FLOYD BRACE ORTHOTICS AND PROSTHETICS

Therapeutic Shoe Documentation Requirements

Take this to your **Primary Care Physician**

- **To qualify for diabetic shoes, the patient MUST be diabetic and have been seen for their diabetes within the last six (6) months.**

Providing this benefit for your patient is as easy as….ONE, TWO, THREE

1. **Examine Patient's Feet and Notate Within Office Visit Notes *and* by using the Annual Comprehensive Diabetes Foot Exam Form which has been included**

2. **Complete All Sections of the Statement of Certifying Physician Form**
   (*must be completed and signed by an **M.D.** or **D.O.***)**

3. **Fax Documentation To:** Floyd Brace Company (5 convenient locations to serve you)

   - ✓ **Office Visit Notes Documenting All Conditions found during Foot Exam and Need for Diabetic Shoes and completed Annual Comprehensive Diabetes Foot Exam Form**
     (*Please note: if patient has been seen by Nurse Practitioner, the notes must be countersigned by M.D or D.O.)*

   - ✓ **Statement of Certifying Physician Form**

   - ✓ **Detailed Written Order**

*** Please also include prescription for diabetic shoes and custom inserts ***

TRIDENT
9231 Medical Plaza Dr, Suite D
North Charleston, SC 29406
Tel (843) 824-0625
Fax (843) 824-0127

WEST ASHLEY
648 Saint Andrews Blvd
Charleston, SC 29407
Tel (843) 573-9430
Fax (843) 573-9431

WALTERBORO
138 Bells Highway
Walterboro, SC 29488
Tel (843) 782-3638
Fax (843) 782-3637

GEORGETOWN
1027 Church Street, Ste B
Georgetown, SC 29440
Tel (843) 546-8555
Fax (843) 545-0142

MYRTLE BEACH/CONWAY
164 Waccamaw Medical Park Ct, Ste B
Conway, SC 29526
Tel (843) 234-0627
Fax (843) 234-0629

Annual Comprehensive Diabetes Foot Exam Form

Name: _____ Date: _____ I

I. Presence of Diabetes Complications
1. Check all that apply.
❑ Peripheral Neuropathy
❑ Nephropathy
❑ Retinopathy
❑ Peripheral Vascular Disease
❑ Cardiovascular Disease
❑ Amputation *(Specify date, side, and level)*

_____

Current ulcer or history of a foot ulcer? Y____ N____

For Sections II & III, fill in the blanks with "Y" or "N" or with an "R," "L," or "B" for positive findings on the right, left, or both feet.

II. Current History
1. Is there pain in the calf muscles when walking that is relieved by rest? Y____ N____
2. Any change in the foot since the last evaluation? Y ____ N____
3. Any shoe problems? Y___ N____
4. Any blood or discharge on socks or hose? Y____ N____
5. Smoking history? Y___N___
6. Most recent hemoglobin A1c result _____% _____ *date*

III. Foot Exam
1. Skin, Hair, and Nail Condition
Is the skin thin, fragile, shiny and hairless? Y ___ N___

Are the nails thick, too long, ingrown, or infected with fungal disease? Y ___ N___

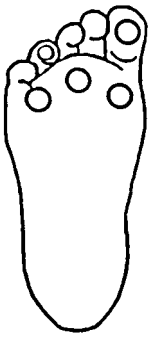
Measure, draw in, and label the patient's skin condition, using the key and the foot diagram below.
C=Callus U=Ulcer PU=Pre-Ulcer
F=Fissure M=Maceration R=Redness
S=Swelling W=Warmth D=Dryness

2. Note Musculoskeletal Deformities
❑ Toe deformities
❑ Bunions (Hallux Valgus)
❑ Charcot foot
❑ Foot drop
❑ Prominent Metatarsal Heads

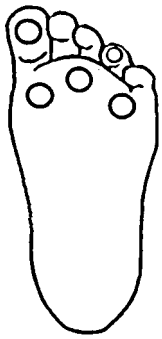
3. Pedal Pulses Fill in the blanks with a "P" or an "A" to indicate present or absent.
Posterior tibial Left_____ Right_____
Dorsalis pedis Left_____ Right_____

