

# Important Forms

This section has important documentation that is required to comply with Medicare guidelines. In this section, we have sample documents and forms that should be used and maintained in the patient's file. The following is a brief description of each document:

1. An example of a patient S.O.A.P.
2. A sample of a cover letter which can be used with the Statement to Certifying Physician. This should be copied onto your letterhead.
3. An alternate cover letter which has a more detailed explanation of the Medicare Therapeutic Shoe Program.
4. The Master Form used to obtain the approval from the primary care physician (Statement of Certifying Physician for Therapeutic Shoe). This is a required document for Medicare and must be kept in the patient's file.
5. Sample prescription form. This should be in the patient's file.
6. Patient Authorization for Payment and Warranty Statement form for A5512 or A5513 Inserts. This should be signed by the patient. A copy should be given to the patient and the original should be kept in their chart.
7. A copy of the Dr. Comfort Return Policy.
8. A Shoe Break-In Procedure. You should review this with the patients and/or give them a copy.
9. Suggested Protocol for Resolving Complaints.
10. Suggested Complaint Log Form for Complaints.
11. Patient Approval and Fitting Form. This can be used to keep track of shoe fittings and approvals.



Examples of Patient Assessment with Plan of Action.

Patient Name: Mary Smith                      April 2, 2002

Chief Complaint:      Insulin dependent diabetic

Subjective Findings: She is requesting diabetic footwear.

Objective Findings: Dorsalis pedis and post tibial pulses are absent. Skin texture is thin and shiny. There are pre-ulcerative keratomas present. She complains of numbness and burning sensation in feet, compatible with diabetic neuropathies.

Assessment: Insulin dependent diabetic with diabetic neuropathies. She appears to be a candidate for diabetic shoe gear with accommodating insoles.

Plan: Letter will be sent to primary care physician and as soon as it is returned, shoes will be fitted and dispensed.

Dr. Edwards

Patient Name: John Hold    April 5, 2002

Chief Complaint:      Non-insulin dependent diabetic

Subjective Findings: This is a 69-year-old high risk, non-insulin dependent diabetic, presents today with complaint of painful feet. He is here to discuss his eligibility for accommodating shoe gear and inserts. He has a history of previous foot ulcerations and poor circulation. He is being evaluated due to his high risk of developing infections and/or ulcerations that could lead to limb loss.

Objective Findings: Pre-ulcerative calluses present on both feet.

Assessment: Non-insulin dependent diabetes, poor circulation and pre-ulcerative calluses.

Plan: Extra depth accommodative and therapeutic shoe gear is medically necessary for this patient to prevent infection and ulcerations. A letter has been sent to the primary care physician to certify his need for shoes and inserts, because of the above condition. Shoes will be dispensed as soon as the letter is returned.

Dr. Jones

Date:

Subject: Therapeutic Footwear

Dear Dr. \_\_\_\_\_

The Podiatric profession and the American Diabetes Association are involved in a joint effort to lower the amputation rate in the diabetic population. To achieve this goal, diabetic patients at risk are being identified and educated about proper footwear and care of their feet. In May of 1993, Medicare established a preventative footwear program for patients with diabetes. Since that time the program has been under-utilized and the amputation rate continues to rise.

As the physician who is managing the patient's diabetic condition, you have the responsibility of certifying the need for footwear and inserts for your patients under the Medicare program. I have enclosed a copy of the Statement of Certifying Physician form that must be completed for the patient to be covered under this program. As defined in the Medicare guidelines, beneficiaries can qualify for footwear and inserts if they have Type I or Type II diabetes and any one of the six qualifying conditions listed on this form.

I have taken the liberty of completing the first and second questions of the form based on my history and examination of the patient. I would ask that you review the form and upon signing it return it to our office. If you have any questions or concerns, please feel free to contact me.

I have taken an active role in the campaign to lower the amputation rate by supplying proper footwear and custom inserts to my diabetic patients at risk. I am achieving excellent results with the type of footwear and inserts that I am dispensing. I am asking for your help in an ongoing effort to lower the amputation rate in this at-risk population by identifying patients at risk and referring them for footwear and inserts when indicated.

