Surviving a Medicare Shoe Audit

Presented by Josh White, DPM, CPed
President/Founder SafeStep
Codingline Expert Panelist
Member APMA DME Subcommittee
Understanding Documentation Requirements:

• Goal:
  o Gain a better understanding of the documentation requirements for the Medicare Therapeutic Shoe Program.
  o Access a checklist and see the documents that are created by our WorryFree DME Program.
Objectives

• Explain compliance documentation required by the Medicare Therapeutic Shoe Program
• Audits = Fear
• Present the WorryFree DME solution
DOCUMENTATION CHECKLIST FOR THERAPEUTIC SHOES

Page 2
Simply Stated:

1. Prescription for Diabetic Shoes and Inserts
2. Documentation of Patient Evaluation Prior to Shoe Selection
3. Statement of Certifying Physician for Therapeutic Shoes sign on or after the date of the in-person visit and within 3 months prior to the delivery of the shoes/inserts
4. Information from Medical Records of In-Person Visit with DPM Documenting that Beneficiary has Qualifying Risk Factors for Therapeutic Shoes
5. Proof of Delivery...Delivery Documentation and Break in Instructions + Supplier Standards
6. Dispensing Chart Notes for Therapeutic Shoes
Let’s break it down

Medicare Compliance Documentation required of Shoe Supplier

From DPM
- Pre-fitting exam (CDFE)
- RX
- Certificate of Receipt
- Dispensing SOAP Notes

From MD/DO
- Certifying Statement
- Relevant Medical Records
### Prescription - Shoes and Inserts

**Rx**

<table>
<thead>
<tr>
<th>Quantity</th>
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<tr>
<td>3 Pair</td>
<td>Aetrex - Anti-Shox Conform Orthotics (A5512) to prevent pedal ulceration</td>
</tr>
</tbody>
</table>

**Dx:**
Type II, Controlled Diabetes without neurovascular manifestations and with structural deformity (250.00)
Hammer toe (735.4)
Unspecified deformity of ankle and foot, acquired (736.70)

**Therapeutic objective(s):**
- Prevent pedal ulceration
- Facilitate gait
- Maximally distribute plantar pressure

**Duration of usage:** 6 Months

**Signature:** ______________________ **Date:** ______________________
2nd of 6 required documents: Supplier in person evaluation, Exam perform prior to shoe selection (CDFE)

Documentation of Patient Evaluation Prior to Shoe Selection
To be completed by non-physician shoe supplier

Patient
Name: __________________________ Date: __________________________

Assessment

Plantar Temperature: ☐ Normal ☐ Abnormal

- Callus: ☐ Yes ☐ No
- Amputation: ☐ Yes ☐ No
- Deformities: ☐ None ☐ Bunion ☐ Hammer toes ☐ Scarring
  - Clawing ☐ Overlapping ☐ Other: __________________________
- Edema: ☐ None ☐ Present / Describe: __________________________
- Fat Pads: ☐ Normal ☐ Inadequate / Describe: __________________________
- Arch: ☐ Normal ☐ Flattened longitudinal arch ☐ Cavus
- Vascularity: ☐ Normal ☐ Limited / Describe: __________________________
- Foot Color: ☐ Normal ☐ Blush ☐ Red
- Hair Growth: ☐ Normal ☐ Reduced growth ☐ Hair absent
- Range of Motion: ☐ Normal ☐ Abnormal
- Muscle testing: ☐ Normal ☐ Abnormal
- Skin Moisture: ☐ Normal ☐ Abnormal

Previous 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
☐ Other: __________________________

Shoe Ordering Information

Shoe Size based on measuring stick, fit of currently worn shoes and try-on sample:
Length: __________________________ Width: __________________________

Selected Shoe Brand __________________________ Selected Shoe Model / Sku __________________________

Selected Inserts: ☐ Prefabricated Heat molded ☐ Heat molded ☐ Insert Quantity: ☐ 3 ☐ 2 ☐ 1

Fitter’s Signature: __________________________ Date: __________________________

Note calluses, corns, or deformities using symbol key below:

