

# Comprehensive Diabetic Foot Exam & Shoe Order Form

**Required to satisfy Medicare requirement of in-person visit to determine need for shoes.**

Complete form for ordering shoes and inserts using "WorryFree DME" at SafeStep.net

**Patient Information** (Only complete if information not yet in SafeStep system):

Enter all information into "WorryFree DME" on SafeStep website to guarantee Medicare compliance.

Title:  Mr.  Ms.  Mrs.  Dr. Gender:  M  F

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

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Email: \_\_\_\_\_ Patient's Insurance ID #: \_\_\_\_\_

If patient has Medicare, is this the primary insurance?  Yes  No

If patient has diabetes and Medicare, has he/she received shoes under the Therapeutic Shoe Program this calendar year?  Yes  No

Which feet does patient have?  Both  Left  Right

**Certifying Physician Managing Diabetes Care** (Only complete if information not yet in SafeStep system):

Enter all information into WorryFree DME. SafeStep will obtain required documentation from the Certifying Physician.

Degree:  MD  DO

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

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_

## Complete this form to create:

1. Documentation of Patient Evaluation Prior to Shoe Selection

**Enter information at safestep.net. "WorryFree DME" will create:**

2. Prescription for Diabetic Shoes and Inserts

**SafeStep will create and fax to MD:**

3. Physician Notes on Qualifying Condition(s)

4. Statement of Certifying Physician

**Once signed forms received from Certifying Physician, "WorryFree DME" will create:**

5. Certificate of Patient Receipt

**Once shoes indicated as being dispensed, "WorryFree DME" will create:**

6. In Person Dispensing Chart Notes

# Podiatrist / Supplier In-Person Evaluation Prior to Shoe Selection

Performing evaluation satisfies Medicare requirement to document medical necessity for shoes.

Patient visit may be billable as 99213 if there is documented change in patient's condition.

Patient's Name: \_\_\_\_\_ Date of CDFE: \_\_\_\_\_

Estimated duration of diabetes: \_\_\_\_\_ Date of most recent CDFE: \_\_\_\_\_

Date last seen by MD/DO\*: \_\_\_\_\_

*\*Medicare requires that for shoes to be covered, the patient must have been seen by the physician managing the diabetes no more than six months prior to when shoes fit.*

Do you examine your feet daily?: \_\_\_\_\_

Foot Complaints: \_\_\_\_\_

## Review of Patient (Check all that apply)

FINDINGS MAY INDICATE THE NEED FOR FURTHER EVALUATION, OTHER SERVICES

### Ortho:

- Joint aches/pains
- Deformities
- Stiffness
- Weakness
- Have you fallen in the past 6 months?  
When? \_\_\_\_\_ How? \_\_\_\_\_
- Do you stumble or shuffle when you walk?
- Do you have to touch or hold onto the wall or furniture while walking?
- Do your legs or ankles feel weak or unsteady?

### Vascular:

- Claudication
- Edema
- Temperature Changes

**NOTE: If there is a history of falls or unsteadiness, consider fall risk assessment.**

### Derm:

- Skin Rash
- Pruritus (Itching)
- Nail Changes
- Scaling
- Dryness

### Neuro:

- Numbness
- Tingling
- Paresthesia
- Abnormal Sensation
- High Sensitivity

**NOTE: If there is evidence of neuropathy, consider nerve fiber density testing, NeuRemedy.**

## Physical Exam (Class Findings)

Vascular	Right		Left	
	<input type="checkbox"/> normal	<input type="checkbox"/> diminished	<input type="checkbox"/> normal	<input type="checkbox"/> diminished
Dorsalis Pedis	<input type="checkbox"/> normal	<input type="checkbox"/> diminished	<input type="checkbox"/> normal	<input type="checkbox"/> diminished
Posterior Tibial	<input type="checkbox"/> normal	<input type="checkbox"/> diminished	<input type="checkbox"/> normal	<input type="checkbox"/> diminished
Capillary Refill Time	<input type="checkbox"/> < 3 sec.	<input type="checkbox"/> > 3 sec	<input type="checkbox"/> < 3 sec.	<input type="checkbox"/> > 3 sec
Edema Present	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no
Other				

