*Please fax this back, with attached "Physician Notes on Qualifying Conditions" and "Prescription for Therapeutic Shoes".*
**Please fax to Leverage O&P at 970.797.1865** *Keep original in your patient's chart.*

# Statement of Certifying Physician for Therapeutic Shoes

* Ensure that physical exam includes a qualifying risk factor.
* Ensure that if neuropathy is indicated as qualifying condition that physical exam also determines there to be callus present.
* Ensure that the condition notes are consistent with clinical findings noted on physical exam.
* Ensure that the physician has signed and dated form. Stamps are not allowed.
* Ensure that the form is not completed by a NP or PA.
* Ensure that the note is dated no more than 90 days prior to when shoes will be dispensed.

**Patient:** _____ **HICN:** _____ **DOB:** ____/____/____
*Supplier can enter* *Supplier can enter* *Supplier can enter*

Please indicate all risk factors for diabetic foot ulcerations.

***When completing and signing this form, please make certain that the following checked condition(s) are the same as you indicated on the Physician Notes on Qualifying Condition(s).***

I certify that all the following statements are true:

1. The patient has diabetes mellitus.
2. This patient has one or more of the following conditions (indicate all that apply):
   - ☐ Foot deformity
   - ☐ History of partial or complete amputation of the foot
   - ☐ History of preulcerative callus
   - ☐ History of previous foot ulceration
   - ☐ Peripheral neuropathy with evidence of callus formation
   - ☐ Poor circulation/PAD

***Acknowledgment Statement***

I am treating this patient's diabetes under a comprehensive plan of care. This patient requires diabetic shoes and heat-molded or custom-moded inserts to help prevent ulcers and further complications.

**Physician Signature:** _____ **Date:** _____
*(stamped signature not allowable)* *Stamped date not allowable. Shoes must be dispensed not more than 90 days from when dated.*

**Physician Name (printed):** _____ **Physician NPI #:** _____
*NP, PA not permitted*

**Physician Address:** _____ **Physician Phone #:** _____

_____

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# Physician Notes on Qualifying Condition(s) for Therapeutic Shoes

*** Please complete ALL steps as indicated.** *** As required by Medicare, save in patient's chart.**

**Patient:** _____ **HICN:** _____ **Date of Evaluation:** ____/____/____
*Supplier can enter* *Supplier can enter* *Supplier can enter*

**Diabetes Management:** *(Required to support discussion of diabetes management.)*

**Plan of Care:** ☐ Diet ☐ Oral Meds ☐ Injection ☐ Pump Treatment Plan Start Date: ____/____/____

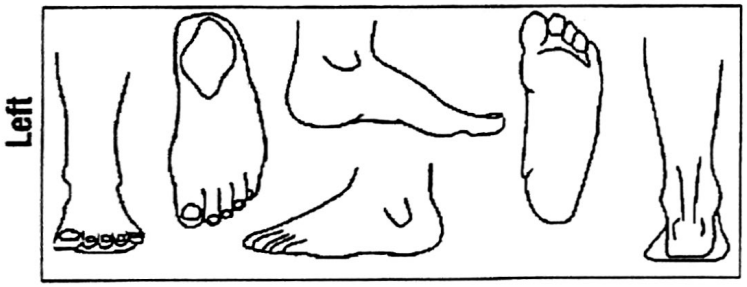
Duration of DM: _____ Date of last FBS: ____/____/____

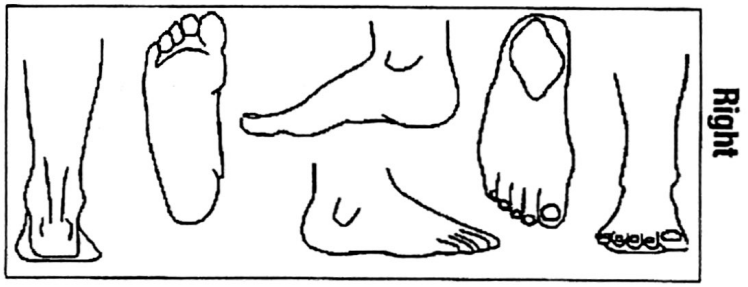
**Physical Exam** - Please refer to the findings when noting secondary risk factor(s) on "Statement of Certifying Physician".

