Dear Doctor,

Your patient recently received a preliminary diabetic foot evaluation and may, after your examination of the patient's feet, require diabetic shoes. Please see the enclosed forms for the diabetic foot exam that are required for Medicare's Therapeutic Shoe Program.

Medicare Requirements for patient eligibility include:

- Signed "Statement of Certifying Physician" from the physician managing the patient's diabetes
- Documentation in your records indicating that you are managing the patient's diabetes
- The presence of secondary risk factors as listed on the "Statement of Certifying Physician" form

Completing the attached forms while seeing your patients with diabetes may be a billable visit. Patient eligibility for shoes requires that this visit be documented within six months prior to when the shoes are dispensed.

See the attached letter from Paul J. Hughes, MD, Medicare Senior Medical Director, et al.

Please complete, as required, the following forms that are included with this letter and fax them to 407-999-0057:

- Physician Notes on Qualifying Condition(s)
- Statement of Certifying Physician for Therapeutic Shoes
- Prescription for Diabetic Shoes and Inserts

Your cooperation is very much appreciated. If you have any questions or need additional information, please contact us at 407-999-8977

Sincerely,
Physician Notes on Qualifying Condition(s) for Therapeutic Shoes

As required by Medicare, save in patient chart.

1st form of 3

[ ]

Patient Name: _______________________________ Date of Birth: _______________________________

Treatment Plan
Start Date: _____________________ Duration of DM: _____________________

Plan of Care
☐ Diet ☐ Meds ☐ Oral ☐ Injection

Diabetes Type: ☐ Type I, Controlled ☐ Type II, Controlled

☐ Type I, Uncontrolled ☐ Type II, Uncontrolled

Name of MD/DO Supervising DM*:

(Please sign Certifying Physician Acknowledgment below)

Date of Last FBS: _______________________________

Physical Exam:

Neurological (Use Y or 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

Note any calluses, bunions, swelling, redness, deformities or amputations using the symbol key below:

Callus C Bunion B Swelling S Redness R Deformity D Hammer/Claw Toe HC Amputation A Wound W

* 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 care for this patient includes therapeutic shoes and insoles.

Please fax this back to us with the attached Statement of Certifying Physician for Therapeutic Shoes and Prescription for Therapeutic Shoes and Inserts and keep original in your patient's chart. Thank you.

Physician Signature: _______________________________ Date: _______________________________

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

2014

Note: Shoes must be dispensed within 6 months from when diabetes care discussed by Certifying Physician with patient.

PLEASE FAX TO 407-999-0057

1st form of 3
Statement of Certifying Physician for Therapeutic Shoes

I certify that all of the following are true:

Diabetes Type:
- [ ] Type II, Controlled
- [ ] Type I, Controlled
- [ ] Type II, Uncontrolled
- [ ] Type I, Uncontrolled

Primary diagnosis:
- [ ] Diabetes with neurological manifestations
- [ ] Diabetes with peripheral circulatory disorder
- [ ] Diabetes without neurovascular manifestations and with structural deformity

Foot Deformity
- [ ] Arthropathy associated with neurological disorders
- [ ] Bunion
- [ ] Claw toe
- [ ] Hallux rigidus
- [ ] Hallux valgus
- [ ] Hammer toe
- [ ] Unspecified deformity of ankle and foot, acquired
- [ ] Unspecified acquired deformity of toe

History of partial or complete amputation of the foot
- [ ] Lower limb amputation, foot
- [ ] Lower limb amputation, great toe
- [ ] Lower limb amputation, lesser toe(s)

History of preulcerative callus
- [ ] History of pre-ulcerative callus

History of previous foot ulceration
- [ ] Ulcer of heel and midfoot
- [ ] Ulcer other part of foot

Peripheral neuropathy with evidence of callus formation
- [ ] Neuropathy in diabetes

Poor circulation/PAD
- [ ] Atherosclerosis of the extremities with intermittent claudication
- [ ] Atherosclerosis of the extremities with ulceration
- [ ] Atherosclerosis of the extremities, unspecified
- [ ] Peripheral angiopathy
- [ ] Peripheral vascular disease unspecified

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

Physician Signature: _______________________________ Date: _______________________________

Physician Name (Printed): ___________________________ Physician NPI #: ___________________________
Must be the MD or DO who is actively treating the patient’s diabetes.

Physician Address: ____________________________________________ Physician Phone: ___________________________

Note: Shoes must be dispensed within 3 months of date Certifying Statement signed by physician.

