



Compounding & Wellness Specialists

Physician Diabetic Shoe Documentation Requirements

Dear Physician,

Your patient has been referred to our facility for diabetic shoes and inserts. Please submit the following documentation and supporting information in order to process this request.

1. A signed detailed written order (see attached)
2. A signed and dated Statement of Certifying Physician filled out completely (see attached)
3. Clinical documentation within the past 6 months pertaining to the patient's diabetic condition. Please include detailed information about their foot exam and any conditions relating to that exam. (History of foot problems, wounds, callus, deformities, etc)
4. Received notes from other healthcare providers, written agreement with their findings and need for shoes---signed and dated.
5. Please include all medications the patient is currently taking in the documentation.
6. Please make sure to complete all forms included in the packet and that you have **signed and dated** in all the appropriate places.

Medicare, Medicaid and most private insurance companies require this information for diabetic shoes and inserts. It is very important that we receive relevant medical records and supporting documentation in order to provide your patient with their diabetic shoes. We will not be able to order your patients shoes/inserts until all documentation and paperwork has been filled out with the supporting medical records and returned to us complete.

We understand that your time is valuable and the last thing you need is more paperwork, however, these are the Medicare guidelines and we cannot proceed without the required documentation.

We appreciate your help as we work to keep your patients feet healthy and feeling good. If you have any questions or need any additional information please feel free to contact us at 940-382-1618.

Medicare Documentation for Diabetic Footwear

Chart Notes:

1. Must clearly state in chart notes that patient requires both shoes and inserts (inserts don't automatically come with shoes but are a very important part of shoe therapy). If inserts aren't requested in chart notes we cannot dispense them.
2. Must clearly document supporting evidence for the condition that is marked. All documentation must be signed/dated by the Certifying Physician (MD or DO) who is taking care of the patients diabetic condition. Here is what Medicare is now looking for in 6 qualifying conditions:
 - a. **History of partial or complete amputation of foot, or of both feet-** we need to have complete documentation of history of amputation. If chart notes are available from the Doctor that did amputation then please send those with prescribing Doctor signing off that he/she concurs. It must be mentioned in notes within past 6 months visit with detailed description of which foot and/or area of foot had amputation.
 - b. **History of previous foot ulceration of either foot-** this also needs documentation within last 6 months with detailed description of dates this occurred, as well as where on foot this occurred. Cannot take patients word on this...must have supporting documentation (from previous Doctor this occurred while patient was under their care-must concur by signing this documentation stating you concur)
 - c. **History of pre-ulcerative callous of either foot-** this also needs documentation within last 6 months with detailed description of dates this occurred as well as where on foot this occurred. Cannot take patients word on this...must have supporting documentation (from previous Doctor this occurred while patient was under their care-must concur by signing this documentation stating you concur)
 - d. **Peripheral Neuropathy with evidence of callous formation-**this requires testing such as Semmes-Weinstein monofilament test that documents in detail areas on feet that show NO sensation and supports that the patient has neuropathy. IN ADDITION, callousing must be present and documented in detail as to where callousing is occurring on feet. Patient must have both to be eligible (i.e. cannot document just neuropathy)
 - e. **Foot deformity of either foot-**This requires documentation of specific deformity (i.e. bunion, hallux valgus, hammertoes, etc) with specific areas on feet/toes this is occurring (i.e. 3rd and 4th digit on right foot exhibits hammertoes). Must be documented in notes within last 6 months
 - f. **Poor Circulation-**this now requires sending the patient for testing-doppler, ultrasound, angiography, etc. (must document that you are sending patient for this testing) and confirming results of tests and its effect on the feet in chart notes.
3. In addition, if patient is sent to DPM or other specialist for patients conditions mentioned above, it must be documented in patient's chart. You may use that specialists chart notes as long as you clearly mark that you concur with that specialists findings and sign and date. If you don't mention in the chart notes that you have sent patient to specialist, the specialist chart notes cannot be used.