**Diagnosis Code** - Coding Tip: Please refer to this exam when completing "Statement of Certifying Physician".

| Vascular | Right | Left |
|---|---|---|
| Dorsalis Pedis | ☐ normal ☐ diminished | ☐ normal ☐ diminished |
| Posterior Tibial | ☐ normal ☐ diminished | ☐ normal ☐ diminished |
| Capillary Refill Time | ☐ < 3 sec ☐ > 3 sec | ☐ < 3 sec ☐ > 3 sec |
| Edema Present | ☐ yes ☐ no | ☐ yes ☐ no |
| Other | | |

| Neurological (LOPS) | Right | Left |
|---|---|---|
| Vibration perception (tuning fork) | ☐ normal ☐ diminished | ☐ normal ☐ diminished |
| Loss of Protective Sensation (LOPS) | ☐ toes ☐ mets ☐ heels | ☐ toes ☐ mets ☐ heels |
| DTR | ☐ normal ☐ diminished | ☐ normal ☐ diminished |
| Sharp/Dull | ☐ yes ☐ no | ☐ yes ☐ no |




**Please indicate** 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** | Wound **W**

| Condition | Type 1 Diabetes | Type 2 Diabetes |
|---|---|---|
| Diabetes mellitus without complications | ☐ E10.9 | ☐ E11.9 |
| Diabetes mellitus with diabetic polyneuropathy | ☐ E10.42 | ☐ E11.42 |
| Diabetes mellitus with diabetic peripheral angiopahty without gangrene | ☐ E10.51 | ☐ E11.51 |
| Diabetes mellitus with foot ulcer | ☐ E10.621 | ☐ E11.621 |

**** Certifying Physician Acknowledgment***

I am the MD/DO 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 car for this patient includes therapeutic shoes and insoles.

**Physician Signature:** _____ **Date:** _____
*(stamped signature not allowable)* *Stamped date not allowable. Shoes must be dispensed not more than 90 days from when dated.*

**Physician Name (printed):** _____ **Physician NPI #:** _____
*Supplier can enter*

*Please fax this back, with attached "Physician Notes on Qualifying Conditions" and "Statement of Certifying Physician".*
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# Prescription for Therapeutic Shoes and Inserts

* Confirm and indicate if both a pair of shoes and three pair of either prefabricated or custom molded inserts are needed.
* Ensure that the condition and primary diagnosis code is noted and consistent with findings of physical exam.
* Ensure that the condition(s) noted is consistent with the clinical findings noted on physical exam.

**Patient:** _____ **HICN:** _____ **DOB:** ____/____/____
*Supplier can enter* *Supplier can enter* *Supplier can enter*

| **Quantity** (please check) | **HCPCS Code** | **Description** |
|---|---|---|
| ☐ 1 | A5500 | Diabetic Depth Shoes, pair |
| ☐ 3 ☐ 2 ☐ 1 | A5512 | Prefabricated inserts pairs - muliple density, direct formed, molded to foot with external heat source (i.e. heat gun). Medicare allows up to three pairs of inserts per year. |
| **OR** | | |
| ☐ 3 ☐ 2 ☐ 1 | A5514 | Custom-molded inserts - multiple density, molded to model of patient's foot. Medicare allows up to three pairs of inserts per year. |
| **OR** | | |

☐ 1 Left Partial Foot Filler (L5000) ☐ 3 Right Custom Inserts ☐ 1 Right Partial Foot Filler (L5000) ☐ 3 Left Custom Inserts

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

| **Condition** | **Type 1 Diabetes** | **Type 2 Diabetes** |
|---|---|---|
| Diabetes mellitus without complications | ☐ E10.9 | ☐ E11.9 |
| Diabetes mellitus with diabetic polyneuropathy | ☐ E10.42 | ☐ E11.42 |
| Diabetes mellitus with diabetic peripheral angiopahty without gangrene | ☐ E10.51 | ☐ E11.51 |
| Diabetes mellitus with foot ulcer | ☐ E10.621 | ☐ E11.621 |

Duration of usage: 12 Months

**Physician Signature:** _____ **Date:** _____
*(stamped signature not allowable)* *Stamped date not allowable.*

**Physician Name (printed):** _____ **Physician NPI #:** _____
*Supplier can enter*