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
407 Church Street, Suite D
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:_____ ID#: _____

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 (Hallus 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____

Physician Signature _____

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
❑ Custom shoes
❑ Depth shoes

4. **Referto:**
❑ 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: _____

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

____Diabetic Footwear, Custom Molded from casts (A5501) – 1 pair

____ 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:_____