **must** be in the notes (i.e. blood glucose levels and AI c).

. Results of

- Must explicitly state: "I am treating the patient under a comprehensive plan of care for diabetes." The
 doctor must use that exact phrase. The doctor should elaborate other portions of the plan of care (i.e.
 medicine, nutrition, education, and other specialists).
- Must explicitly state: "The patient would benefit from diabetic footwear to protect their feet." The
 doctor must use this exact phrase.
- 4. Must explicitly document a foot exam and one or more of the required conditions. This includes details of tests, exams, inspections, findings, etc that were used to come to the conclusion that the condition exists. You may rely on findings of other doctors (i.e. foot doctor), but must explicitly site them and sign off on them.
 - Lower limb amputation, foot
 - Lower limb amputation, great toe
 - Lower limb amputation, lesser toe
 - Ulcer of heel and mid-foot
 - Ulcer of other part of foot
 - History of pre-ulcerative callus
 - Polyneuropathy in diabetes
 documented*

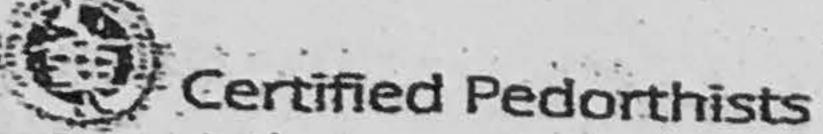
and History of pre-ulcerative callus

*Both must be

- Claw toe
- Hammer Toe
- Hallux valgus
- Hallux rigidus
- Unspecified acquired deformity of toe
- Unspecified acquired deformity of ankle and foot
- Charcot Arthropathy
- Atherosclerosis of the extremities, unspecified
- Atherosclerosis of the extremities with intermittent claudication
- Atherosclerosis of the extremities with ulceration
- Peripheral vascular disease, unspecified

We know these requirements place a burden on you and your staff. Our Industry groups are lobbying Medicare to remove this ruling and we will inform all doctors when/if we are successful. In the meantime, please know that these efforts will ensure your patient gets the footwear that they need covered by Medicare. Thank you for your cooperation and assistance.





Statement of Certifying Physician for Therapeutic Shoes

ICD 10:	t Name:	Birthdate: / /	
certify	fy that all of the following statements are true:		
1. Thi	is patient has diabetes mellitus.		
2. Thi	is patient has one or more of the following conditions. (Circl	le 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.			
1. This	is patient needs special shoes (depth or custom-molded shoe	es) because of his/her diabetes.	
hysicia	ian signature:		
)ate Si	igned:		
hysicia	ian name (printed - MUST BE AN M.D. OR D.O.):		
hysicia	ian address:		
hysicia	an NPI:		

Prescription for Therapeutic Footwear

This section to be completed by MD, DO or DPM.

Items must be fitted within three months of physician's signature or this Rx will be considered VOID.

Rx -	Please dispense the following (Check one only):	
	One Pair of Extra Depth Diabetic Shoes / Three Pairs of Diabetic Inlays	
	One Pair of Extra Depth Diabetic Shoes / Three Pairs of Custom Molded Inlays	
	One Pair of Custom Molded Diabetic Shoes / Two Extra Pairs of Custom Molded Inlays	
	Amputation Toe Filler/Foot Filler Right Left	
Other	lease explain)	
	n of use: 12 months. ICD-10 CODE to justify the need for the items being	
prescri		
	CIAN SIGNATURE Must be MD, DO or DPM. Original signature only. No signature star	mp.
Signat	reDate	
	PhysicianName	
	PracticeName	
Street		
City	StateState	
ZIP		
Phon	Fax #	
NPI#		

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