- Callus (C)
- Ulcer (U)
- Bunion (B)
- Redness (R)
- Swelling (S)
- Hammer / Claw toe (HC)
- Amputation (A)

Current footwear assessment

Is style of current footwear appropriate? ☐ Yes ☐ No
Is current footwear worn and in need of replacement? ☐ Yes ☐ No
Are current inserts worn and in need of replacement? ☐ Yes ☐ No

Separate this sheet and save in patient file. May be required in event of audit.
Give the blank copies of Physician Notes of Qualifying Condition(s), Statement of Certifying Physician, and Prescription for Therapeutic Shoes and Inserts to the patient to bring to MD/DO managing patient’s diabetes
Enter patient, physician and shoe ordering information at SafeStep.net
3rd of 6 required documents:
Documents form Certifying Physician that meet LCD criteria: Relevant Medical Records and in-person visit- Signed by MD/DO

Information From Medical Records of In-Person Visit with DPM Documenting That Beneficiary has Qualifying Risk Factor(s) for Therapeutic Shoes

PLEASE SIGN, DATE AND FAX THIS TO (203) 306-3158

Dear Dr. Gooding,

On Thursday, November 08, 2012 your patient, Mrs. Darlene test, presented to our office for evaluation to determine the risk of ulceration related to her Type I, Controlled diabetes.

Physical examination determined the following:
- Hallux rigidus
- Neuropathy in diabetes, use w/ 250.60, 250.61 (loss of vibratory perception)

Based on these findings, Mrs. test was determined to be Foot Risk Category (2), Neuropathy, PVD and/or Deformity and was prescribed therapeutic footwear and accommodative inserts.

Qualification for therapeutic footwear under the Medicare program requires documentation that the Certifying Physician is managing the patient’s diabetes under a comprehensive plan of care, agrees with the above findings, agrees that the patient requires therapeutic shoes and inserts and that diabetes management was discussed with the patient no more than six month prior to getting fit with shoes and inserts.

We appreciate the opportunity to work together to reduce the chance of foot ulceration and your cooperation to satisfy Medicare documentation requirements. If you have any questions regarding this report please feel free to contact my office at (712) 367-0166 to discuss.

Thank-you,

Ms. Darlene White

Includes: Attestation that patient had been seen by MD for care of diabetes not more than 6 months prior and that they agree that patient needs shoes and inserts.

I am the (MD/DO) supervising Mrs. Darlene test comprehensive plan of care for Diabetes Mellitus. I agree with the above findings and that the patient needs therapeutic shoes and inserts. As required by Medicare, this report is to be incorporated as part of my medical records and if requested, a copy will be provided.

Date Mrs. test last seen by Dr. Gooding during which diabetes management was addressed:

Date last seen is required and must be written! According to Medicare, patient must have been seen by their Certifying Physician within 6 months prior to having fit shoes.

Signature: ____________________________
David Gooding, DO

Date: ____________________________
Information From Medical Records of In-Person Visit with DPM Documenting that Beneficiary has Qualifying Risk Factor(s) for Therapeutic Shoes

PLEASE SIGN, DATE AND FAX THIS TO (203) 306-3158

Patient: [Redacted] HICN: [Redacted] DOB: [Redacted]

Dear Dr. Gooding,

On Thursday, November 08, 2012 your patient, [Redacted], presented to our office for evaluation to determine the risk of ulceration related to her Type 1, Controlled diabetes.

Physical examination determined the following:
- Hallux rigidus
- Neuropathy in diabetes, use w/ 250.60, 250.61 (loss of vibratory perception)

Based on these findings, Mrs. test was determined to be Foot Risk Category (2), Neuropathy, PVD and/or Deformity and was prescribed therapeutic footwear and accommodative inserts.

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We appreciate the opportunity to work together to reduce the chance of foot ulceration and your cooperation in meeting documentation requirements. If you have any questions regarding this report please feel free to contact my office at (732) 397-0166 to discuss.