Neurological (LOPS)	Right			Left		
	<input type="checkbox"/> normal	<input type="checkbox"/> diminished		<input type="checkbox"/> normal	<input type="checkbox"/> diminished	
Vibration perception (tuning fork)	<input type="checkbox"/> normal	<input type="checkbox"/> diminished		<input type="checkbox"/> normal	<input type="checkbox"/> diminished	
Loss of Protective Sensation (LOPS)	<input type="checkbox"/> toes	<input type="checkbox"/> mets	<input type="checkbox"/> heel	<input type="checkbox"/> toes	<input type="checkbox"/> mets	<input type="checkbox"/> heel
DTR	<input type="checkbox"/> normal	<input type="checkbox"/> diminished		<input type="checkbox"/> normal	<input type="checkbox"/> diminished	
Sharp/Dull	<input type="checkbox"/> normal	<input type="checkbox"/> diminished		<input type="checkbox"/> normal	<input type="checkbox"/> diminished	

**If there is evidence of neuropathy, consider nerve fiber density testing and NeuRemedy.**

## Peripheral Arterial Disease (PAD) Review

Do you have foot, calf, buttock, hip or thigh discomfort (aching, fatigue, tingling, cramping or pain) when you walk which is relieved by rest?  Yes  No

Do you experience any pain at rest in your lower leg(s) or feet?  Yes  No

Do you experience foot or toe pain that disturbs your sleep?  Yes  No

Are your toes or feet pale, discolored, or bluish?  Yes  No

Do you have skin wounds or ulcers on your feet or toes that are slow to heal (8-12 weeks)?  Yes  No

Has your doctor ever told you that you have diminished or absent pedal (foot) pulses?  Yes  No

Have you suffered a severe injury to the leg(s) or feet?  Yes  No

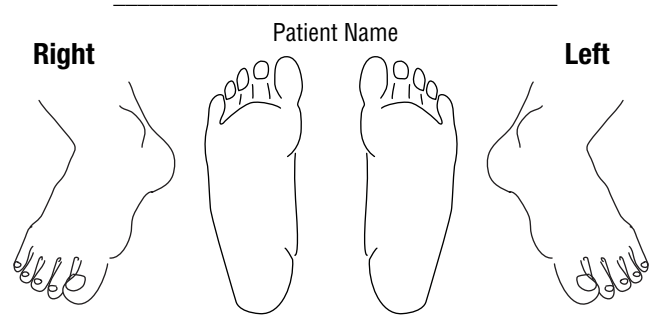
**NOTE: If there is evidence of PVD, consider non-invasive vascular testing**

Dermatological	Right	Left
Hair growth (decrease or absence)	<input type="checkbox"/>	<input type="checkbox"/>
Skin texture (thin, shiny)	<input type="checkbox"/>	<input type="checkbox"/>
Pigmentary changes (discoloration)	<input type="checkbox"/>	<input type="checkbox"/>
Wounds	<input type="checkbox"/>	<input type="checkbox"/>
Infection Locations (Current, Past)	<input type="checkbox"/>	<input type="checkbox"/>
Onychomycosis	<input type="checkbox"/>	<input type="checkbox"/>
Interdigital Spaces	<input type="checkbox"/> clear <input type="checkbox"/> macerated	<input type="checkbox"/> clear <input type="checkbox"/> macerated
Keratomas (Calluses)	<input type="checkbox"/>	<input type="checkbox"/>
Temperature Assessment	<input type="checkbox"/> inc <input type="checkbox"/> dec <input type="checkbox"/> norm	<input type="checkbox"/> inc <input type="checkbox"/> dec <input type="checkbox"/> norm
Other		

# Podiatrist / Supplier In-Person Evaluation Prior to Shoe Selection (Continued)

Patient visit may be billable as 99213 if there is documented change in patient's condition.

