“WorryFree DME” 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)

*2012 SafeStep Rev. 101712
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  ☐ Scar
cing  ☐ 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

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): ___________________________

Neurological (Use Y or N)

☐ Loss of Vibration Perception

☐ Loss of Protective Sensation

Right  Left

Right  Left

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

'2012 SafeStep  Rev. 101712
Dear Doctor,

Your patient recently received a preliminary diabetic foot evaluation and may, after your examination of the patient’s feet, require diabetic shoes. Please see the enclosed forms for the diabetic foot exam that are required for Medicare's Therapeutic Shoe Program.

Medicare Requirements for patient eligibility include:

- Signed "Statement of Certifying Physician" from the physician managing the patient’s diabetes
- Documentation in your records indicating that you are managing the patient’s diabetes
- The presence of secondary risk factors as listed on the “Statement of Certifying Physician” form

Completing the attached forms while seeing your patients with diabetes may be a billable visit. Patient eligibility for shoes requires that this visit be documented within six months prior to when the shoes are dispensed.

See the attached letter from Paul J. Hughes, MD, Medicare Senior Medical Director, et al.

Please complete, as required, the following forms that are included with this letter and fax them to 203.306.3158:

- Physician Notes on Qualifying Condition(s)
- Statement of Certifying Physician for Therapeutic Shoes
- Prescription for Diabetic Shoes and Inserts

Your cooperation is very much appreciated. If you have any questions or need additional information, please contact us at 866.712.7837

Sincerely,
Physician Notes on Qualifying Condition(s) for Therapeutic Shoes

Physician Signature: ________________________________   Date: ________________

Physician Name (Printed): ____________________________  Physician NPI #: __________

Note: Shoes must be dispensed within 6 months from when diabetes care discussed by Certifying Physician with patient.

Please fax this back to us with the attached Statement of Certifying Physician for Therapeutic Shoes and Prescription for Therapeutic Shoes and Inserts and keep original in your patient’s chart. Thank you.

Certifying Physician Acknowledgment:

I am the MD/DO supervising the patient under a comprehensive plan of care for Diabetes Mellitus. I have personally conducted this foot examination or have authorized an eligible prescriber to conduct this exam on my behalf and agree with the findings. I have incorporated this exam as part of my medical records. Part of the comprehensive plan of care for this patient includes therapeutic shoes and insoles.

Please fax this back to us with the attached Statement of Certifying Physician for Therapeutic Shoes and Prescription for Therapeutic Shoes and Inserts and keep original in your patient’s chart. Thank you.

Patient Name: ____________________________   Date of Birth: ________________

Treatment Plan

Start Date: ________________   Duration of DM: ________________

Diabetes Type:  
- Type I, Controlled
- Type II, Controlled

Plan of Care

- Diet
- Meds
- Oral
- Injection

Vascular (Circle appropriate level)

- Dorsalis Pedis (3 = normal)
- Posterior Tibial (3 = normal)

Neurological (Use Y or N)

- Loss of Vibration Perception
- Loss of Protective Sensation

Note any calluses, bunions, swelling, redness, deformities or amputations using the symbol key below:

Callus C  Bunion B  Swelling S  Redness R  Deformity D  Hammer/Claw Toe HC  Amputation A  Wound W

Note: Shoes must be dispensed within 6 months from when diabetes care discussed by Certifying Physician with patient.
Statement of Certifying Physician for Therapeutic Shoes

I certify that all of the following are true:

Diabetes Type:
- Type II, Controlled
- Type I, Controlled
- Type II, Uncontrolled
- Type I, Uncontrolled

Primary diagnosis:
- Diabetes with neurological manifestations
- Diabetes with peripheral circulatory disorder
- Diabetes without neurovascular manifestations and with structural deformity

Foot Deformity
- Arthropathy associated with neurological disorders
- Bunion
- Claw toe
- Hallux rigidus
- Hallux valgus
- Hammer toe
- Unspecified deformity of ankle and foot, acquired
- Unspecified acquired deformity of toe

History of partial or complete amputation of the foot
- Lower limb amputation, foot
- Lower limb amputation, great toe
- Lower limb amputation, lesser toe(s)

History of preulcerative callus
- History of pre-ulcerative callus

History of previous foot ulceration
- Ulcer of heel and midfoot
- Ulcer other part of foot

Peripheral neuropathy with evidence of callus formation
- Neuropathy in diabetes

Poor circulation/PAD
- Atherosclerosis of the extremities with intermittent claudication
- Atherosclerosis of the extremities with ulceration
- Atherosclerosis of the extremities, unspecified
- Peripheral angiopathy
- Peripheral vascular disease unspecified

Acknowledgement Statement:
I am managing and treating this patient's diabetes under a comprehensive plan of care. This patient requires diabetic shoes and heat-molded or custom-molded inserts to help prevent ulcers and further complications.

Physician Signature: ___________________________ Date: ________________

Physician Name (Printed): ___________________________ Physician NPI #: ___________________________

Must be the MD or DO who is actively treating the patient’s diabetes.

Physician Address: ___________________________

Physician Phone: ___________________________

Note: Shoes must be dispensed within 3 months of date
Certifying Statement signed by physician.

PLEASE FAX TO 203.306.3158

2nd form of 3
**Prescription for Therapeutic Shoes and Inserts**

**PLEASE FAX TO 203.306.3158.**

3rd form of 3

**Patient Name: ___________________________**  **HICN: ___________**  **Date of Birth: _________________**

**Prescriber Name: ___________________________**  **Prescriber Phone: ___________________________**

<table>
<thead>
<tr>
<th>Quantity (Please check)</th>
<th>HCPC Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 1</td>
<td>A5500</td>
<td>Diabetic Depth Shoes, pair</td>
</tr>
</tbody>
</table>

**Prefabricated inserts pairs – multiple density, direct formed, molded to foot with external heat source (i.e. heat gun). Medicare allows up to three pairs of inserts per year.**

**OR**

| 3 2 1                  | A5512     | Custom-molded inserts – Multiple density, molded to model of patient’s foot. Medicare allows up to three pairs of inserts per year. |

**Primary Diagnosis Code: ______ ______ ______ ______ ______**

Please confirm that the entered Diagnosis Codes match your charting documentation.

**Diabetes, without complications**
- 250.00 Type II controlled
- 250.01 Type I controlled
- 250.02 Type II uncontrolled
- 250.03 Type I uncontrolled

**Diabetes with neurological manifestations**
- 250.60 Type II controlled
- 250.61 Type I controlled
- 250.62 Type II uncontrolled
- 250.63 Type I uncontrolled

**Diabetes with peripheral circulatory disorders**
- 250.70 Type II controlled
- 250.71 Type I controlled
- 250.72 Type II uncontrolled
- 250.73 Type I uncontrolled

**Duration of usage: 12 Months**

**Prescriber Signature: ________________________________**

**Date: _________________**

**Prescriber Name (Printed): ___________________________**

**Prescriber NPI #: ___________________________**

Must be the MD, DO or other eligible prescriber who is actively treating patient's diabetes (e.g. PA, Licensed Nurse Practitioner, Clinical Nurse Specialist, DPM)

PLEASE FAX TO 203.306.3158

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