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 . Results of tests, exams, findings **must** be in the notes (i.e. blood glucose levels and Al c).
2. 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).
3. 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 and History of pre-ulcerative callus ***Both must be documented***
- 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.

Walk Well
PROFESSIONAL SHOE FITTERS
Certified Pedorthists
413 Springfield Avenue, Summit, NJ 07901
908.273.7979

Statement of Certifying Physician for Therapeutic Shoes

Patient Name:_____ **Birthdate: / /**

ICD 10: _____

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.

Physician signature: _____

Date Signed:_____

Physician name (printed - **MUST BE AN M.D. OR D.O.**):

_____

Physician address:

_____

_____

_____

Physician NPI: _____

Walk Well Shoes Fax number: 908 273-7617

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 Custom Molded Diabetic Shoes / Two Extra Pairs of Custom Molded Inlays
__ Amputation Toe Filler/Foot Filler Right___ Left_____
Other Please explain)_____
Duration of use: 12 months. ICD-10 CODE to justify the need for the items being prescribed._____
PHYSICIAN SIGNATURE Must be MD, DO or DPM. Original signature only. No signature stamp.

Signature_____Date _____

PhysicianName_____
PracticeName_____
Street_____
City_____ State_____
ZIP_____
Phone # Fax #
NPI#_____

Walkwell Shoes, 413 Springfiled Ave., Summit, NJ | *phone* **908.273.7979** | *fax* **908.273.7617**

Certified Pedorthic Facility & Professional Orthotics
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