PLEASE FAX TO: 407-999-0057

2014
Prescription for Therapeutic Shoes and Inserts

PLEASE FAX TO 407-999-0057

3rd form of 3

Patient Name: ____________________________  HICN: ____________________________  Date of Birth: ____________________________

Prescriber Name: ____________________________  Prescriber Phone: ____________________________

<table>
<thead>
<tr>
<th>Quantity (Please check)</th>
<th>HCPC Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A5500</td>
<td>Diabetic Depth Shoes, pair</td>
</tr>
<tr>
<td>3</td>
<td>A5512</td>
<td>Prefabricated inserts pairs – multiple 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</td>
</tr>
<tr>
<td>3</td>
<td>A5513</td>
<td>Custom-molded inserts – Multiple density, molded to model of patient’s foot. Medicare allows up to three pairs of inserts per year. OR</td>
</tr>
</tbody>
</table>

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

Primary Diagnosis Code: ____________

Please confirm that the entered Diagnosis Codes match your charting documentation.

Diabetes, without complications  Diabetes with neurological manifestations  Diabetes with peripheral circulatory disorders
250.00 Type II controlled  250.60 Type II controlled  250.70 Type II controlled
250.01 Type I controlled  250.61 Type I controlled  250.71 Type I controlled
250.02 Type II uncontrolled  250.62 Type II uncontrolled  250.72 Type II uncontrolled
250.03 Type I uncontrolled  250.63 Type I uncontrolled  250.73 Type I uncontrolled

Duration of usage: 12 Months

Prescriber Signature: ____________________________  Date: ____________________________

Prescriber Name (Printed): ____________________________  Prescriber NPI #: ____________________________

Must be the MD, DO or other eligible prescriber who is actively treating patient’s diabetes (e.g. PA, Licensed Nurse Practitioner, Clinical Nurse Specialist, DPM)

2014
Dear Physician:

The Comprehensive Error Rate Testing (CERT) Contractor, under contract with the Centers for Medicare & Medicaid Services (CMS), performs medical review audits for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) provided to Medicare beneficiaries to determine the paid claims error rate for Medicare contractors and providers.

Medicare covers therapeutic shoes and inserts for persons with diabetes as established by the Social Security Act §1861(s)(12). You may access the Therapeutic Shoes for Persons with Diabetes (TSPD) LCD and Related Policy Article on the CMS web site under the Medicare Coverage Database. In order for your patient to qualify for these shoes and inserts, Medicare statute mandates specific coverage and documentation requirements that must be met.

The most common CERT errors center on missing documentation from the certifying physician of the patient having diabetes, the existence of one or more of the conditions for coverage and the therapeutic plan of care. Three criteria are critical to coverage and form the majority of physician-related CERT errors:

1. Documenting your management of the beneficiary’s diabetes. You are considered the “Certifying Physician” and there is no substitute for this documentation requirement. The Certifying Physician, by statute, must be an M.D. or D.O. and not a nurse practitioner, physician assistant or clinical nurse specialist;

2. Documenting a qualifying foot condition. As opposed to the criteria above regarding documentation of the beneficiary’s diabetes management, the documentation of the qualifying foot condition may come from your records or by your indication of agreement (signified by initialing and dating) with information from the medical records of an in-person visit with a podiatrist, another M.D or D.O., physician assistant, nurse practitioner, or clinical nurse specialist that is within 6 months prior to delivery of the shoes/inserts.

3. Failure of the records to substantiate that an in-person visit occurred within 6 months prior to the delivery of the shoes or inserts.

It is important to note that even though you may complete and sign a form attesting that all of the coverage requirements from the policy have been met, there also must be documentation in your records to indicate that you are managing the patient’s diabetes and records from either your chart or that of another practitioner documenting a qualifying foot condition.

Please refer to the Local Coverage Determination (LCD) on Therapeutic Shoes for Persons with Diabetes (TSPD), the related Policy Article and the Supplier Manual for additional information about coverage, billing and documentation requirements. Thank you for your assistance in reducing the CERT error rate.

Sincerely,

Paul J. Hughes, M.D.  Robert D. Hoover, Jr., MD, MPH, FACP
Medical Director, DME MAC, Jurisdiction A  Medical Director, DME MAC, Jurisdiction C
NHIC, Corp.  CGS Administrators, LLC

Stacey V. Brennan, M.D., FAAFP  Eileen M. Moynihan, MD, FACP, FACR
Medical Director, DME MAC, Jurisdiction B  Medical Director, DME MAC, Jurisdiction D
National Government Services  Noridian Healthcare Solutions

NHIC, Corp.