HILL COUNTRY
Orthotics & Prosthetics

Diabetic Shoe Documentation Requirements
by Insurance Plan

We must have all documentation on file prior to scheduling an appointment for your patient. To ensure that they receive timely and efficient care, please provide the following:

WellMed Managed Insurance Plans

- ☐ **Patient Demographics** (including insurance information)
- ☐ **Valid Prescription** (see attached) or **Standard Written Order**
  - Must include a covered diabetic diagnosis.
  - Must specify all devices needed (including the type of inserts being ordered) and quantities (i.e. Diabetic shoes x2, Custom inserts (Left) x3, Toe filler (Right) x1).

Other Insurance Plans (Guidelines set by Medicare)

- ☐ **Patient Demographics** (including insurance information)
- ☐ **Valid Prescription** (see attached) or **Standard Written Order**
  - Must include a covered diabetic diagnosis.
  - Must specify all devices needed (including the type of inserts being ordered) and quantities (i.e. Diabetic shoes x2, Custom inserts (Left) x3, Toe filler (Right) x1).
- ☐ **Statement of Certifying Physician** (see attached)
  - Must be filled out and signed or cosigned by the **MD or DO** treating the patient's diabetes (not a PA, NPA, or Podiatrist).
  - Must be signed within 3 months of final shoe delivery.
- ☐ **Progress Notes** from Face-to-Face visit and Foot Exam
  - Must support the findings and diagnoses listed on the Statement of Certifying Physician.
  - Must be signed or cosigned by the **MD or DO** treating the patient's diabetes (not a PA, NPA, or Podiatrist).
  - Must be signed within 6 months of final shoe delivery.
- ☐ **Humana Prior Authorization** (Humana Insurance Plans only)
  - Must be submitted to Humana by PCP.

Hill Country Orthotics & Prosthetics Locations

Phone: 210-614-8777 • **Fax:** 210-694-4581

San Antonio, Medical Center
4242 Medical Drive
Building 2, Suite 2100
San Antonio, TX 78229

San Antonio, South Side
6631 S. Zarzamora St.
San Antonio, TX 78211

Corpus Christi
226 S. Enterprize Pkwy., Suite 110
Corpus Christi, TX 78405

Harlingen
1821 Hale Ave., Suite 17
Harlingen, TX 78550

McAllen
600 N. McColl, Suite 602
McAllen, TX 78501

El Paso
1326 E. Yandell Dr.
El Paso, TX 79902

HILL COUNTRY
Orthotics & Prosthetics

Prescription for Diabetic Shoes & Inserts

Fax Orders to: (210) 694-4581

Patient Name: _____ **Date:** _____

ICD 10: _____ **Diagnosis:** _____ **DOB:** _____

Length of Need (Number of Months or Lifetime)**:** _____ **Start Date:** _____

Items Needed:

- ☐ Diabetic Shoes A5500 x2 with Diabetic Inserts, heat molded A5512 x6
- ☐ Diabetic Shoes A5500 x2 with Diabetic Inserts, custom A5513/A5514 x6
- ☐ Diabetic Shoes A5500 x2 with (select one):
  - ☐ **Right Side** Toe Filler L5000 x1 and **Left Side** Diabetic Inserts, custom A5513/A5514 x3
  - ☐ **Left Side** Toe Filler L5000 x1 and **Right Side** Diabetic Inserts, custom A5513/A5514 x3
  - ☐ **Bilateral** Toe Filler L5000 x2

☐ Additional Items* (To prescribe any additional items not listed above, please fully describe items below (include Quantity and Right/Left/Bilateral)

*Other services include but are not limited to upper and lower extremity prosthetics, custom/off-the-shelf upper and lower extremity orthotics, custom and prefabricated lumbar orthotics.

Letter of Medical Necessity:

The above patient has been under my care and is in need of the prescribed orthopedic product. This product was prescribed to aid and/or accelerate the rehabilitation process and is deemed medically necessary.

Physician Name: _____ **NPI#:** _____
(Please Print)

Physician Signature: _____ **Date:** _____
(Medicare Requires Hand Signature and Date)

Central Intake Phone: (210) 614-8777

HILL COUNTRY Orthotics & Prosthetics

Hill Country Orthotics and Prosthetics

4242 Medical Dr, Bldg 2, Suite 2100
San Antonio, TX 78229-5641

Tel: (210) 614-8777
Fax: (210) 694-4581

Statement of Certifying Physician

Patient Information		
Patient Name (Last, First, MI)	Patient ID	Patient DOB
Device Type	Diagnosis Code(s)	Visit Date
HIC Number		

The physician listed below certifies that all of the following statements are true:
(Physician must be an MD or DO)

1. **This patient has diabetes mellitus.**
2. **This patient has the following conditions (please check all that apply):**
   - ☐ History of partial or complete amputation of the foot
   - ☐ History of previous foot ulceration
   - ☐ History of pre-ulcerative callus
   - ☐ Peripheral neuropathy with evidence of callus formation
   - ☐ Foot deformity
   - ☐ 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.**
5. **I have seen this patient for diabetes management within the last 6 months. I understand that the shoes must be delivered within 3 months of the signature date on this form AND within 6 months of the last in-person physician visit.**

Physician Name	Physician NPI
Physician Address	

The above procedures and any repair and/or parts to maintain proper fit and function are appropriate for this patient, and are deemed medically necessary.