Thank-you,

David Gooding, DO

I am the (MD/DO) supervising MD/DO providing the healthcare for Diabetes Mellitus. I agree with the above findings and that the patient needs therapeutic shoes and inserts. As required by Medicare, this report is to be incorporated as a separate medical record. If requested, a copy will be provided.

**Date patient was last seen:** Must have been seen within 6 months prior to having fit shoes

**Date last exam is required and must be written:** According to Medicare, patient must have been seen by their Certifying Physician within 6 months prior to having fit shoes.

Signature: [Redacted]    Date: [Redacted]

[Signature]

Be Safe - Document created exclusively by SafeStep

Ph: 555-574380CN

Signed by physician managing patient's diabetes, save in patient's chart
Statement from Certifying Physician for Therapeutic Shoes

Please sign, date and fax this to (203) 306-3158

Patient Information:

I certify that all of the following statements are true:

1. This patient has diabetes mellitus.
2. This patient has the following conditions.
   - Foot deformity
   - History of partial or complete amputation of the foot
   - History of pre-ulcerative callus
   - History of previous foot ulceration
   - Peripheral neuropathy with evidence of callus formation
   - Poor circulation
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 shoes) because of his/her diabetes.

Dr. David Gooding
123 Medicare Way
Englewood FL 34223

Signature: ___________________________ (must be an M.D. or D.O.)
David Gooding, DO

Fax to: (555) 555-5555 for signature
Phone: (555) 555-5555

According to Medicare, if shoes are not fit within 3 months of physician signature, this certification is considered void.

Date: ________________

Expires in 90 days
4th of 6 required documents: 
Statement of Certifying Physician for Therapeutic Shoes - Signed by MD/DO

Statement from Certifying Physician for Therapeutic Shoes

PLEASE SIGN, DATE AND FAX THIS TO (203) 306-3158

I certify that all of the following statements are true:

1. This patient has diabetes mellitus.
2. This patient has the following conditions.
   - Foot deformity
   - History of partial or complete amputation of the foot
   - History of pre-ulcerative callus
   - History of previous foot ulceration
   - Peripheral neuropathy with evidence of callus formation
   - Poor circulation
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 shoes) because of his/her diabetes.

A few things to note on the Statement of Certifying Physician

SafeStep types the name of the Certifying Physician to comply with "legible signature"

Signature: ________________________ (must be an M.D. or D.O.)

David Gooding, DO

Fax to: (555) 555-5555 for signature
Phone: (555) 555-5555

According to Medicare, if shoes are not fit within 3 months of physician signature, this certification is considered void.

Date: ____________________

Be Safe - Document created exclusively by SafeStep

Prt: S6567O574380CM

Signed by physician managing patient's diabetes, save in patient's chart
5th of 6 required documents:
Documents from Prescribing Physician, Dispensing SOAP Note

### Dispensing Chart Notes

**Patient Information:**

Mr. JOSEPH MASEFIELD  
HCN: 195249818A  
DOB: 6/20/1933

**Diagnosis:**

Type II, Controlled Diabetes without neurovascular manifestations and with structural deformity (250.00)  
Hammer toe (735.4)  
Unspecified deformity of ankle and foot, acquired (736.70)

**Dispensing Chart Notes:**

S) Patient presents for dispensing of depth shoes and three pairs of prefabricated, heat molded inserts to prevent diabetic ulceration.

O) There is certification of therapeutic necessity from the physician managing patient diabetes in the chart. The insoles contain a base layer of 3/16 inch, shore A, 40 durometer material. They were heated to over 230 degrees Fahrenheit and full weight bearing was performed on a foam pillow. During molding patient foot was protected from the heated insole by use of a Stockinette or sock. After molding, there was total contact between the plantar surface of patient foot, including the arch and the insert.

A) Good fit. Patient indicates that the shoes and inserts were comfortable.

P) Fitting of depth shoes with three pair of prefabricated multiple density custom molded inserts to prevent diabetic ulceration. Proper use and care was reviewed. All questions were answered. Written instructions and warrantee information was given and the list of the twenty-one (21) Durable Medical Equipment Supplier Guidelines.

