STEP BY STEP INSTRUCTIONS FOR THERAPEUTIC SHOES

STEINMANN PROSTHETICS & ORTHOTICS
3885 FOOTHILLS ROAD, STE. 1, LAS CRUCES, NM 88011
P: 575-532-5900 | F: 575-532-6008

Steinmann Prosthetics & Orthotics is looking forward to supporting you with getting therapeutic shoes. Before we can schedule your fitting appointment, Medicare requires a few steps with your doctor.

Please follow the instructions below.

STEP 1 — Make sure you qualify. You must have:

✓ Diabetes Mellitus (E0.8.00 through E13.0)

AND

✓ One of these **foot conditions for each foot:**

- Previous foot or toe amputation
- Previous foot ulcer
- Pre-ulcerative callus
- Peripheral neuropathy with callus formation
- Foot deformity (bunions, hammertoes, Charcot, deformity of toe/foot, etc.)
- Poor circulation in either foot

Please note: A diabetes diagnosis alone does not qualify.

STEP 2 — Visit your Doctor who manages your diabetes

You must have a visit with the doctor who manages your diabetes. This doctor must be an MD or DO. NPs or PAs can conduct the visit if they are working “Incident to” a supervising physician. During this visit your doctor will:

- Review your diabetes care
- Document your foot condition
- Sign the attached Prescription, CMS and Certification for Diabetic Shoes

Please note: This visit must happen within 6 months before receiving your shoes.

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STEP 3 — If Another Provider Checks Your Feet

Sometimes a podiatrist, nurse practitioner (NP), or physician assistant (PA) may examine your feet.
If this happens:
• They will document your foot condition
• Your primary doctor (MD/DO) must review and sign off approving their clinical note.
Please note: Medicare requires the MD/DO managing your diabetes to sign the final certification.

STEP 4 — You or your doctor must send us these records

Before we can move forward with ordering your shoes and inserts, we must receive:

1. **Diabetes clinical visit notes** from your recent diabetes appointment
2. **Foot exam clinical notes** showing your qualifying foot conditions
3. **Prescription, CMS and certification forms** signed by a certifying MD/DO (see attached forms)

Please note: Medicare requires detailed clinical notes. Diagnosis codes alone are not enough.

STEP 5 — Schedule your appointment with Steinmann Prosthetics & Orthotics

Once we receive your doctor's qualifying documentation, we will contact you to schedule your appointment.

Important Reminder

If we do not receive the required documentation from your doctor, Medicare will deny coverage and you will be responsible for the total cost. Following these steps helps ensure your shoes are approved as quickly as possible. Please contact our office if you have any questions regarding documentation criteria.

PRESCRIPTION FOR THERAPEUTIC SHOES

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Patient Name: **Date:**

DOB: **Gender:**

Primary Insurance: **Primary ID:**

Secondary Insurance: **Secondary ID:**

Diagnosis Codes:

Diabetes Code (E0.8.00 - E13.0) _____

Qualifying Foot ICD-10 Code(s)_____

Check which is recommended (Please note: up to 1 toe filler per side or 3 inserts per side can be ordered)

- ☐ _____ pairs of custom molded multi-density insert(s) (A5513) with 1 pair of extra depth shoes (A5500).
- ☐ _____ pairs of heat molded multi-density insert(s) (A5512) with 1 pair of extra depth shoes (A5500)
- ☐ _____ custom toe filler (L5000) and _____ custom molded multi-density insert(s) (A5513) with 1 pair of extra depth shoes (A5500)
- ☐ Other options - Specify: _____
- ☐ Insert or toe filler modification(s) - Specify: _____

Check all that apply:

- ☐ To reduce pain by restricting mobility of the affected body part.
- ☐ To facilitate healing following a surgical procedure on the affected body part or related soft tissue.
- ☐ Patient has had changes to the shape of affected body part due to change in diagnosis/surgery, weight loss/gain.

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☐ To facilitate healing following injury to the affected body part or related soft tissue.

☐ Replacement of device due to normal wear and tear or (all attempts to repair device have been made).

☐ To support weak muscles or a deformity of the affected body part.

I, the undersigned, certify that the above is medically indicated, and, in my opinion is reasonable and necessary with reference to the current accepted standards and treatments of this patient's physical condition. The effective date of medical need is immediate and the duration of the need is indicated by the patient's progress.

Provider Signature: _____ Date: _____

NPI #: _____Provider Name: _____

Provider Address: _____

Provider Phone: _____ Provider Fax: _____

For insurance compliance, if the above signature is not from an MD/DO, please obtain the MD/DO signature below:

MD/DO Name: _____ NPI: _____

MD/DO Signature: _____ Date: _____

STATEMENT OF CERTIFYING PHYSICIAN FOR THERAPEUTIC SHOES

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Patient Name: **DOB:**

I, the undersigned, certify that all the following statements are true:

☐ This patient has diabetes mellitus. **ICD-10 Code (E0.8.00 - E13.0**) _____

AND this patient has one or more of the following conditions. (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

Specify on each side - the diagnosis code and the location of the problem (e.g. patient has bilateral hammer toes #2-#5; ICD-10 Code M20.41 and M20.42)

Left Side: _____

Right Side: _____

Confirm All (Must complete and check boxes):

☐ I am treating this patient under a comprehensive plan of care for his/her diabetes.
☐ This patient needs special shoes (depth or custom-molded shoes) because of his/her diabetes.
☐ The above information is documented in the patient's medical record.

PA-C's or ARNP's are not eligible to sign this form per Medicare guidelines for Therapeutic Shoes.

MD/DO Name: _____ NPI: _____

MD/DO Signature: _____ Date: _____

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved OMB
No. 0938-0679
Expires 02/2024

CERTIFICATE OF MEDICAL NECESSITY
CMS-854 — CONTINUATION FORM

DME 11.02

PATIENT NAME	MEDICARE ID

SECTION C Narrative Description of Equipment and Cost *(continued)*

(1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule Allowance for each item, accessory and option. (see instructions on back.)

SECTION D PHYSICIAN Attestation and Signature/Date

I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE_____ DATE _____/_____/_____