ThedaCare At Home
Understanding Diabetic Shoes

Updated 07-11-18

Step 1

Your doctor *– Your MD or DO must have seen you in the past 3 months.*

- Needs to see you in the office for an appointment for management of your diabetes.
- At that appointment, if you have any of the following you could possibly qualify for diabetic shoes covered by Medicare:
    - Poor circulation
    - Foot deformity
    - Peripheral neuropathy with evidence of callus formation
    - History of pre-ulcerative callus
    - History of previous foot ulceration
    - History of partial or complete amputation of the foot.
- The above condition(s) need to be described in your medical record.
- Your provider that is managing your diabetes **will not** be your Podiatrist, but will be your **Primary Care Physician or Internal Medicine Physician *(must be an M.D or D.O.)*** Your provider will have to complete the **Statement of Certifying Physician form**. This form explains your conditions and certifies they are the physician managing your diabetes.
- You will need a thorough diabetic foot assessment. This can be completed by your Podiatrist or a Nurse Practitioner but this **assessment and findings must be reviewed and entered into your medical record by your Primary Care Physician or Internal Medicine Physician.**
- A Podiatrist is unable to manage your diabetes. They can write a prescription for the diabetic shoes, but you will first need the Statement of Certifying Physician before you get the prescription. Your Primary Care Physician is also able to write the prescription at the time of your appointment.

Step 2

Your doctor -

- Needs to complete the **Prescription for Diabetic Shoes and Inserts**, along with any special instructions.

Step 3

Your doctor -

- Will provide a copy of **your patient notes** - the sections showing:
  - Your diagnosis of the qualifying condition.
  - And the treatment of the patient's diabetes.
- The most recent office visit to your Primary Care Physician that discussed your diabetes and qualifying condition must be within 6 months of the patient receiving diabetic shoes and inserts.

Step 4

You will -

- Need to schedule an appointment with a provider to go over the paperwork, get an authorization if needed and get measured for shoes and inserts.
- Take the ***Statement of Certifying Physician***, the ***Prescription for Diabetic Shoes and Inserts*** and the ***Patient Notes***, to your appointment with provider.

A comprehensive foot health program is an important part of managing a patient's diabetes.

- *More than 60 % of non-traumatic lower limb amputations are a result of diabetes.*
- *The rate of amputation for people with diabetes is 10 times higher than for people without diabetes.*
- *60-70% of diabetics have mild to severe forms of nervous system damage resulting in impaired sensation in the feet.*
- *According to the Centers for Disease Control, a comprehensive foot care program can reduce diabetic foot amputations by as much as 85%.*

ThedaCare At Home is a provider of Dr. Comfort Diabetic Shoes and Inserts. It is recommended to schedule an appointment with a specialist for fittings or questions at the following locations or by calling 920-969-0919:

ThedaCare At Home *Kensington Place Mall* *3000 E College Avenue, Suite A* *Appleton*	*ThedaCare At Home* *West Gate Plaza* *2100 Omro Road* *Suite C* *Oshkosh*	*ThedaCare At Home* *710 Riverside Drive* *Waupaca*	*ThedaCare At Home* *1405 Mill St,* *New London*	*ThedaCare At Home* *100 County Road B* *Shawano*

Prescription for Diabetic Shoes and Inserts

Patient Name: _____DOB: _____

Date of Diabetic Face to Face Visit (required): _____

1. Type of shoes prescribed (Please check):

   ☐Extra Depth (A5500) 1 pair, unless otherwise noted

2. Type of inserts prescribed (Please check):

   ☐Custom fabricated (A5513/ K0903) 3 pairs, unless otherwise noted

ICD Notes and/or special instructions:

_____
_____
_____
_____
_____
_____

Physician signature: _____

Must be an MD, DO, DPM, PA, NP or Clinical Specialist

The medical professional writing this order must be knowledgeable in diabetic shoes and insert.

Physician name (printed) _____

NPI #: _____ Date: _____

Physician phone: _____

Physician address: _____
_____

The patient will need to give the **Statement of Certifying Physician**, the **Prescription for Diabetic Shoes** and the **Patient Notes** from their medical record to a provider of diabetic shoes.

Please fax to 920-969-0020 or give a copy to the patient to bring to the diabetic shoe provider.

Statement of Certifying Physician

(To be signed by Certifying Physician within 3 months prior to the prescription)

Patient Name: _____DOB: _____

Date of Diabetic Face to Face Visit (required): _____

1. This patient has diabetes mellitus:

   ☐Type II

   ☐Type I

2. Qualifying Conditions: I have diagnosed and will include my notes showing that this patient has one or more of the following:

   ☐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 for care of his/her diabetes.
4. This patient needs special shoes (extra depth or custom molded) because of his/her diabetes.
5. This patient needs shoe inserts (heat molded or custom fabricated) because of his/her diabetes.

Physician Signature: _____

Must be an MD or DO

The Certifying Physician provides the medical care for and manages the beneficiary's systemic diabetic condition.

Physician name (printed) _____

NPI #: _____ Date: _____

Physician phone: _____

Physician address: _____

_____

The patient will need to give the **Statement of Certifying Physician**, the **Prescription for Diabetic Shoes** and the **Patient Notes** from their medical record to a provider of diabetic shoes.

Please fax to 920-969-0020 or give a copy to the patient to bring to the diabetic shoe provider.

Foot Assessment

Patient Name: _____ DOB: _____ Today's Date: _____

A1C: _____ Current footwear: _____

Allergies (specifically to shoe materials): _____

Previous diabetic footwear experience: _____

Examination Checklist: R L

Biomechanical:

Ankle:

Plantar/Dorsiflexion:

Great toe: Plantar/Dorsiflexion

Ankle: Adduction/Abduction

Ankle: Eversion/Inversion

Examination Checklist:

Vascular:

Temp: Dorsal R _____ Plantar R _____

Dorsal L _____ Plantar L _____

Hair: Rt - Present/Absent Lt - Present/Absent

Color: _____

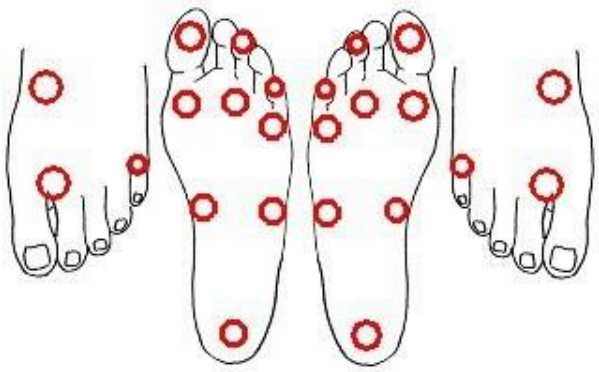
Capillary Refill - R _____ sec L _____ sec

Texture: Fragile, Thin, Shiny _____

Pulse: Posterior Tibial Rt/ Lt Present/Absent

Dorsalis Pedis Rt/ Lt Present/Absent

Neurologic:	R	L
Vibratory Sensation:	pass/fail	pass/fail
Sensation:	pass/fail	pass/fail



- Circled areas are test sites for 10g monofilament- indicate "+" if the patient can feel and "-" if the patient is unable to feel the monofilament. 128 Hz Tuning fork conducted on the dorsum of the great toe proximal to the nail bed.
- Draw and label the skin conditions using the following key:
  Callus /// Wound ● Bunion > Redness R Swelling S Hammertoes ^

Pedograph Digital Photograph Scanner	Comments: Gait observation: Shoe wear patterns:

Clinician Name: _____ Signature: _____ Date: _____