### Product List:

<table>
<thead>
<tr>
<th>Quantity</th>
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<td>Men - Athletic Walker White Lace - X826M (A5500) to prevent pedal ulceration</td>
</tr>
<tr>
<td>3 Pair</td>
<td>Actrex - Anti-Shox Conform Orthotics (A5512) to prevent pedal ulceration</td>
</tr>
</tbody>
</table>

**DPM/Supplier signs and saves**

Dispensing SOAP Note

**Signature:**

Dr. Write Wells
Delivery Documentation and Break-In Instructions

Congratulations on receiving your new shoes. In accordance with Medicare regulations, they have been selected from our own inventory, from another company or have been fabricated to provide you with optimum comfort and protection.

Getting used to your shoes
People with decreased feeling in their feet may have a false sense of security as to how much at risk their feet actually are. An ulcer under the foot can develop in a couple of hours even if the shoes are expertly fit. In order to best avoid irritation, adhere to the following break-in schedule:

FIRST DAY  Wear One Hour
SECOND DAY  Wear Two Hours – Check feet after first hour
THIRD DAY  Wear Three Hours
FOURTH DAY  Wear Four Hours – Check feet after two hours
FIFTH DAY  Wear Full Day – Check after lunch

* IF AT ANY TIME YOU SEE RED SPOTS OR DARKNESS ON THE TOES OR OTHER BONY AREAS DURING THE FIRST FIVE DAYS: Discontinue wearing the shoes for the rest of the day and start routine again the next day beginning with one hour of wear.
* IF A RED SPOT OR DARKNESS APPEARS WITH EVERY WEARING – DO NOT WEAR SHOES. Call Ms. White for an adjustment appointment.
* BE SURE TO INSPECT YOUR FEET EVERY DAY.

Follow-Up
You should have regularly scheduled visits with Drs. Ornstein and Gooding. Please direct any questions to this office. Billing questions may be directed to your Medicare carrier. Every four months get rid of the inserts in your shoes and put in a new pair. In one year, you will receive a reminder to return to Ms. White to evaluate the condition of these shoes.

Return Policy
Shoes that are unsuitable may be returned within one week of dispensing. The shoes must be in good condition, i.e., no scuffmarks, outside dirt or obvious wear on the soles and in original packaging. We strongly urge you to wear these shoes in your home for the first week. Substandard shoes may also be returned as all warranties, expressed and implied under applicable State law will be honored.

I certify that I have received the item(s) marked below in good condition. The Doctor has explained, in detail, the proper use and care of this device and has fit it to me. The Doctor has asked me to call the office if I encounter any problems with the device or if I have any questions. I have been informed of the Medicare DMEPOS Supplier Standards.

Patient Signature: ___________________________ Date _____________

Description of items provided:
1. Aetrex Women - High Performance Reina Runner Violet - X532W
2. Aetrex Aetrex - Anti-Shox Conform Orthotics
So what is happening...

• Why are there so many prepayment audits...
• Are there many failures...
• Why are there so many failures
• What did you do wrong...
Pre-payment audit letters are sent to less than 10% of all DPM's...

• Receiving a letter does not indicate that anything has been done wrong...
• It is an inquiry to be sure all documentation is clear and available.


Beneficiary Services: 1-800-MEDICARE (1-800-633-4227)
1-877-486-2048 (TDD)
Provider Services: 1-877-320-0390

Beneficiary Name:
Patient
Case ID:

Dear

This claim has been selected for complex medical review. These reviews are performed by Medicare Administrative Contractors based on contractual obligation to the Centers for Medicare and Medicaid Services.

You must provide the documentation indicated below and return this letter to our office within 45 days from the date of this letter. Failure to respond within 45 days may result in partial or complete denial of the claim.

In the late summer, some MACs began accepting solicited documentation from providers sent via the Electronic Submission of Medical Documentation (esMD) mechanism. For more information about esMD, see www.cms.gov/esMD.

