

Statement of Certifying Physician

Therapeutic Shoes & Inserts for Persons with Diabetes

(The certifying physician must be the M.D. or D.O. caring for the patient's diabetic condition and may be different from the prescribing physician)

Effective January 1, 2011: For Therapeutic Shoes & Inserts for Persons with Diabetes to be covered by Medicare, the patient's medical record must contain sufficient documentation about the patient's medical condition to substantiate the qualifications and medical necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable).

Patient Name: _____ **DOB:** ____/____/____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Medicare #: _____ **Phone:** (____) _____

Last Office Visit Documenting the Below Conditions: ____/____/____

I certify that all of the following statements are true:

1.) This patient has diabetes mellitus. **Insulin** **Non-Insulin** (ICD-9 Code? _____)

2.) This patient has one or more of the following conditions: **(Check all that apply)**

____ History of partial or complete foot amputation _____ Foot deformity

____ History of pre-ulcerative callous _____ Poor circulation

____ Peripheral neuropathy w/ callous formation _____ Previous ulcer(s)

NOTE: If you check one or more of these conditions; it must be clearly marked in the patient's medical records.

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) and/ or insert(s) because of his/her diabetes.

Certifying Physician Information:

Signature: _____

Name (printed) _____ **Date:** ____/____/____ **NPI #:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: (____) _____ **Fax:** (____) _____

Dear Doctor:

Thank you for helping your patient receive their Diabetic Footwear. Medicare has for years required you to fill out and submit the Statement of Certifying Physician (SCP). However, in February 2011, Medicare increased your paperwork requirements.

PLEASE NOTE **WE MUST HAVE CLINICAL NOTES THAT SUPPORT THE 4 MAJOR PORTIONS OF THE SCP.** IF YOUR CLINICAL NOTES DO NOT MIRROR THE SCP, THE STATEMENT IS RENDERED VOID.

CLINICAL NOTES GUIDELINES:

1. Must explicitly **CERTIFY THAT YOUR PATIENT HAS DIABETES AND ASSIGN a 5 DIGIT ICD-9** (249.00 to 250.53). Results of tests, exams, findings must be in the notes (i.e. blood glucose levels and A1c), not merely the ICD-9, although the ICD-9 is also required.
2. Must state and show **"I AM TREATING THE PATIENT UNDER A COMPREHENSIVE PLAN OF CARE FOR DIABETES"**. The doctor must use this exact phrase. The doctor should elaborate other portions of the plan of care (medicine, nutrition, education, other specialists).
3. Must state and show, **"THE PATIENT WOULD BENEFIT FROM DIABETIC FOOTWEAR TO PROTECT THEIR FEET"**.
4. Must explicitly **document a foot exam and one or more of the below required conditions in its entirety. THIS INCLUDES THE DETAILS OF TESTS, EXAMS, INSPECTIONS, FINDINGS, ETC. THAT WERE USED TO COME TO THE CONCLUSION THAT THE CONDITION EXISTS.** You may rely on the findings of other doctors (i.e. podiatrist) but must specifically cite them and sign off on them.
(a) Previous amputation of the other foot, or part of either foot, OR **(b)** History of previous foot ulceration of either foot, OR **(c)** History of pre-ulcerative calluses of either foot, OR **(d)** Peripheral neuropathy with evidence of callus formation of either foot, OR **(e)** Foot deformity or either foot, OR **(f)** Poor circulation in either foot.

We know & understand that these requirements place a burden on you and your staff. Please know that these efforts will ensure your patient gets the footwear that they need and with Medicare reimbursement.

Thank you for your assistance.

Foot Solutions at STORE NAME
ADDRESS
CITY,ST, ZIP
Tel: (XXX) XXX-XXXX

DON'T FORGET TO DOCUMENT
THE FINDING AND THE METHOD
OF HOW THE FINDING WAS
FOUND

Doctor's Written Order for Therapeutic Shoes/Inserts for Persons with Diabetes

(Prescribing Physician may be an M.D., D.O., or D.P.M, physician assistant, nurse practitioner, clinical nurse specialist and may be different than certifying physician)

Patients Name: _____ Birth Date: ____/____/____

Last Office Visit Documenting the Diabetic Condition & Footwear Needs: ____/____/____

Select One:

- One pair of extra-depth in-lay **shoes** with (3) pairs of **heat molded** inserts. OR
- One pair of extra-depth in-lay **shoes** with (3) pairs of **custom molded** multi-density inserts. OR
- Custom** therapeutic **shoes** molded from casts of the patient's feet with **custom molded** multi-density inserts.

(Note : Custom molded shoes are only covered when the patient has a foot deformity that cannot be accommodated by off-the shelf depth shoes.)

Diagnosis: _____

Doctors Comments: _____

Prescribing Physician Information:

Signature: _____

Date Signed: _____

Name Printed: _____

NPI #: _____

Please understand that we cannot dispense footwear prior to receiving a complete written order