Sincerely,

Dr.

Date: \_\_\_\_\_

Subject: Therapeutic Shoes and Inserts

Patient Name: \_\_\_\_\_

Dear Dr. \_\_\_\_\_

A Physical examination revealed that your patient has the condition(s) listed on the attached form. It is our recommendation that the patient be fitted with extra depth shoes with inserts. Extra depth shoes and custom molded inserts are covered under the Medicare Therapeutic Shoe Bill. This Bill was instituted by the Federal Government to reduce foot complications associated with diabetes. Medicare guidelines require that the physician who is managing the patient's diabetic condition certify the patient for footwear and inserts.

Our office staff is trained to properly fit the diabetic patient, mold the inserts and dispense them to the patient. With properly fitting "extra depth" shoes and custom molded inserts, we can assure the patient long-term comfort and thereby increase the overall compliance to this therapeutic benefit.

Please sign and return the certifying statement by fax or mail. If you have any questions concerning this patient please do not hesitate to call. Thank you for your cooperation in this matter.

Sincerely,

Dr.

## 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. ICD-9  
\_\_\_\_\_ Diabetes Type II (non-insulin dependent) 250.00  
\_\_\_\_\_ Diabetes Type I (insulin dependent) 250.01

2. This patient has one (or more) of the following conditions:

- \_\_\_\_\_ 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.

Physician signature: \_\_\_\_\_

Date signed: \_\_\_\_\_

Physician name (printed – **MUST BE A M.D. OR D.O.**):

\_\_\_\_\_

Physician address:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Physician NPI: \_\_\_\_\_

## **Patient Authorization for Payment and Warranty Statement**

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I have received \_\_\_ individual Dr Comfort (style: \_\_\_\_\_) “extra depth” shoes and \_\_\_ individual Dr Comfort full contact custom diabetic inserts (A5513 compliant). The inserts were made from a cast/bio-foam impression of my feet. I am satisfied with the fit and authorize Medicare and my supplemental insurance carrier to pay Dr. \_\_\_\_\_ directly. I understand that Medicare pays for up to one pair of shoes (2 individual) and 3 pair inserts (6 individual) per calendar year. I understand that I am responsible for any deductible and unpaid balance that Medicare or my co-insurance does not cover. I have not received any other shoes or inserts under this plan from any other supplier in this calendar year.

### **Patients Warranty Statement**

Dr Comfort will accept returns of any Dr Comfort shoes, for any reason, within thirty days of the shoes being dispensed. If, within thirty days, the podiatrist notes that the shoes do not fit properly, Dr Comfort will replace them, at no charge, with a properly fitted shoe. Dr Comfort shoes that have been dispensed for a period of over thirty days will only be exchanged or credited at the sole discretion of Dr Comfort. Any shoe that is returned must be returned in the original shoe box for proper credit.

### **Supplier Standards and Break in Procedure**

The office staff has disclosed the CMS Medicare DMEPOS Supplier Standards to me and educated me on the proper break-in procedure for my Dr Comfort shoes.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_



## **Patient Authorization for Payment and Warranty Statement**

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I have received \_\_\_ individual Dr. Comfort (style: \_\_\_\_\_) “extra depth” shoes and \_\_\_ individual Dr. Comfort Elite inserts (A5512 compliant). The inserts were heat molded to my feet to obtain full contact per my medical condition(s). I am satisfied with the fit and authorize Medicare and my supplemental insurance carrier to pay Dr. \_\_\_\_\_ directly. I understand that Medicare pays for up to one pair of shoes (2 individual) and 3 pair inserts (6 individual) per calendar year. I understand that I am responsible for any deductible and unpaid balance that Medicare or my co-insurance does not cover. I have not received any other shoes or inserts under this plan from any other supplier in this calendar year.