Signature

Date

Print Name

ANNUAL COMPREHENSIVE DIABETES FOOT EXAM FORM

Name: _____ Date: _____ ID#: _____

I. Presence of Diabetes Complications
1. Check all that apply.
❑ Peripheral Neuropathy
❑ Nephropathy
❑ Retinopathy
❑ Peripheral Vascular Disease
❑ Cardiovascular Disease
❑ Amputation *(Specify date, side, and level)*

_____

Current ulcer or history of a foot ulcer?
Y____ N____

For Sections II & III, fill in the blanks with "Y" or "N" or with an "R," "L," or "B" for positive findings on the right, left, or both feet.

II. Current History
1. Is there pain in the calf muscles when walking that is relieved by rest?
Y____ N____
2. Any change in the foot since the last evaluation? Y ____ N____
3. Any shoe problems? Y___ N____
4. Any blood or discharge on socks or hose? Y____ N____
5. Smoking history? Y___N___
6. Most recent hemoglobin A1c result
_____% _____ *date*

III. Foot Exam
1. Skin, Hair, and Nail Condition
Is the skin thin, fragile, shiny and hairless? Y ___ N___

Are the nails thick, too long, ingrown, or infected with fungal disease? Y ___ N___

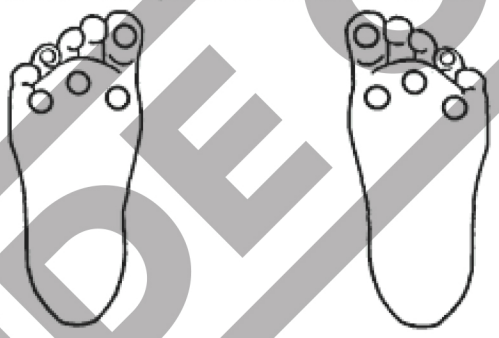
Measure, draw in, and label the patient's skin condition, using the key and the foot diagram below.
C=Callus U=Ulcer PU=Pre-Ulcer
F=Fissure M=Maceration R=Redness
S=Swelling W=Warmth D=Dryness

2. Note Musculoskeletal Deformities
❑ Toe deformities
❑ Bunions (Hallus Valgus)
❑ Charcot foot
❑ Foot drop
❑ Prominent Metatarsal Heads

3. Pedal Pulses Fill in the blanks with a "P" or an "A" to indicate present or absent.
Posterior tibial Left_____ Right_____
Dorsalis pedis Left_____ Right_____

4. Sensory Foot Exam *Label sensory level with a "+" in the five circled areas of the foot if the patient can feel the 5.07 (10-gram) Semme ament and "-" if the patient cannot feel the filament.*

Notes



Right Foot

Left Foot

5. Vibration Perception with 128-Hz tuning fork
Check appropriate box.
❑ Normal (+)
❑ Abnormal (-)

IV. Risk Categorization *Check appropriate box.*

❑ **Low Risk Patient**
All of the following:
❑ Intact protective sensation
❑ Pedal pulses present
❑ No deformity
❑ No prior foot ulcer
❑ No amputation

❑ **High Risk Patient**
One or more of the following:
❑ Loss of protective sensation
❑ Absent pedal pulses
❑ Foot deformity
❑ History of foot ulcer
❑ Prior amputation

V. Footwear Assessment *Indicate yes or no.*
1. Does the patient wear appropriate shoes? Y___ N ___
2. Does the patient need inserts? Y ___ N ___
3. Should corrective footwear be prescribed? Y ___ N ___

VI. Education *Indicate yes or no.*
1. Has the patient had prior foot care education? Y __N__
2. Can the patient demonstrate appropriate foot care? Y__N__
3. Does the patient need smoking cessation counseling? Y__N__
4. Does the patient need education about HbA1c or other diabetes self-care? Y__N__

VII. Management Plan *Check all that apply.*
1. Self-management education:
Provide patient education for preventive foot care. Date: _____
Provide or refer for smoking cessation counseling. Date: _____
Provide patient education about HbA1c or other aspect of self-care. Date: _____
2. Diagnostic studies:
❑ Vascular Laboratory
❑ Hemoglobin A1c (at least twice per year)
❑ Other: _____

3. Footwear recommendations:
❑ None
❑ Athletic shoes
❑ Accommodative inserts
❑ Custom shoes
❑ Depth shoes
❑ Socks

4. Refer to:
❑ Primary Care Provider
❑ Diabetes Educator
❑ Podiatrist
❑ RN Foot Specialist
❑ Pedorthist
❑ Orthotist
❑ Endocrinologist
❑ Vascular Surgeon
❑ Foot Surgeon
❑ Rehab. Specialist
❑ Other: _____

5. Follow-up Care:
Schedule follow-up visit. Date: _____

Provider Signature _____

Documentation of foot exam and findings must be added to the patient's medical record.