Walk Well
PROFESSIONAL SHOE FITTERS
Certified Pedorthists
413 Springfield Avenue, Summit, NJ 07901
908.273.7979
Fax: 866-321-4579

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 PATIENTS SYSTEMIC DIABETIC CONDITION.*

Patient Name: _____

Covered Procedures:

- **o DEPTH SHOES (A5500)- indicate inserts below**
- **o Customized Inserts (heat molded pre-fab. Average life is 4 months each pair*)**
  (A5512) # of pair(s) 3 2 1 (Medicare allows up to 3 pair*)
- **o Custom Manufactured Inserts (Custom made from mold of the patients foot)**
  (A5513) # of pair(s) 3 2 1 (Medicare allows up to 3 pair. Average life 4 months)
- o **Custom Toe Filler (L5000) (Please circle Left or Right)**
- o **Custom Molded Shoes (A5501) and a total of 3 pairs of custom inserts (A5513)**
- o **Rigid Rocker Bottom Sole or Bar (A5503)**
- o **Sole/Heel Wedge (please circle one) (A5504)**
- o **Metatarsal Bar (A5505)**
- o **Other modifications (Medial Stabilizers, Lateral Stabilizers, etc.) (A5507)**

Dx ICD-9 Code _____

"Medicare allows up to 3 pair per annum of either Prefab or Custom inserts. THE AVERAGE DIABETIC INSERT LASTS ABOUT 4 Months. For 12 months protection, patients should receive no less than 3 pair of inserts per year, regardless of other items the patient may need. Medicare will not pay for extra items, they are the financial responsibility of the patient.

Rx Instructions _____

Prescribing Physician Information:
Physician Name (Printed) _____ _____
Address _____ _____
City: _____ State: _____ Zip: _____
Phone: Fax: _____
Physician NPI #: _____

Signature: _____ Date: _____

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Statement of Certifying Physician for Therapeutic Footwear

(The certifying physician must be the MD or DO caring for the patient's diabetic condition)

Patient Name:_____ Medicare #:_____

Address:_____ Phone:_____

City:_____ State:_____ Zip:_____

I certify that all of the following statements are true:

1) This patient has diabetes mellitus (ICD- Code): _____ (250.00-250.91)
2) This Patient has one or more of the following conditions (Check all that apply):
   - ___ History of partial or complete foot amputation
   - ___ History of pre-ulcerative callous
   - ___ Peripheral neuropathy with callous formation
   - ___ Foot deformity
   - ___ Poor Circulation
   - ___ Previous ulcer(s)
3) I am treating this patient under a comprehensive plan of care for his/her diabetes.
4) This patient needs special shoes and/or inserts because of their diabetic condition.

Certifying Physician information:

Name (Printed):_____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

NPI#:_____

By signing this form I agree that I have performed an in person evaluation of this patient within the last 6 months, and there is documentation in the patient's medical records indicating my management of the patient's diabetes, and that documentation of one or more of the conditions listed under item #2 is present in those records.
(Please include applicable clinical notes)

Signed:_____ Date:_____

This form must be accompanied by a detailed doctor's order. (Prescription)

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- 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.