### **Patients Warranty Statement**

Dr. Comfort will accept returns of any Dr. Comfort shoes, for any reason, within thirty days of the shoes being dispensed. If, within thirty days, the podiatrist notes that the shoes do not fit properly, Dr. Comfort will replace them, at no charge, with properly fitted shoes. Dr. Comfort shoes that have been dispensed for a period of over thirty days will only be exchanged or credited at the sole discretion of Dr. Comfort. Any shoe that is returned must be returned in the original shoe box for proper credit.

### **Supplier Standards and Break-In Procedure**

The office staff has disclosed the CMS Medicare DMEPOS Supplier Standards to me and educated me on the proper break-in procedure for my Dr Comfort shoes.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_



## Sample Prescription Form

### Prescription Form for Diabetic Patients Who Require Therapeutic Shoes

Note: This form is to be used by the prescribing physician after the patient has been certified as eligible by the physician treating their diabetes.

Patient Name:  
Address:

Date:

Patients Medicare ID#

Date of Birth:

Per Statement of the Certifying Physician, the patient has one or more of the following foot conditions.

Previous Amputation     Peripheral Neuropathy     Previous Ulceration  
 Foot Deformity         Pre Ulcerative Callus     Poor Circulation

Type of Shoe Prescribed:

Extra-Depth                       Custom Molded Shoes

If custom molded shoes are required, the foot deformity or ICD-9 code:

Custom molded shoes were required due to: \_\_\_\_\_

Additional Shoe Modifications: \_\_\_\_\_

#### **Sample Notes for A5512 Heat Molded Insert**

Heat-Molded Only: This patient's flexible plantarflexed 2<sup>nd</sup> left and 2<sup>nd</sup> right metatarsal head with intractable plantar keratosis, is sufficiently at high risk to substantiate the use of a heat molded customized insert, but not sufficient enough at risk or have a sufficiently fixed or gross deformity to substantiate the use of a custom made inserts. Their deformity and at risk status is significant enough to preclude the use of pre-made non-molded inserts. 3 pairs were ordered.

#### **Sample Notes for A5513 Custom Insert**

For custom devices only: A Bio-Foam or cast impression was taken so that custom inserts with customized accommodations integral to the inserts could be fabricated (see shoe order form sent to manufacturer). 3 pairs were ordered. This patient requires custom inserts because their deformities are so fixed and so severe that they cannot be accommodated in heat molded inserts and/or previous attempts at heat molded inserts failed to alleviate the patient's pain and/or at risk condition.

Supplier's Signature: \_\_\_\_\_ UPIN# \_\_\_\_\_ Date: \_\_\_\_\_



## **Return Policy for DME Supplier**

Dr. Comfort will allow shoes to be returned for any reason within 60 days of date of shipment, except where shoes have been modified, i.e. heel lifts, wedges or custom stretching. **All returns must be accompanied by a Shoe Return Form.** A master copy and instructions are in Section 5. Credit will be issued after we receive and inspect the shoes. Any shoe that is returned must be returned in the original shoe box for proper credit. Any shoe that is returned without proper documentation will be subject to a \$10.00 processing fee. Split pairs which are returned will only receive credit for standards list price. No refund will be issued for the premium.

Credits will not be given for custom made products, toe fillers, shoe modifications and custom insert as they are customized to your specifications.

For shoes that are greater than 60 days old, prior authorization from Dr. Comfort is required before they can be returned. Credit on these shoes is at Dr. Comfort's sole discretion. Shoes must be returned in the original shoe box. Shoes that come back which show abuse or excessive wear will not be credited.

Per DMERC policy: If shoes are returned for credit, you must refund any payment Medicare has made regarding those returned shoes.



## **Shoe Care Instructions**

### **Break-In Period for Shoes with Heat Molded or Custom Inserts**

The shoes that were dispensed were specifically selected and dispensed with a level of medical knowledge as required by Medicare guidelines. Thus, these shoes are measured to fit your feet. You may, however, experience some issues when walking due to your specific gait and the mechanics of your feet. In order to ensure that your shoes become an extension of your pedorthic medical care, please follow these instructions.

