

# RICHEY & Co. SHOES

## Step-By-Step Instructions for Receiving Therapeutic Footwear for Diabetics from Medicare

Welcome to Richey & Co. We are excited to help you protect your feet from breakdown and/or ulceration by using properly fitted diabetic footwear. Please follow these instructions so that we can expedite the process of getting you into your new shoes.

1. Take the enclosed Diabetic Footwear Prescription Form (see Page 2) to either your MD or your podiatrist (DPM) to complete – the prescription must be specific as to the exact number of inserts you and your doctor decide that you need. Please remember that this prescription is only valid for 90 days from the date it is signed. You must receive your new items within 90 days of the prescription date, so please don't delay in returning to our store.
2. Take the enclosed Statement of Certifying Physician (see Page 3) and the Addendum to Clinical Notes (see page 4) to your Medical Doctor (MD) or Doctor of Osteopathy (DO) who is treating you for your diabetes and have them complete both forms in their entirety.
3. Once all of your paperwork is complete, return to our store with your completed paperwork and all of your insurance cards (Primary and Secondary). Our pedorthist will have you complete a Patient Registration Form. Subsequent to filling out your paperwork in the store, our Medical Information Manager must verify your coverage, deductible and co-pays with your insurance companies. We will contact you if we have any questions. Once all of your paperwork is in order, our pedorthist will provide you with your prescribed footwear.
4. Once you have received and paid for all of your footwear, we will bill your insurance company for you. Please allow approximately 45 days from the date you receive the footwear to receive reimbursement from your primary insurance and then an additional 45 days to receive payment from any secondary insurance you may have.
5. If you have any questions regarding your insurance or the billing of your claim, you may call our main office toll free at 1-877-874-2439 x 12.
6. Make sure you continue to visually inspect your feet daily, or have a friend or loved-one help you. If you notice any red spots, please come see our pedorthists immediately.
7. Rotate your inserts throughout the year. Inserts have an average life of four months. Visually inspect them for signs of wear or breakdown. If you have any questions, please come see our pedorthists immediately.
8. Mark your calendar for January 1<sup>st</sup>; your benefits renew each calendar year.
9. Enjoy! Please call us with any questions.

***PATIENTS: PLEASE CALL AHEAD FOR AN APPOINTMENT***

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**QUESTIONS: CALL TOLL FREE 1-8778-RICHEY • WWW.RICHEYCO.COM**

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## DIABETIC FOOTWEAR PRESCRIPTION FORM

*NOTE: FOR COVERAGE BY MEDICARE UNDER THE THERAPEUTIC SHOES FOR DIABETICS PROGRAM— THIS PRESCRIPTION MUST BE ACCOMPANIED BY A SIGNED STATEMENT OF CERTIFYING PHYSICIAN (SCP). **THE SCP MUST BE SIGNED BY THE M.D. OR D.O. MANAGING THE PATIENT'S SYSTEMIC DIABETIC CONDITION.** BLANK COPIES OF THE SCP ARE AVAILABLE AT [WWW.RICHEYCO.COM](http://WWW.RICHEYCO.COM)*