Please FAX required documentation and a copy of this letter to 1-701-277-7888 or mail to the address listed above. **MR-400**

<table>
<thead>
<tr>
<th>LN</th>
<th>NUMB</th>
<th>PROC</th>
<th>SERVICE CODE</th>
<th>SERVICE DATES</th>
<th>SUBMIT CHARGE</th>
<th>PROVIDER NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>2.0</td>
<td>a5500kxltr</td>
<td>JAN 11, 2013</td>
<td>163.90</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
This is an audit letter
Please submit a copy of the following records on the above named beneficiary:

1) Treating physician's dispensing and written order; and, if the prescribing physician is the supplier, a separate order is not required, but the item provided must be clearly noted in the patient's record.

2) Documentation from the certifying physician that meets LCD criteria; and,

3) Documentation to support in-person visit/evaluation made by the supplier that meets LCD criteria; and,

4) Statement of Certifying Physician for Therapeutic Shoes signed on or after the date of the in-person visit and within 3 months prior to the delivery of the shoes/inserts; and,

5) Documentation from the prescribing physician (if applicable); and,

6) Proof of delivery; and,

7) The Advanced Beneficiary Notice (if applicable); and,

8) Any other supporting documentation.

Medicare requires that medical record entries for services provided/ordered be authenticated by the author. The method used shall be one of the following: handwritten or electronic signature. Stamp signatures are not acceptable.
...let’s understand what is needed
Primary documentation errors that resulted in denial of claims

- 26% of A5500 claims received a denial as Criterion 2 was not met per Policy Article (PA) A37076.

There must be documentation to support that the certifying physician has documented in the patient's medical record one or more of the following conditions:

- 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 of either foot, or
- f. Poor circulation in either foot;

In order to meet criterion 2, the certifying physician must either:

- g. Personally document one or more of criteria a – f in the medical record of an in-person visit within 6 months prior to delivery of the shoes/inserts and prior to or on the same day as signing the certification statement; or
- h. Obtain, initial/sign, date (prior to or on the same day as signing the certification statement), and indicate agreement with information from the medical records of an in-person visit with a podiatrist, other M.D or D.O., physician assistant, nurse practitioner, or clinical nurse specialist that is within 6 months prior to delivery of the shoes/inserts, and that documents one of more of criteria a – f.

Note: The certification statement is not sufficient to meet the requirement for documentation in the medical record.
In order to meet criterion 2, the certifying physician must either:

1. Personally document one or more of criteria a – f in the medical record of an in-person visit within 6 months prior to delivery of the shoes/inserts and prior to or on the same day as signing the certification statement; OR...

2. Obtain, initial/sign, date (prior to or on the same day as signing the certification statement), and indicate agreement with information from the medical records of an in-person visit with a podiatrist, other M.D or D.O., physician assistant, nurse practitioner, or clinical nurse specialist that is within 6 months prior to delivery of the shoes/inserts, and that documents one of more of criteria a – f.
SafeStep collects the results of the CDFE to create a report that is sent to the certifying physician, along with a cover letter and the "Statement of Therapeutic Necessity".

To make things perfectly clear to the auditor, we call this report, "Information from Medical Records of In-Person Visit with DPM Documenting that Beneficiary has Qualifying Risk Factors for Therapeutic Shoes".

It includes the following statements and then requests signature and date from the certifying physician:

- "I am the MD supervising "PATIENT NAME'S" comprehensive plan of care for Diabetes Mellitus. I agree with the above findings and that he patient needs therapeutic shoes and inserts. As required by Medicare, this report is to be incorporated as pat of my medical records and if requested, a copy will be provided."

- "Date "PATIENT NAME" last seen by Dr. MD/ DO during which diabetes management was addressed: DATE."
• 20% of A5500 claims received a denial as Criterion 3 was not met per PA A37076.

