# DIABETIC FOOTWEAR PRESCRIPTION FORM

Patient:_____ DOB: _____

Date of Order: _____ HICN: _____

| Quantity: (please check) | HCPCS Code: | Description: |
|---|---|---|
| ☐ 1 Pair | A5500 | Diabetic Depth Shoes, pair |
| ☐ 3 Pair | A5512 | Prefabricated inserts pairs-multiple density, direct formed, molded to foot with external heat source (i.e. heat gun). Medicare allows three pairs of inserts per year. |
| | OR | |
| ☐ 3 Pair | A5514 | Custom-molded inserts – multiple, density, molded to model of the patient's foot. Medicare allows up to three pairs of inserts per year. |

☐ 1 Left Partial Foot Filler (L5000)

☐ 1 Right Partial Foot Filler (L5000)

☐ 3 Right Custom Inserts

☐ 3 Left Custom Inserts

**Primary ICD-10 Diagnosis Code:** _____

(According to "Physician Notes on Qualifying Condition(s)")

Please confirm that the entered Diagnosis Code matches your charting documentation.

Duration of usage: 12 Months

Prescriber Signature: X_____ Date: _____

Prescriber Name: (printed) _____ NPI _____

# STATEMENT OF CERTIFYING PHYSICIAN
# for Therapeutic Shoes

Documentation must be in your records to indicate that **you are managing the patient's diabetes** and that **one of the conditions listed below is present.** If requested by the supplier, you must provide copies of those records.

Patient: _____ DOB: _____

HICN:

**1** This patient has diabetes mellitus: ☐ Type II ☐ Type I

(Diabetes ICD-10 Codes: E08.00 - E13.9)

**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

☐ b. History of previous foot ulceration

☐ c. History of pre-ulcerative callus

☐ d. Peripheral neuropathy with evidence of callus formation

☐ e. Foot deformity (can include: thickened and hard to trim toenails, ingrown toenails, corns, calluses, bunions, deformed or hammered toes)

☐ f. Poor circulation

**3** Not only am I treating this patient under a comprehensive plan of care for Diabetes, but I also recently saw this patient in-person on ____ / ____ /_____. Their staged diagnosis has been personally documented by me in their file.

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

**5** The above information is documented in the patient's medical record, **as indicated in the attached clinical notes**.

Physician or NP Signature **X** _____ Date: _____

Physician Name: _____ NPI #: _____

Physician Address: _____

_____

## PHYSICIAN NOTES ON QUALIFYING CONDITION(S) FOR THERAPEUTIC SHOES

Patient Name: _____ HICN: _____

Date of Exam: _____

### 1 Diabetes Type:

☐ Type I, Controlled **(1)** ☐ Type II, Controlled **(0)** ☐ Type I, Uncontrolled **(3)** ☐ Type II, Uncontrolled **(2)**

### 2 Diabetes Management (Required supporting discussion of diabetes management)

**Plan of Care:** ☐ Diet ☐ Oral Meds ☐ Injection ☐ Pump

**Treatment Plan:**

Start Date: _____ Duration of DM: _____ Date of Last FBS: _____

### 3 Physical Exam:

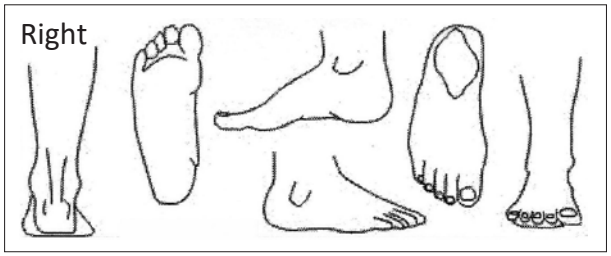
| **Neurological** (use Y / N) | **Right** | **Left** |
|---|---|---|
| Loss of Vibration Perception | | |
| Loss of Protective Sensation | | |