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

<p style="text-align: center;"><b><u>Patient must have at least one of the following (CHECK ALL THAT APPLY):</u></b></p> <p><input type="checkbox"/> Lower limb amputation, foot (V49.73 &amp; 755.38)</p> <p><input type="checkbox"/> Lower limb amputation, great toe (V49.71 &amp; 755.39)</p> <p><input type="checkbox"/> Lower limb amputation, lesser toe(s) (V49.72 &amp; 755.39)</p> <p><input type="checkbox"/> Ulcer of heel and midfoot (707.14)</p> <p><input type="checkbox"/> Ulcer other part of foot (707.15)</p> <p><input type="checkbox"/> History of pre-ulcerative callus (707.9)</p> <p><input type="checkbox"/> Polyneuropathy in diabetes (357.2) <u>and</u> History of pre-ulcerative callus (707.9)</p> <p><input type="checkbox"/> Claw toe (735.5)</p> <p><input type="checkbox"/> Hammer toe (735.4)                      Other _____</p> <p><input type="checkbox"/> Hallux valgus (735.0)</p> <p><input type="checkbox"/> Hallux rigidus (735.2)</p> <p><input type="checkbox"/> Unspecified acquired deformity of toe (735.9)</p> <p><input type="checkbox"/> Unspecified deformity of ankle and foot, acquired (736.70)</p> <p><input type="checkbox"/> Charcot Arthropathy (713.5)</p> <p><input type="checkbox"/> Atherosclerosis of the extremities, unspecified (440.20)</p> <p><input type="checkbox"/> Atherosclerosis of the extremities with intermittent claudication (440.21)</p> <p><input type="checkbox"/> Atherosclerosis of the extremities with ulceration (440.23)</p> <p><input type="checkbox"/> Peripheral vascular disease, unspecified (443.9)</p> <p><b>D<sub>x</sub> Indicate ICD-9 Code: 2____.____</b>  <i>(249.00-250.93 please include 2-digit ending)</i></p>	<p><b><u>COVERED PROCEDURES:</u></b></p> <p><input type="checkbox"/> <b>Depth Shoes (A5500)</b>—<u>indicate inserts below</u></p> <p><input type="checkbox"/> <b>Customized Inserts</b> (heat molded prefab-average life is 4 months each pair*) (A5512)                  # of pair: 3 2 1 (<u>Medicare allows up to 3 pair*</u>)</p> <p><input type="checkbox"/> <b>Custom Orthoses (A5513)</b> (avg. life up to 1 year*) Will not work for all foot types.                  # of pair: 3 2 1 (<u>Medicare allows up to 3 pair*</u>)</p> <p><input type="checkbox"/> <b>Custom Toe Filler (L5000)</b>                  (Left Right) # of units per foot: 3 2 1</p> <p><input type="checkbox"/> <b>Custom Molded Shoes (A5501) and total of 3 pairs of custom inserts (A5513)</b> (average life 4 months).</p> <p><input type="checkbox"/> <b>Rigid Rocker Bottom Sole or Bar (A5503)</b></p> <p><input type="checkbox"/> <b>Sole/Heel Wedge</b> (please circle one) (A5504)</p> <p><input type="checkbox"/> <b>Metatarsal Bar (A5505)</b></p> <p><input type="checkbox"/> <b>Other Modifications</b> (Medial Stabilizers, Lateral Stabilizers, etc.) (A5507)</p>
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*\*Medicare allows up to 3 pair per annum of either Prefab or Custom inserts. THE AVERAGE PREFAB INSERT HAS AN AVERAGE LIFE OF 4 MONTHS. For 12 months of protection, patients should receive no less than 3 pair of prefab inserts per year, regardless of other items the patient may need. Medicare will not pay for extra items—they are the financial responsibility of the patient. Patients are responsible for their choices of coverage level. The life of each device is determined by the materials used to make it.*

**R<sub>x</sub> Instructions:** \_\_\_\_\_  
**PRESCRIBING PHYSICIAN INFORMATION:**

Physician Name (printed) \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician Address \_\_\_\_\_

Physician NPI # \_\_\_\_\_

Physician Phone # \_\_\_\_\_

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# STATEMENT OF CERTIFYING PHYSICIAN FOR THERAPEUTIC FOOTWEAR

*NOTE: FOR COVERAGE BY MEDICARE UNDER THE THERAPEUTIC SHOES FOR DIABETICS PROGRAM—THIS DOCUMENT MUST BE SIGNED BY THE M.D. OR D.O. MANAGING THE PATIENT'S SYSTEMIC DIABETIC CONDITION AND THE STATEMENTS DOCUMENTED BELOW MUST BE DOCUMENTED IN THE PATIENT'S MEDICAL RECORD—WHICH WE MUST ALSO RECEIVE A COPY OF TO VERIFY THE ITEMS BELOW. THIS SCP MUST BE ACCOMPANIED BY A SIGNED DIABETIC FOOTWEAR PRESCRIPTION FORM.*

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

I certify that all of the following statements are true:

- 1) This patient has diabetes mellitus- ICD-9 Code: 2\_\_\_\_\_. \_\_\_\_\_ (Five digit ICD-9 Diagnosis Code Required 249.00-250.93)
- 2) This patient has **one or more** of the following conditions (check all that apply):