There must be documentation to support that the certifying physician has certified that indications (1) and (2) are met and that he/she is treating the patient under a comprehensive plan of care for his/her diabetes and that the patient needs diabetic shoes. For claims with dates of service on or after 1/1/2011, the certifying physician must:

a. Have an in-person visit with the patient during which diabetes management is addressed within 6 months prior to delivery of the shoes/inserts; and
b. Sign the certification statement (refer to the Documentation Requirements section of the related Local Coverage Determination) on or after the date of the in-person visit and within 3 months prior to delivery of the shoes/inserts.

Note: Per Policy Article A37076 the Certifying Physician is defined as a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) who is responsible for diagnosing and treating the patient's diabetic systemic condition through a comprehensive plan of care. The certifying physician may not be a podiatrist, physician assistant, nurse practitioner, or clinical nurse specialist.
"No documentation submitted of an in-person visit with the patient by the certifying physician during which diabetes management is addressed within 6 months prior to delivery of shoes/inserts."

If get a denial of prepayment audit for not meeting criteria 3, obtain actual chart notes consistent with MD/DO attestation (medical records) and submit with re-determination.
How to contest an audit ...

- If fail audit, does not mean that documentation was incorrect. Consider appealing!
- Sample Re-determination form
- Link to Re-determination guide on SafeStep website
MEDICARE DME Redetermination Request Form

Supplier Information
Supplier Name
PTAN NPI
Tax ID
Address
City
State Zip Code
Phone Number

Beneficiary Information
Patient Name
Medicare Number
State Phone Number

Requestor's Name/Supplier Contact Name
Requestor's Signature (required) Date

Overpayment Appeal
Yes If yes, who requested overpayment: Medical Review CERT ZPIC/PSC Recovery Auditor

Date of Service HCPCS & Modifiers CCN Date of Initial Determination

Suggested Documentation Check List: Medicare Remittance Advice ABN CMN/DIF/Physician's Written Order Medical Documentation

Reasons/Rationale

Fax Numbers
NHIC, Corp. 1-781-741-3118
National Government Services, Inc. 1-317-525-4737
CGS 1-615-762-4630
Noridian Administrative Services, LLC 1-701-277-7688

Page 1 of 1
August 16, 2012.
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# Medicare Redetermination Request Form — 1st Level of Appeal

1. **Beneficiary’s name:**

2. **Medicare number:**

3. **Item or service you wish to appeal:**

4. **Date the service or item was received:**

5. **Date of the initial determination notice (please include a copy of the notice with this request):**
   
   (If you received your initial determination notice more than 120 days ago, include your reason for the late filing.)

5a. **Name of the Medicare contractor that made the determination (not required):**

5b. **Does this appeal involve an overpayment?**
   
   [ ] Yes  [ ] No
   
   (for providers and suppliers only)

6. **I do not agree with the determination decision on my claim because:**

7. **Additional information Medicare should consider:**

8. [ ] I have evidence to submit. Please attach the evidence to this form or attach a statement explaining what you intend to submit and when you intend to submit it. You may also submit additional evidence at a later time, but all evidence must be received prior to the issuance of the redetermination.

   [ ] I do not have evidence to submit.

9. **Person appealing:**
   
   [ ] Beneficiary  [ ] Provider/Supplier  [ ] Representative

10. **Name, address, and telephone number of person appealing:**

11. **Signature of person appealing:**

12. **Date signed:**

**PRIVACY ACT STATEMENT:** The legal authority for the collection of information on this form is authorized by section 1809(a)(3) of the Social Security Act. The information provided will be used to further document your appeal. Submission of the information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the determination of your appeal. Information you furnish on this form may be disclosed by the Centers for Medicare and Medicaid Services to another person or government agency only with respect to the Medicare Program and to comply with Federal laws requiring or permitting the disclosure of information or the exchange of information between the Department of Health and Human Services and other agencies. Additional information about these disclosures can be found in the system of records notice for system no. 09-70-0566, as amended, available at 71 Fed. Reg. 54680 (2006) or at http://www.cms.gov/Regulations-and-Guidance/Guidance/Downloadable-Files/0566.pdf
Issues contributing to podiatrists not utilizing the Medicare shoe program:

