

"WorryFree DME"SM Diabetic Shoe Order Entry Form

Non-Physician Supplier Medicare Compliance Documentation Guide

Shoe Fitter Responsibility/Actions

1. Complete "Patient Evaluation Prior to Shoe Selection".
2. Select Shoe Size and Style.
 - Measure feet and use display stand to select shoe according the 4 S's: Size, Shape, Stability, Style.
3. Enter "Shoe Ordering Information" at SafeStep.net and print out:
 - Prescription.
 - Physician Notes on Qualifying Condition(s).
 - Statement of Certifying Physician.

Give customized forms to patient to be signed by Certifying Physician.
Make appointment for patient with MD / DO.

4. Alternatively, print out in advance, "Medicare Required Documentation for Therapeutic Shoes to be signed by Certifying Physician" from "Forms" section of SafeStep.net.
5. Click on "Forms to Save in Patient Chart" to print out "Certificate of Patient Receipt" and "Supplier Standards". Save in patient's chart until patient returns to pick up shoes.

Patient Responsibility/Actions

6. Patient visits MD / DO, has foot evaluation.
 - Following evaluation, physician completes forms, signs, dates and faxes to SafeStep.

SafeStep Responsibility/Actions

7. SafeStep evaluates forms, reviews to ensure Medicare compliance and ships shoes and inserts.*
 - If compliance forms incomplete or inaccurate, SafeStep follows up with certifying physician.
 - Once forms determined to be accurate and complete, notification sent to non-physician supplier and forms archived online. Shoes and inserts shipped.

Shoe Fitter Responsibility/Actions

8. Supplier contacts patient, fits shoes and signs compliance documentation.
9. Once shoes are indicated as being dispensed, "WorryFree DME" creates:
 - "Documentation of In-Person Fitting at Time of Dispensing."

Print additional copies of this form by logging onto SafeStep.net and selecting the "Forms" section.

Enter at safestep.net for "WorryFree DME"

For Medicare orders, SafeStep will:

- Review signed and dated copy of Prescription and Certifying Statement.
- Ensure that Certifying Physician has in their medical records an office visit note that describes one of the qualifying conditions for therapeutic shoes.
- Ensure that Certifying Physician has office visit note that shows he / she is managing the patient's diabetes and that the note is written within 6 months prior to delivery of shoes and inserts.

Once Completed:

- Save the "Patient Evaluation" as required by Medicare. It may be requested in event of audit.
- Enter patient, physician and shoe ordering information at SafeStep.net.
- Give patient: Physician Notes of Qualifying Condition(s), Statement of Certifying Physician, and Prescription for Therapeutic Shoes and Inserts. Tell patient to bring forms to MD/DO managing their diabetes.

\$10,000 Guarantee

If SafeStep receives faxed documentation forms required of the Supplier and you fail a Medicare audit due to insufficient documentation and exhaust all appeals, SafeStep will reimburse up to \$10,000 of loss.*

*Guarantee limited to documentation faxed to and reviewed by SafeStep and required by Medicare. Information entered must be accurate. Guarantee only applies to situations where liability is based solely on inadequate documentation. Other issues – such as medical necessity, improper code selection, inaccurate information and over utilization – do not apply.

Enter orders at SafeStep.net
Questions? Call 866.712.STEP (7837)



Documentation of Patient Evaluation Prior to Shoe Selection

To be completed by non-physician shoe supplier

Name: _____ Address: _____

Phone: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Email: _____

Patient's insurance ID #: _____ Secondary Insurance #: _____

Does the patient have Medicare as the primary insurance? Yes No

Has the patient received shoes under the Medicare Therapeutic Shoe Program this calendar year? Yes No

Certifying Physician Managing Diabetes Care

Name: _____

Assessment

Which feet does patient have? Bot Left Right

- Callus: Yes No Amputation: Yes No
- Deformities: None Bunion Hammer toes Scarring
 Clawing Overlapping Other: _____
- Edema: None Present / Describe: _____
- Fat Pads: Normal Inadequate / Describe: _____
- Joint Stability: Normal Flattened longitudinal arch Cavus
- Vascularity: Normal Limited / Describe: _____
- Foot Color: Normal Bluish Red
- Range of Motion: Normal Abnormal
- Muscle Testing: Normal Abnormal
- Skin Integrity: Normal Abnormal
- Skin Temperature: Normal Abnormal
- Cognitive Awareness: Normal Abnormal

Neurological (Use Y or N)

	Right	Left
Loss of Vibration Perception		
Loss of Protective Sensation		



Note corns, calluses or deformities using symbol key below:

- Corn/Callus (C) Wound (W) Bunion (B) Redness (R)
- Swelling (S) Hammer/Claw toe (HC) Amputation (A)

If patient has previously received **shoes** covered by Medicare, are they worn and in need of replacement? Yes No

If patient has previously received **inserts** covered by Medicare, are they worn and in need of replacement? Yes No

Has patient worn therapeutic footwear? Yes No

Functional goals for patient services (check all that apply)

- Protection of sensation-compromised foot
- Provision of appropriate footwear for protection, support, stability, and comfort
- Refer to MD/DO follow-up
- Other: _____

Shoe Ordering Information

Shoe Size based on measuring device, fit of currently worn shoes and try-on sample:

Length: _____ Width: _____

Selected Shoe Brand: _____ Selected Shoe Model / Sku: _____

Selected Inserts: Prefabricated heat molded Custom molded Insert Quantity (Prs): 3 2 1

If Partial Foot Filler is required:

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

Qualified Fitter's Signature: _____ Date: _____

Qualified Fitter's Name (Printed): _____