History of partial or complete amputation of the foot.	<input type="checkbox"/> Lower limb amputation, foot (V49.73) <input type="checkbox"/> Lower limb amputation, great toe (V49.71) <input type="checkbox"/> Lower limb amputation, lesser toe(s) (V49.72)
History of previous foot ulceration.	<input type="checkbox"/> Ulcer of heel and midfoot (707.14) <input type="checkbox"/> Ulcer other part of foot (707.15)
History of pre-ulcerative foot callus.	<input type="checkbox"/> History of pre-ulcerative callus (707.9)
Peripheral neuropathy <u>and</u> evidence of callus formation.	<input type="checkbox"/> Polyneuropathy in diabetes (357.2) <u>and</u> History of pre-ulcerative callus (707.9)
Foot deformity.  Other ICD-9: _____	<input type="checkbox"/> Claw toe (735.5) <input type="checkbox"/> Hammer toe (735.4) <input type="checkbox"/> Hallux valgus (735.0) <input type="checkbox"/> Hallux rigidus (735.2) <input type="checkbox"/> Unspecified acquired deformity of toe (735.9) <input type="checkbox"/> Unspecified deformity of ankle and foot, acquired (736.70) <input type="checkbox"/> Charcot Arthropathy (713.5)
Poor circulation in either foot.  Other ICD-9: _____	<input type="checkbox"/> Atherosclerosis of the extremities, unspecified (440.20) <input type="checkbox"/> Atherosclerosis of the extremities with intermittent claudication (440.21) <input type="checkbox"/> Atherosclerosis of the extremities with ulceration (440.23) <input type="checkbox"/> Peripheral vascular disease, unspecified (443.9)

- 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) and/or inserts because of his/her diabetes.
- 5) With diabetic footwear, the patient's prognosis is \_\_\_\_\_.
- 6) **The above information is documented in the patient's medical record, as indicated in the attached clinical notes.**

**CERTIFYING PHYSICIAN INFORMATION:**

Physician Name (printed)	MD or DO <small>(circle one)</small>	Physician Signature	Date
Physician Address		Physician NPI #	
		Physician Phone #	

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## ADDENDUM TO CLINICAL NOTES

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

Date of Last Visit: \_\_\_\_\_

This addendum is being added to the clinical notes of the above patient in order to comply with the documentation requirements of this patient's insurance company. These findings were all observed by me while this patient has been under my care, and are hereby incorporated into my official clinical notes and I certify that a copy of this form has been placed with this patient's chart.

1. This patient has diabetes mellitus- ICD-9 Code: 2\_\_\_\_\_. \_\_\_\_\_ (Five digit ICD-9 Diagnosis Code Required 249.00-250.93)
2. This patient has the following checked conditions:

History of partial or complete amputation of the foot.	<input type="checkbox"/> Lower limb amputation, foot (V49.73 & 755.38) <input type="checkbox"/> Lower limb amputation, great toe (V49.71 & 755.39) <input type="checkbox"/> Lower limb amputation, lesser toe(s) (V49.72 & 755.39)
History of previous foot ulceration.	<input type="checkbox"/> Ulcer of heel and midfoot (707.14) <input type="checkbox"/> Ulcer other part of foot (707.15)
History of pre-ulcerative foot callus.	<input type="checkbox"/> History of pre-ulcerative callus (707.9)
Peripheral neuropathy <u>and</u> evidence of callus formation.	<input type="checkbox"/> Polyneuropathy in diabetes (357.2) <u>and</u> History of pre-ulcerative callus (707.9)
Foot deformity.  Other ICD-9: _____	<input type="checkbox"/> Claw toe (735.5) <input type="checkbox"/> Hammer toe (735.4) <input type="checkbox"/> Hallux valgus (735.0) <input type="checkbox"/> Hallux rigidus (735.2) <input type="checkbox"/> Unspecified acquired deformity of toe (735.9) <input type="checkbox"/> Unspecified deformity of ankle and foot, acquired (736.70) <input type="checkbox"/> Charcot Arthropathy (713.5)
Poor circulation in either foot.  Other ICD-9: _____	<input type="checkbox"/> Atherosclerosis of the extremities, unspecified (440.20) <input type="checkbox"/> Atherosclerosis of the extremities with intermittent claudication (440.21) <input type="checkbox"/> Atherosclerosis of the extremities with ulceration (440.23) <input type="checkbox"/> Peripheral vascular disease, unspecified (443.9)

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) and/or inserts because of his/her diabetes.
5. With diabetic footwear, the patient's prognosis is \_\_\_\_\_
6. I have documented this information on forms required by the patient's payor. I have provided these forms to a DMEPOS supplier to provide required DMEPOS.

Notes: \_\_\_\_\_

**I CERTIFY THAT A COPY OF THIS DOCUMENT HAS BEEN INSERTED INTO THE PATIENT'S CHART:**

Physician Name (printed)	<u>MD or DO</u> <small>(circle one)</small>	Physician Signature	Date
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