4. Sensory Foot Exam *Label sensory level with a "+" in the five circled areas of the foot if the patient can feel the 5.07 (10-gram) Semmes-Weinstein nylon monofilament and "-" if the patient cannot feel the filament.*

Notes



Right Foot



Left Foot

Notes

IV. Risk Categorization *Check appropriate box.*

❑ Low Risk Patient
All of the following:
❑ Intact protective sensation
❑ Pedal pulses present
❑ No deformity
❑ No prior foot ulcer
❑ No amputation

❑ High Risk Patient
One or more of the following:
❑ Loss of protective sensation
❑ Absent pedal pulses
❑ Foot deformity
❑ History of foot ulcer
❑ Prior amputation

V. Footwear Assessment *Indicate yes or no.*
1. Does the patient wear appropriate shoes? Y___ N ___
2. Does the patient need inserts? Y ___ N ___
3. Should corrective footwear be prescribed? Y ___ N ___

VI. Education *Indicate yes or no.*
1. Has the patient had prior foot care education? Y __N__
2. Can the patient demonstrate appropriate foot care? Y__N__
3. Does the patient need smoking cessation counseling? Y__N__
4. Does the patient need education about HbA1c or other diabetes self-care? Y__N__

VII. Management Plan *Check all that apply.*
1. Self-management education:
Provide patient education for preventive foot care. Date: _____
Provide or refer for smoking cessation counseling. Date: _____
Provide patient education about HbA1c or other aspect of self-care. Date: _____
2. Diagnostic studies:
❑ Vascular Laboratory
❑ Hemoglobin A1c (at least twice per year)
❑ Other: _____

3. Footwear recommendations:
❑ None
❑ Athletic shoes
❑ Accommodative inserts
❑ Depth shoes

4. Refer to:
❑ Primary Care Provider
❑ Diabetes Educator
❑ Podiatrist
❑ RN Foot Specialist
❑ Pedorthist
❑ Orthotist
❑ Endocrinologist
❑ Vascular Surgeon
❑ Foot Surgeon
❑ Rehab. Specialist
❑ Other: _____

5. Follow-up Care:
Schedule follow-up visit. Date: _____

Physician Signature _____

FLOYD BRACE
ORTHOTICS AND PROSTHETICS

DETAILED WRITTEN ORDER

PROVIDER: **FLOYD BRACE COMPANY**
Address: 9231 Medical Plaza Dr, Suite F
North Charleston, SC 29406
Office Number: (843)824-0625
Fax Number: **(843)824-0127**

PATIENT_____
Address _____
_____
Phone _____
DOB _____

PHYSICIAN NAME (Printed) _____ **Date of Visit** _____

Address _____
_____
Phone _____
Fax _____

Length of Need_____
(in months)

NPI # _____

ICD-10 DIAGNOSIS CODE(S) _____**DESCRIPTION**_____

EQUIPMENT/SERVICES: **Check items prescribed**

____ Diabetic Footwear, Non-Custom, Extra Depth (A5500) – 1 pair
____ Diabetic Inserts, Non-Custom, Heat-Molded (A5512) – 3 pairs
____ Diabetic Inserts, Custom Molded, Multiple Density (A5513) - 3 pairs

____ Partial Foot, Shoe Insert with Longitudinal Arch, Toe Filler (L5000) Right
____ Partial Foot, Shoe Insert with Longitudinal Arch, Toe Filler (L5000) Left

Physician Signature _____**Date**_____

FLOYD BRACE
ORTHOTICS AND PROSTHETICS

Statement of Certifying Physician for Therapeutic Shoes

Patient Name:_____ DOB:_____

Insurance ID #_____ Date of Order:_____

Diagnosis: ICD-10 Code_____ Description_____

Equipment:

Qty_____ Proc. Code_____ Item Name:_____

Qty_____ Proc. Code_____ Item Name_____

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 of care for his/her diabetes.
4. This patient needs special shoes (depth or custom molded shoes) because of his/her diabetes.

Duration of need:_____

Physician signature:_____ Date Signed_____

(MUST BE AN M.D. OR D.O.)

Physician address:_____

_____

_____

Physician NPI:_____