Ortho Gravity Medical Supply
4773 NW 183rd St, Miami, FL 33055

Tel: 305-627-3824 Fax: 954-252-3669
info@orthogravity.com www.orthogravity.com
NPI 1932800331 PTAN 8294180001

MEDICARE'S
DIABETIC FOOTWEAR CHECKLIST

#1 STATEMENT OF CERTIFYING PHYSICIANS & PRESCRIPTION

- ✓ Both *Statement of Certifying Physicians* and the *Prescription* must be completed by the **MD/DO only** that is treating the patient under a comprehensive plan of care for their diabetes.
- ✓ Must be completed **on or after** the date of the *In-person Diabetic Management Visit* with MD/DO.
- ✓ Must be signed within **3 months prior to delivery** of the shoes/inserts.

#2 DIABETIC MANAGEMENT RECORDS/ FOOT EXAM PROGRESS NOTES
from an In-person Diabetic Management Visit

- ✓ Must be completed by the **MD/DO** that is treating the patient under a comprehensive plan of care for their diabetes. Must contain verification that the patient has diabetes mellitus and needs diabetic shoes and/or inserts.
- ✓ The face to face visit must be within the past **6 months** and the MD/DO must **sign & date** the notes prior to signing the *Statement of Certifying Physicians*.
- ✓ **MD/DO** must have **ONE** of the following documented conditions to qualify as a compliant Diabetic Management Note:
  1. Previous amputation of the other foot, or part of ether foot
  2. History of previous foot ulceration of either foot
  3. History of pre-ulcerative calluses of either foot
  4. Peripheral neuropathy **with** callous formation of either foot
  5. Foot deformity of either foot (examples: bunion, hammertoe, claw foot, Charcot foot)
  6. Poor circulation in either foot

If the required paperwork is completed by someone OTHER than the MD/DO (for example a Podiatrist, nurse practitioner, physician's assistant, or physician trainee) then the patient's MD/DO must co-sign & date the Foot Exam Visit note and indicate they "agree" with the documentation.

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MEDICAL RECORDS DOCUMENTING OFFICE VISIT FOR DIABETIC SHOES & INSERTS

Patient's Name: _____ **Patient's DOB:** _____

Date of Last Office Visit: _____ **Physician NPI:** _____

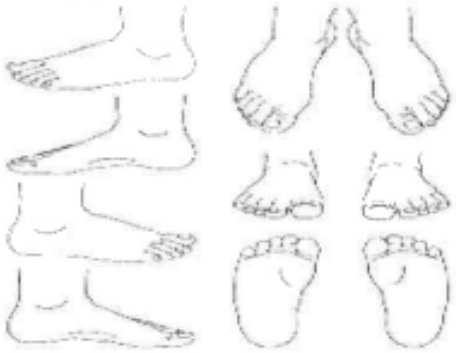
Physician Name: _____ **Physician's Phone #:** _____

~ CHECK OFF ALL APPLICABLE CONDITIONS ~

- ☐ **E10.40/E11.40** (Peripheral Neuropathy w/ evidence of callus formation on either foot)
- ☐ **E10.51/E11.51** (Poor Circulation in either foot)
- ☐ **Z89.9** (Previous amputation of foot or part of foot)
- ☐ **L84** (History of pre-ulcerative calluses on either foot)
  If yes, check which applies
  - ○ 0 - Superficial
  - ○ 1 - Deep
  - ○ 2 - Ulcer
- ☐ **Z86.31** (History of previous foot ulceration on either foot)
  If yes, select ulcer grade:
  - ○ Intact Skin
  - ○ Superficial
  - ○ Tendon or Bone
  - ○ Abscess or Osteo
  - ○ Foot Gangrene
  - ○ Gangrene
- ☐ **M21.969** (Foot Deformities of either foot)
  If yes, check all that apply:
  - ○ Bunions
  - ○ Hammer Toe
  - ○ Claw Foot
  - ○ Amputation Toe / Foot
  - ○ Charcot Arthopathy
  - ○ Misc: _____

Label Skin Conditions
(Measure, Draw, & Label the Patient's skin condition using the key & foot diagram below)

1 = Warmth
2 = Fissure
3 = Swelling
4 = Pre-Ulcerative Lesion
5= Maceration
6 = Dryness
7 = Callus
8 = Ulcer



Monofilament Response:	Ulcer:	Deformity:
☐ +5.07 (10gm)	Yes or No	Yes or No
☐ -5.07 (10gm)	Yes or No	Yes or No
☐ -6.10 (10gm)	Yes or No	Yes or No

Physician's Signature: _____ **Date:** _____

Physicians Name (printed): _____

*If the above medical records from the office visit are completed by a **Podiatrist, PA, CRNP, or CNS**, it **MUST BE SIGNED** & dated by an **MD or DO** indicating agreement with the above evaluation.
By signing this document, I am hereby agreeing with the above assessment.

MD or DO Signature: _____ **Date:** _____

MD or DO Name (printed): _____

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Diabetic Footwear Prescription Form

Please provide a copy of the patient's medical notes showing the indicated condition that was checked off.

Statement of Certifying Physician for Therapeutic Shoes

(This section **must** be filled out by an MD or DO only)

Patient Name: _____ **Patient DOB:** _____

Patient Phone Number: _____

By signing this statement, I certify that all of the following statements are true:

1. The patient has diabetes mellitus (ICD-10 diagnosis codes):
   - ☐ **E11.9**
   - ☐ **E10.9**
   - ☐ Other: _____

2. The patient has one or more of the following conditions **(CHECK ALL THAT APPLY)**:
   - ☐ **Z89.9** (Previous amputation of the other foot, or part of either foot)
   - ☐ **Z86.31** (History of previous foot ulceration of either foot)
   - ☐ **L84 (History of pre-ulcerative calluses of either foot)**
   - ☐ **E10.40/E11.40** (Peripheral neuropathy with evidence of callus formation of either foot)
   - ☐ **M21.969** (Foot deformity of either foot)
   - ☐ **E10.51/E11.51** (Poor circulation in either foot)

3. The certifying physician who is managing the patient's systemic diabetes condition has certified that indications (1) & (2) are met & that he/she is treating the patient under a comprehensive plan of care for his/her diabetes & that the patient needs diabetic shoes.

Physician signature: _____ **Date signed:** _____

Physician name (printed): _____ Physician NPI: _____

Physician address: _____ Telephone #: _____

Prescription Form

Patient Objectives: To transfer forces from high to low pressure areas, provide protection for the insensitive diabetic foot, absorb shock, reduce shear, & maximize comfort.

In order to meet these objectives, _____ requires
(Patient Name)

- **A5500** - Extra Depth Inlay Shoes (Medicare allows 1 pair per year) and **A5512** - Multi-Density Heat Molded Inserts (Medicare allows 3 pairs per year)
- Other (please specify) : _____

Physician signature: _____ Date **signed:** _____

Physician Name (printed): _____ NPI: _____

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