PHYSICIAN CHART NOTE REQUIREMENTS FOR DIABETIC SHOES AND DIABETIC INSOLES

In order for your patient to qualify for diabetic shoes and diabetic insoles the following information must be included in your patient chart notes. Also, chart notes that are presented for medical necessity must be within six months of the patient receiving the shoes. At the bottom of this page is additional information if you are using the patient's podiatrist chart notes to support the medical necessity for the patient secondary diagnoses. Chart notes must be legible (typed).

Physician chart notes must state that the patient is an:

Insulin Treated Diabetic OR Non-Insulin Treated Diabetic

One of the following conditions must be present and details included in the patient chart notes:

History of partial/complete foot amputation
including what side/type of amputation **and** that the patient requires a TOE FILLER

History or previous foot ulceration, including side/location of the foot ulceration

Peripheral neuropathy **WITH evidence** of callus formation, including side/location of callus formation, signs, symptoms and test supporting peripheral neuropathy

History of pre-ulcerative callus, including side/location of pre-ulcerative callus

Foot deformity, including side/location/type (pes cavus/pes planus invalid) of foot deformity

Poor circulation, including signs/symptoms/tests to show poor circulation of the feet
CAD, CHF, Hypertension, Edema are **invalid**
PAD, including supporting doppler tests, test on capillary refill in the feet **may be valid**

Chart notes **must state** that the patient is being treated under a comprehensive plan for diabetes

Chart notes **must state** that the patient needs diabetic shoes and diabetic insoles

Chart notes must be within the last **6 months** or less

If there are additional notes from patient's DPM, the DPM notes must be clearly signed and dated by the MD or DO and the MD or DO must document that they 'agree' or 'concur' with the DPM notes and sign and date this addendum – if the doctor's signature is not legible, the name needs to be printed also.

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STATEMENT OF CERTIFYING PHYSICIAN FOR THERAPEUTIC SHOES

(to be completed by an M.D. or D.O.)

Date: ______ HIC#: ______

Account#: ______ Telephone #: ______

Patient's Name: ______ DOB: ______

Patient's Address: ______ Gender: ☐ Male ☐ Female

I certify the following statements are true and* I AM ATTACHING CHART NOTES *to support each diagnosis.

Medical Necessity for item(s) listed:

1. **This patient has Diabetes Mellitus (check one):** ☐ Insulin Treated ☐ Non-Insulin Treated

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

	Condition	**ICD10**
☐	A) History of partial or complete amputation of the foot	
☐	B) History of previous foot ulceration	
☐	C) Peripheral neuropathy with evidence of callus formation	
☐	D) History of pre-ulcerative callus	
☐	E) Foot deformity	
☐	F) Poor circulation	

3. ☐ Yes ☐ No **I am treating this patient under a comprehensive plan of care for his/her diabetes.**

4. ☐ Yes ☐ No **This patient needs special shoes (extra depth or custom-molded) because of his/her diabetes.**

Rx

	Item	Quantity	Code
☐	Diabetic Shoes (off the shelf style)	Quantity = 2/each (1 Pair)	A5500
☐	Diabetic Shoes, Custom Fabricated	Quantity = 2/each (1 Pair)	A5501
☐	Diabetic insoles (off the shelf)	Quantity = 6/each (3 Pairs)	A5512
☐	Diabetic insoles, Custom Fabricated	Quantity = 6/each (3 Pairs)	A5513
☐	Toe Filler, Custom Fabricated	Quantity = 1/each	L5000

Other ______

LENGTH OF NEED = 12 months

NOTE: Prescribing physician (M.D., D.O.) may be different from certifying physician, but must be knowledgeable in the fitting of diabetic shoes and inserts.

Physician's Printed Name: ______ NPI: ______

Address ______

Phone #: ______ Fax: ______

Physician's Signature: **X** ______ Date: **X** ______

Written Order for Diabetic Shoes and Diabetic Insoles

Date: ____________________

Name: ____________________

Description of prescribed items: (check all that may apply)	**Quantity**
☐ Diabetic shoes (off the shelf style) A5500	1 pair
☐ Diabetic shoes (CUSTOM fabricated) A5501	1 pair
☐ Diabetic insoles (off the shelf style) A5512	3 pairs
☐ Diabetic insoles (CUSTOM fabricated) A5513	2 or 3 pairs
☐ Toe filler (CUSTOM fabricated – for partial foot amputees)	1 each

Length of need: 12 months

Physician's Printed Name: ____________________

Physician's Signature:____ Date: _____________