

## LeTourneau Lifelike Orthotics & Prosthetics, Inc.

Dear Patient,

We are pleased that you have chosen LeTourneau Lifelike Orthotics & Prosthetics, Inc. to assist you with your diabetic shoes and inserts. We strive to provide the finest in quality care and service; furthermore, because we want to provide such a high level of care, we make every effort to supply patients with important information pertaining to Medicare rules and regulations for diabetic footwear.

In order for Medicare to cover therapeutic shoes for patients with diabetes, we will need the following things in order to review your case to diabetic shoes:

1.      **Dispensing Order:** within 3 months
2.      **Certifying Physicians Statement:** (*Diabetic Doctor must be the one to fill out*) 3 months from the day you get your shoes
3.      **Medical Documentation Containing Diabetic Management & Face to Face Medical Documentation Containing Foot Condition:** 6 months from the day you get your shoes & must say these exact words in the chart notes:
  - the patient has diabetes and assign a 5-digit ICD-10 (E08.00-E13.9). Results of tests, exams, findings must be in the notes (i.e. blood glucose levels and A1 c), not merely the ICD-10, although the ICD-10 is also required.
  - **"I am treating the patient under a comprehensive plan of care for diabetes"**
  - **"The patient would benefit from diabetic footwear to protect their feet"**
  - **\*\*This includes the details of tests, exams, inspections, finding, etc. that were used to come to the conclusion that the condition exists. \*\***
4.      **DETAILED WRITTEN ORDER:** this will be provided to the Referring physician to sign and date once patient has been measured and will included: ***Narrative description (e.g., diabetic shoes, custom inserts, etc.) or the specific manufacturer and product name umber of the shoe/insert If a custom item is provided, the order must state "custom fabricated."***

Once all required documentation is obtained you can either mail or fax them into our office for review. If everything meets the Medicare requirements, we will then contact you to schedule for measurements. We have attached a letter along with the necessary paperwork that you will need to hand to the doctor during your Face to face examination appointment for the diabetic shoes. If the doctor's office has any question, please have them contact us when you are there during the appointment.

Thank you for choosing us to service your diabetic footwear needs.

Sincerely,

LeTourneau LifeLike Orthotics & Prosthetics, Inc.

## LeTourneau Lifelike Orthotics & Prosthetics, Inc.

Dear Physician,

Thank you for assisting your patient in obtaining Diabetic Footwear.

For years Medicare has required you to fill out and submit the Statement of Certifying Physician (SCP/MD OR DO). However, on October 1, 2015, Medicare increased the paperwork requirements on you. Now we **MUST** have the following information:

### DIABETIC SHOE GUIDELINES:

1. **Dispensing Order**: Must be from the Prescribing Physician – this may be a podiatrist, M.D., D.O., physician assistant, nurse practitioner, or clinical nurse specialist.
2. **Certifying Physicians Statement**: Must be completed by the **Certifying Physician (MD/ DO)**; Must be completed on or after the date of the in-person visit (with MD/DO – refer to section on Medical Documentation Containing Diabetic Management) and within 3 months prior to delivery of the shoes/inserts.
3. **Medical Documentation Containing Diabetic Management & Medical Documentation Containing Foot Condition**:
  - a. Must **explicitly** certify that the patient has diabetes and assign a 5-digit ICD-10 (E08.00-E13.9). Results of tests, exams, findings must be in the notes (i.e. blood glucose levels and A1c), not merely the ICD-10, although the ICD-10 is also required.
  - b. Must **explicitly** state ***"I am treating the patient under a comprehensive plan of care for diabetes". The doctor must use that exact phrase.*** The doctor should elaborate other portions of the plan of care (medicine, nutrition, education, other specialists).
  - c. Must **explicitly** state ***"The patient would benefit from diabetic footwear to protect their feet". The doctor must use that exact phrase.***
  - d. Must **explicitly** document a foot exam and one or more of the required conditions. **\*\*This includes the details of tests, exams, inspections, finding, etc. that were used to come to the conclusion that the condition exists.**  
**\*\*** You may rely on findings of other doctors (i.e. Podiatrist), but must specifically cite them and sign off on them.
    - Previous amputation of the other foot, or part of either foot, or
    - History of previous foot ulceration of either foot, or
    - History of pre-ulcerative calluses of either foot, or
    - Peripheral neuropathy with evidence of callus formation of either foot, or
    - Foot Deformity of either foot, or
    - Poor circulation in either foot;
4. **DETAILED WRITTEN ORDER**: this will be provided to the Referring physician to sign and date once patient has been measured and will include: ***Narrative description (e.g., diabetic shoes, custom inserts, etc.) or the specific manufacturer and product name number of the shoe/insert If a custom item is provided, the order must state "custom fabricated."***

We know these requirements place a burden on you and your staff but we will need everything faxed or mailed to our office for review before we are able to schedule for measurement.

Thank you for your assistance

Sincerely,

LeTourneau LifeLike Orthotics & Prosthetics, Inc.

# LeTourneau Lifelike Orthotics & Prosthetics, Inc.

## Statement of Certifying Physician for Therapeutic Footwear

**\*\* Certifying Physician must be the MD or DO managing the patient's diabetic condition\*\***

Patient Name: \_\_\_\_\_ DOB #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

I certify that all of the following statements are true:

1) This patient has diabetes mellitus (ICD-10 Code): \_\_\_\_\_ (E08.00-E13.9)

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

- History of partial or complete foot amputation
- History of pre-ulcerative callous
- Peripheral neuropathy with callous formation **\*\*Both must be documented\*\***
- Foot deformity
- Poor Circulation (i.e. diagnosis of venous / arterial insufficiency and symptoms, signs test documenting **in detail** one of these diagnoses.)
- Previous ulcer(s)

Patient was last seen within the last 6 months in my office on:

Date:

\_\_\_\_\_

3) I am treating this patient under a comprehensive plan of care for his/her diabetes.

4) This patient needs special shoes and/or inserts because of their diabetic condition.

Certifying Physician(MD/DO) information:

Name (Printed): \_\_\_\_\_ NPI #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

By signing this form, I agree that I have performed an in person evaluation of this patient within the last 6 months, and there is documentation in the patient's medical records indicating my management of the patient's diabetes, and that documentation of one or more of the conditions listed under item #2 is present in those records.

Signed: \_\_\_\_\_ Today's Date: \_\_\_\_\_