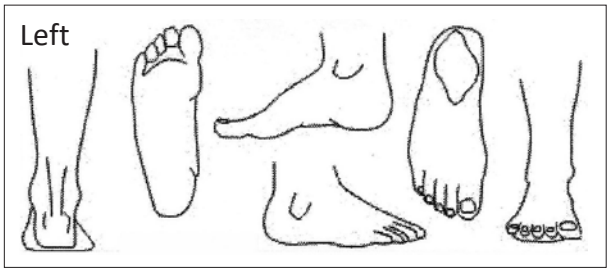
| **Vascular** (circle appropriate level) | **Right** | **Left** |
|---|---|---|
| Dorsalis Pedis (3 = normal) | 0 1 2 3 4 | 0 1 2 3 4 |
| Posterior Tibial (3 = normal) | 0 1 2 3 4 | 0 1 2 3 4 |

### 4 Physical Exam Part 2: Please refer to the findings when noting secondary risk factor(s) on "Statement of Certifying Physician"

**Please Indicate** any calluses, bunions, swelling, redness, deformities, amputation or wounds using the symbol key below:

Callus **C** Bunion **B** Swelling **S** Redness **R**
Deformity **D** Hammer/Claw Toe **HC**
Amputation **A** History of Pre-Ulcer Callus **HPC**
Wound **W** History of Previous Ulceration **HU**




### 5 Diagnosis Code: _____ . _____

### 6 Certifying Physician Acknowledgment*

I am the MD/DO/NP supervising the patient under a comprehensive plan of care for Diabetes Mellitus. I have personally conducted this foot examination **or have authorized an eligible prescriber to conduct this exam on my behalf and agree with the findings**. I have incorporated this exam as part of my medical records. Part of the comprehensive plan of care for this patient includes therapeutic shoes and inserts.

Physician/NP Signature: **X** _____ Date: _____

Physician Name (Printed): _____ Physician NPI #: _____

**FOR MD/DO/NP USE FOR FOOT EXAM IF NEEDED**

# IMPORTANT NOTE:

**In order for this form to be valid, it must be accompanied by DETAILED CLINICAL NOTES regarding the above indicated foot conditions!**

## GUIDELINE FOR CLINICAL NOTES

**Thank you for helping our mutual patient receive Diabetic Footwear. Medicare has for years required you to fill out and submit the Statement of Certifying Physician (SCP). However, over the last few years Medicare has increased the paperwork requirements on suppliers and referring physicians.**

**WE MUST HAVE RECENT CLINICAL NOTES (WITHIN SIX MONTHS OF THE DATE YOU SIGN THE SCP) 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, THE STATEMENT IS RENDERED VOID.**

***YOU MAY SUBSTITUTE CHART NOTES FROM THE PATIENT'S PODIATRIST, BUT YOU MUST SIGN, DATE AND INDICATE AGREEMENT WITH THEIR FINDINGS.***

## *CLINICAL NOTES GUIDELINES*:

**1. Must explicitly certify that the patient has diabetes and assign an applicable ICD-10 code. Results of tests, exams, findings must be in the notes (i.e. blood glucose levels and A1c).**
**2. Must explicitly document a foot exam and one or more of the required conditions.**

**THIS INCLUDES THE DETAILS OF TESTS, EXAMS, INSPECTIONS, FINDINGS, ETC. THAT WERE USED TO CONCLUDE THE CONDITION EXISTS.**

**You may rely on findings of other doctors, such as the patient's Podiatrist, but you must sign, date and make a note on their document indicating your agreement with their findings and then send that document along with the Statement of Certifying Physician that you have also completed, signed and dated.**

**If you are noting a particular problem, such as a foot deformity, please specify which foot and the type and location of the problem (e.g. Patient has bilateral hammer toes #2-#5).**
**The following are commonly found foot conditions that place a diabetic patient at increased risk and thus qualify them to receive therapeutic footwear through Medicare and other payers:**

**Lower limb amputation, toes, foot or limb**
**Ulcer of foot**
**History of pre-ulcerative callus – specify location of callus**
**Polyneuropathy in diabetes and History of pre-ulcerative callus**
**Claw toe**
**Hammer toe**
**Hallux valgus and/or Bunion**
**Hallux rigidus Deformity of toe or foot**
**Charcot Arthropathy**
**Atherosclerosis of the extremities**