1. When you arrive home, place your new shoes (with the inserts in them) on your feet (with socks) and wear them for 30 to 60 minutes – only on carpeting at first
2. Remove your shoes and look for any areas of redness (ask a family member for assistance, if necessary)
3. Once you have verified that the shoes do not rub your skin (absence of redness), wear your shoes around your home for a day or two; check again for areas of redness
4. After you have verified that you can wear your shoes for comfortably, you need to wear your shoes at different times of the day. As you know, feet can swell
5. Once you (or your family member) have verified that you are not having problems with these new shoes, you are ready to wear them outside the home
6. Remember, even after this break-in period, you should always check your shoes and feet each day - looking for anything out of the ordinary

The therapeutic shoe bill provides for a pair of shoes and three pairs of inserts in one calendar year. These specially-made inserts contain different materials that 1) ensure contact with your foot and 2) help to prevent ulcerations by cushioning the forces and reducing friction. The maximum lifespan of these inserts is about 4 months. Please remove each insert as instructed every 4 months (mark your calendar now) and replace it with the other inserts provided. If used properly, 3 pairs of inserts should last one year. Please note that any tears in these devices should be reported at once - as they may be the source of a foot irritation or ulceration.

### **Care of the Shoes (Leather)**

1. Clean your shoes regularly – will give life back to the leather (saddle soap works great)
2. Use a leather crème for the leather shoes. This crème will keep the leather clean and supple. Leather crèmes can be found at any drug, shoe or grocery store.
3. Simply apply the crème with a clean dry cloth and work it into the leather.
4. Never use shoe polish, as the shoes are hand-tanned. Shoe polish will ruin the finish.

### **Care of the Shoes (Nubuck)**

1. This material can be cleaned by the using a small stiff brush to brush-away the dirt.
2. There are sprays on the market designed to refurbish suede or nubuck materials (the Kiwi-brand works great). Try the spray in a small area first to test for any discoloration
3. Do not immerse the nubuck shoes in water and do not use a shoe polish

### **Care of the Shoes (Lycra)**

- 1 Never put this shoe in the washing machine.
- 2 We suggest using any fabric protector on this material to help retard the dirt.
- 3 Spray the shoes after the appropriate break in period and before you wear them regularly.
- 4 If they do get soiled, use a small amount of soap and water - or a small amount of Woolite and water to remove the dirt (especially on the beige).
- 5 Try a baby wipe! (works great if the shoe has first been sprayed with a fabric protector)



*DME Supplier, Inc.  
17 Main Street  
Anywhere, SC 29999*

**PROTOCOL FOR RESOLVING COMPLAINTS  
FROM MEDICARE BENEFICIARIES**

The patient has the right to freely voice grievances and recommend changes in care or services without fear of reprisal or unreasonable interruption of services. Service, equipment, and billing complaints will be communicated to management and upper management. These complaints will be documented in the *Medicare Beneficiaries Complaint Log*, and completed forms will include the patient's name, address, telephone number, and health insurance claim number, a summary of the complaint, the date it was received, the name of the person receiving the complaint, and a summary of actions taken to resolve the complaint.

All complaints will be handled in a professional manner. All logged complaints will be investigated, acted upon, and responded to in writing or by telephone by a manager within a reasonable amount of time after the receipt of the complaint. If there is no satisfactory resolution of the complaint, the next level of management will be notified progressively and up to the president or owner of the company.

The patient will be informed of this complaint resolution protocol at the time of set-up of service.

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17 Main Street  
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**MEDICARE BENEFICIARY COMPLAINT LOG**

Date of receipt of complaint: \_\_\_\_\_

Patient's name: \_\_\_\_\_

Patient's address: \_\_\_\_\_

\_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Patient's telephone number: \_\_\_\_\_

Patient's Medicare or Health Insurance Claim Number: \_\_\_\_\_

Description of complaint: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Action taken to resolve the complaint: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of representative \_\_\_\_\_ Date \_\_\_\_\_