• A host of issues have contributed to many podiatrists not utilizing the Medicare shoe program.
• Fear of Medicare audits based on lack of understanding of compliance requirements.
• Difficulty complying with revised Medicare documentation requirements.
• Lack of cooperation from certifying physicians who are required to sign and date compliance documentation.

http://www.safestep.net/Members/SectionCompliance.asp?OrderForID=6567
References

• Local Coverage Determination and Policy Article titled Therapeutic Shoes for Persons with Diabetes
  - http://www.medicarenhic.com

• Healthcare Fraud Charges
  - DMEPOSAccreditationStandards
Summary

• Medicare has initiated many audits and a lot of practices have failed
• A consequence is that the number of diabetic shoes dispensed have decreased significantly
• Medicare has clearly provided information about documentation requirements
• A solution exists such that physician suppliers can confidently participate in the Medicare Therapeutic Shoe program...It's called WorryFree DME
Don't be overwhelmed...There is a SOLUTION!
Required Medicare Compliance Documentation

The Medicare Therapeutic Shoe Program requires that each diabetic shoe order have information concerning the patient’s diabetic conditions and certification from his/her MD. For your convenience, SafeStep will create these forms from the info you enter online during the ordering process. Then we will send and request back these signed documents from the patient’s MD, twice a week, for up to three weeks, until received:

- Statement of Certifying Physician for Therapeutic Footwear
- "Relevant Medical Records Documenting that Beneficiary has Qualifying Risk Factor(s)"

Other customized documents created include:

- Detailed written order
- Supplier in-person evaluation prior to selecting shoes
- Assurance that shoes fit within 3 months of physician signing certification statement
- Proof of delivery
Step by Step
How the process works:

• Every Patient with diabetes and Medicare should be scheduled for annual CDFE (pre fitting exam)
• Patients having qualifying risk factors are fit for shoes and shoe selection made
Pre-Fitting Exam

Supplier in-person evaluation conducted prior to selection of items that documents an examination of the beneficiary's feet with a description of the abnormalities; specified Medicare requirements:

- Neurological exam
- Vascular exam
- Dermatological exam among other qualifying risks factors that establish the need for shoes/inserts/modifications.
PQRS G8410, 2028F
Step by Step
How the process works:

• WorryFree DME sends Certifying Statement and Relevant Medical Records from DPM CDFE findings to MD so that staff does not have to.
  1. Certifying Statement
  2. Relevant Medical Records (physician exam findings)

• Includes:

  Attestation that patient had been seen by MD for care of diabetes not more than 6 months prior and that they agree that patient needs shoes and inserts.
Step by Step
How the process works:

• MD faxes to SafeStep signed, dated copies of
  1. Certifying Statement (3rd form of 6)
  2. Relevant Medical Records (physician exam
     findings) {4th form of 6}

• Documents are reviewed to ensure complete
  and compliant (reviewed to guarantee
  Medicare compliant)

• Also that patient seen by MD
  within 6 months

• Archived online
Step by Step
How the process works:

The Shipping Process

Documentation, shoes and inserts shipped by SafeStep to DPM
DPM fits shoes and inserts. Indicates on website and prints out:

- Dispensing SOAP Note (5th form of 6)

SafeStep WorryFree DME creates dispensing SOAP note (no need for dictation) after shoes indicated as dispensed.
Step by Step
How the process works:

When shoes received by DPM, staff indicates on website and prints out:

• Patient Certificate of Receipt (6th form of 6)

SafeStep WorryFree DME creates certificate of receipt and supplier standards when shoes come in. Cert. of Receipt includes patient address and mention of warranty as required by Medicare.
Streamlining utilization: SafeStep WorryFree DME:

• Identify every patient in practice with Medicare and DM.
• Perform CDFE on every one; if qualify, use display stand to fit for shoes.
• Enter orders using WFDME, let SafeStep take it from there.
Complimentary Webinars

www.safestep.net/Members/WebinarInfo.asp
Schedule a free Training Session with a DME Expert at SafeStep.net
Questions?