NOTICE TO PATIENTS

REGARDING DIABETIC SHOES AND INSERTS

Your insurance requires specific documentation before it will pay any benefit for diabetic shoes and inserts. The enclosed pages will assist you in obtaining the necessary documentation from your physician(s) in order to satisfy your insurance provider's requirements.

In addition to your prescription, insurance requires the information outlined below from your PRESCRIBING PHYSICIAN and your CERITIFYING PHYSICIAN (the M.D./D.O. who treats your diabetes).

ENCLOSED:	ACTION NEEDED:
• **"REQUEST TO PRESCRIBING PHYSICIAN"**	• Add patient's name and DOB and provide to the PRESCRIBING PHYSICIAN
• **"REQUEST TO CERTIFYING PHYSICIAN"**	• Add patient's name and DOB and provide to the CERTIFYING PHYSICIAN
• **"MEDICARE'S POLICY QUOTED"**	• Provide to the CERTIFYING PHYSICIAN for their info
• **"Certificate of Medical Necessity: Therapeutic Footwear for Individuals with Diabetes"**	• Provide blank form to the CERTIFYING PHYSICIAN **if MEDICAID is the primary insurance** OR
• **"Statement of Certifying Physician for Therapeutic Shoes"**	• Provide blank form to the CERTIFYING PHYSICIAN **if MEDICARE or other insurance is the primary insurance**

If you have not heard from us, it is because we have not received what is needed from your physician(s). You may wish to contact their office to inquire because we have no control over their responsiveness to your request.

After all required documentation has been received in our office, we will call to schedule your appointment.

We appreciate your business and look forward to serving your diabetic shoe/insert needs.

American Orthopedics

COLUMBUS
1151 W. 5TH AVE.
COLUMBUS, OH 43212
614-291-6454
FAX 614-291-2874

LIMA
855 W. MARKET ST.
LIMA, OH 45805
419-909-0404
FAX 567-289-6024

MARION
1459 MARION WALDO RD.
MARION, OH 43302
740-375-9100
FAX 614-291-2874

SPRINGFIELD
2200 N. LIMESTONE ST. #108
SPRINGFIELD, OH 45503
937-342-0150
FAX 937-342-0170

REQUEST TO PRESCRIBING PHYSICIAN

INSTRUCTIONS FOR PATIENT:
Add your name and date of birth in the spaces provided and give this sheet to your **prescribing physician**.

Patient Name: _____ (PRINT CLEARLY)

Patient DOB: _____ / _____ / _____

INSTRUCTIONS FOR PHYSICIAN:
Please provide the documentation requested below to **American Orthopedics, Inc.** for the above-named patient.

Dear Healthcare Provider:

YOU ARE RECEIVING THIS AS YOU ARE THE PRESCRIBING PHYSICIAN FOR THE ABOVE-NAMED PATIENT AND THEIR DIABETIC FOOTWEAR.

To successfully fulfill your patient's prescription and have their insurance cover the device(s) they need, our office requires the following:

1) **Your clinical notes from the PRESCRIPTION DATE ONLY**

Please send by FAX to (614) 291-2874 or by mail to American Orthopedics, 1151 W. 5th Ave., Columbus, OH 43212.

On behalf of the above-named patient, thank you for your prompt attention to this request.

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REQUEST TO CERTIFYING PHYSICIAN (M.D. or D.O.)

INSTRUCTIONS FOR PATIENT:
Add your name and date of birth in the spaces provided and give this sheet to the **physician who treats your diabetes**.

Patient Name: _____ (PRINT CLEARLY)

Patient DOB: _____ / _____ / _____

INSTRUCTIONS FOR PHYSICIAN:
Please provide the documentation requested below to **American Orthopedics, Inc.** for the above-named patient.

