The Orthotic & Prosthetic Centers

Providing Superior Orthotic,
Prosthetic and Pedorthic Services in
Pediatric and Adult Care

oandpcenters.com

Dear Patient:

In order for Medicare and Medicare replacement products to pay for diabetic shoes and/or diabetic inserts we must follow their strict requirements. You will need to provide the two pages that follow this letter to the physician who is managing your diabetic condition (usually either your primary care provider or endocrinologist). They contain a letter to your physician with directions for supplying Medicare compliant physician's notes and a Medicare "Statement of Certifying Physician for Therapeutic Shoes" form that must be accurately completed.

For your convenience, we have provided you with a check list to be sure all Medicare requirements have been met prior to returning these documents to our office:

1. Prescription for diabetic shoes and/or diabetic inserts.
2. Statement Of Certifying Physician for Therapeutic Shoes Form:
    a. All Applicable conditions are checked off
    b. The diabetic diagnosis code is indicated
    c. The Physician's signature, printed name, address, NPI & date are completed
3. Physician's office visit Notes:
    a. All of the office visit notes are included and they are no more than 6 months old
    b. The notes document all requirements of Medicare Policy
    c. A letter of medical necessity is not acceptable.

It is your responsibility to obtain these documents and ensure that our office receives them. Our office will not "chase" the required paperwork. We will not make an appointment for any patients until we have both the "Statement of Certifying Physician for Therapeutic Shoes" form and your physician's **Medicare compliant** office notes. If either of these are not complete or compliant, we will not be able to see you until they have been revised by your physician. It will be your responsibility to return the paperwork to your physician for revision.

If you have any questions regarding this process, please feel free to call our administrative staff.

For our Braintree, Methuen, and North Smithfield, RI offices:
Phone: 781-794-9991
Fax: 781-794-1769
For out West Yarmouth and Plymouth offices:
Phone: 508-775-2570
Fax: 508-775-7609

Thank you,

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Dear Physician,

Your patient would like to set up an appointment with our office to be evaluated for diabetic shoes and diabetic inserts that were prescribed by either your office or the patient's podiatrist. The patient has Medicare or a Medicare replacement plan as their health insurance. Medicare coverage guidelines require physician/clinic notes from a face to face visit with the patient within the last six months. The clinical notes should specify that the patient is diabetic and has one or more of the qualifying diabetic foot deficits (see below). They should also contain the patient's current ICD-10 codes that are relevant to their diabetes and foot deficits. **These clinical notes must come from the patient's physician (MD or DO only) who manages their diabetes. These clinical notes cannot be from a PA, NP, CNS, or DPM (per Medicare coverage guidelines).**

In order to be eligible for diabetic shoes through Medicare or a Medicare replacement plan, the patient must have diabetes and one or more of the following conditions in their feet/foot:

1. History of partial or complete amputation of the foot
2. History of previous foot ulceration
3. History of pre-ulcerative callous
4. Peripheral neuropathy with evidence of callous formation
5. Foot deformity (specific)
6. Poor circulation

These clinical notes cannot be in the form of a letter of medical necessity, but can be added as an addendum to your current clinical notes.

This is a Medicare/Medicare replacement plan requirement, and, therefore, we cannot deliver your patient's diabetic shoes and/or inserts until we receive the proper documentation needed. Our fax numbers are below.

For our Braintree, Methuen, and North Smithfield, RI offices:
Phone: 781-794-9991
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Statement of Certifying Physician for Therapeutic Shoes

Patient Name:_____

HIC #: _____

I certify that all of the following statements are true:

1. This patient has diabetes mellitus.

2. This patient has one or more of the following conditions. (Circle all that apply):
   a) History of partial or complete amputation of the foot
   b) History of previous foot ulceration
   c) History of pre-ulcerative callus
   d) Peripheral neuropathy with evidence of callus formation
   e) Foot deformity
   f) 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.

Physician signature: _____

Date Signed: _____

Physician name: _____
(printed - MUST BE AN M.D. OR D.O.)

Physician address: _____

_____

_____

Physician NPI: _____