Dear Healthcare Provider:

YOU ARE RECEIVING THIS AS YOU ARE THE CERTIFYING PHYSICIAN FOR YOUR PATIENT THAT WAS PRESCRIBED DIABETIC FOOTWEAR…NOT NECESSARILY THE PRESCRIBING PHYSICIAN. THIS DOCUMENTATION IS A REQUIREMENT BY MEDICARE AND PRIVATE INSURANCE THAT FOLLOWS MEDICARE'S GUIDELINES. THE POLICY ARTICLE IS QUOTED ON THE FOLLOWING PAGE.

To successfully fulfill your patient's prescription and have their insurance cover the device(s) they need, our office requires the following:

1) **A <u>completed and signed</u> therapeutic shoe form (template provided), and**
2) **Your <u>clinical notes</u> from the above patient's most recent encounter**

Your note must meet the standard put forth by Medicare for the device to be covered. A SAMPLE PARAGRAPH THAT MEETS DOCUMENTATION REQUIREMENTS:

> *"As part of a comprehensive diabetic footcare program and diabetes care management this patient needs shoes and foot orthoses to protect the integrity of the compromised diabetic foot secondary to poor circulation. Reducing shear forces and allowing adequate room within the shoe is imperative for the diabetic foot. I intend on following this patient within the next 6 months."*

Please send by FAX to (614) 291-2874 or by mail to American Orthopedics, 1151 W. 5th Ave., Columbus, OH 43212.

On behalf of the above-named patient, thank you for your prompt attention to this request.

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MEDICARE'S POLICY QUOTED

INSTRUCTIONS FOR PATIENT:
Provide this sheet to the **physician who treats your diabetes** for their review.

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 beneficiary'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.

Therapeutic shoes, inserts and/or modifications to therapeutic shoes are covered if all the following criteria are met:

1) The beneficiary has diabetes mellitus (Reference diagnosis code section below); and
2) The certifying physician has documented in the beneficiary'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; and

The certifying physician has certified that indications (1) and (2) are met and that he/she is treating the beneficiary under a comprehensive plan of care for his/her diabetes and that the beneficiary needs diabetic shoes. For claims with dates of service on or after 01/01/2011, the certifying physician must:

1) Have an in-person visit with the beneficiary during which diabetes management is addressed within 6 months prior to delivery of the shoes/inserts; and
2) Sign the certification statement (refer to the Policy Specific Documentation Requirements section below) on or after the date of the in-person visit and within 3 months prior to delivery of the shoes/inserts.
3) 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 obtain, initial, date (prior to 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 or more of criteria (a) – (f).

The requirement that the in-person visit(s) be within 6 months prior to delivery of the shoes/inserts is effective for claims with dates of service on or after 1/1/2011. Note: The certification statement is not sufficient to meet the requirement for documentation in the medical record.

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Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY: THERAPEUTIC FOOTWEAR FOR INDIVIDUALS WITH DIABETES

Identifying Information [This section may be completed by the provider.]

Individual	Prescriber	Provider
Name	Name	Name American Orthopedics, Inc.
Medicaid ID number	Medicaid provider number	Medicaid provider number
Date of birth	NPI	NPI
	Telephone number	

Certification [This section may be transcribed by the provider.]

Mark all items that apply.

Diagnosis code(s)

☐ This individual has diabetes mellitus.

☐ The following conditions of coverage are met.

- ☐ An entire foot (i.e., the foot for which footwear is not being prescribed) has been amputated.
- ☐ Part of either foot has been amputated.
- ☐ In either foot, the individual has a history of
  - ☐ ulceration.
  - ☐ pre-ulcerative calluses.
  - ☐ peripheral neuropathy with evidence of callus formation.
  - ☐ foot deformity.
  - ☐ poor circulation.

☐ This individual is being treated for diabetes under a comprehensive plan of care by the prescriber.

☐ Therapeutic footwear is medically necessary for this individual because of diabetes.

☐ All relevant information is documented in this individual's medical record.

Comments or clinical information

Attestation [This section must be completed by the prescriber.]

I hereby attest that the certification information above is true, correct, and complete.	
Signature of prescriber	Date of signature

False certification constitutes Medicaid fraud.

Statement of Certifying Physician

For Therapeutic Shoes

Patient Name:_____

MBI:_____

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 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:_____

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