Physical Exam (Continued)	Right	Left
Foot Deformities (including hallux valgus, hammertoes)	<input type="checkbox"/>	<input type="checkbox"/>
Equinus	<input type="checkbox"/>	<input type="checkbox"/>
Plantarflexed Metatarsal	<input type="checkbox"/>	<input type="checkbox"/>
Charcot Deformities	<input type="checkbox"/>	<input type="checkbox"/>
Previous Amputations	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>
Quantified areas of excessive pressure		
Foot type (planus, cavus, medium arch)		



Note corns, calluses or deformities using symbol key below:

Corn/Callus (C) Wound (W) Bunion (B) Redness (R)  
Swelling (S) Hammer/Claw toe (HC) Amputation (A)

Annual visit to determine ulcerative risk factors and style of prescribed shoe may be billable as 99213 if class findings are present.

Class findings \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medicare provides coverage for shoes each calendar year based on medical necessity and determination of need for replacement.

If patient has previously received shoes covered by Medicare, are they worn and in need of replacement?  Yes  No

If patient has previously received inserts covered by Medicare, are they worn and in need of replacement?  Yes  No

Shoe Size based on measuring device, fit of current worn shoes and try-on sample:

Length: \_\_\_\_\_ Width: \_\_\_\_\_

If fabricating custom inserts, please indicate method of foot impression:

Foam  Scanner  Plaster

### Risk Stratification

- (0) No LOPS, No PAD, No Deformity
- (1) Peripheral Neuropathy (LOPS)
- (2) Neuropathy, Deformity and/or Vascular Disease (PVD)
- (3) Previous Ulcer or Amputation

### Education and Counseling

	Yes	No
Explanation of systematic risks of diabetes and importance of proper glucose control.	<input type="checkbox"/>	<input type="checkbox"/>
Explanation of dangers of neuropathy and loss of "gift of pain".	<input type="checkbox"/>	<input type="checkbox"/>
Counseling on risk stratification and exam frequency.	<input type="checkbox"/>	<input type="checkbox"/>
Promote practical self care skills and routine podiatric care.	<input type="checkbox"/>	<input type="checkbox"/>

**Consider non-invasive vascular testing and vascular consult if PAD present.**  
**Consider prescription footwear and inserts if ulcerative risk factors present.**  
**Consider Fall Risk Assessment if there is a history of unsteadiness or falls.**

### Actions Taken

Prescriptions ordered: \_\_\_\_\_

Referred to (Physician's Name or Department): \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

### Diagnostic Studies:

Fall Risk Assessment  Non-invasive vascular testing  Nerve fiber density testing  Other: \_\_\_\_\_

Procedures: \_\_\_\_\_

Duration of visit: \_\_\_\_\_ min

Podiatrist Signature  
(Should be the same as the podiatrist prescribing and supervising fitting of footwear.)

Date

Performing CDFE will satisfy PQRS measure G9226 towards avoiding end of year penalty of 2% of total Medicare allowable charges.

# DPM Documentation of Beneficiary Qualifying Criteria Provided to Physician Treating Patient's Diabetes

Enter into "WorryFree DME" website to receive signed, dated copy of the Statement of Certifying Physician and signed agreement of physician notes on qualifying condition(s).

## Diabetes

	Type I	Type II
w/o complications	<input type="checkbox"/> E10.9	<input type="checkbox"/> E11.9
w/ diabetic neuropathy, unspecified	<input type="checkbox"/> E10.40	<input type="checkbox"/> E11.40
w/ other circulatory complications	<input type="checkbox"/> E10.59	<input type="checkbox"/> E11.59
w/ diabetic mononeuropathy	<input type="checkbox"/> E10.41	<input type="checkbox"/> E11.41
w/ diabetic polyneuropathy	<input type="checkbox"/> E10.42	<input type="checkbox"/> E11.42
w/ diabetic peripheral angiopathy without gangrene	<input type="checkbox"/> E10.51	<input type="checkbox"/> E11.51
w/ diabetic neuropathic arthropathy	<input type="checkbox"/> E10.610	<input type="checkbox"/> E11.610
w/ hyperglycemia	<input type="checkbox"/> E10.65	<input type="checkbox"/> E11.65
w/ foot ulcer	<input type="checkbox"/> E10.621	<input type="checkbox"/> E11.621

*Use additional code to identify site of ulcer (L89.6-, L89.8-)*

## Foot Deformity

	Right	Left
Hallux valgus	<input type="checkbox"/> M20.11	<input type="checkbox"/> M20.12
Hammer toe(s)	<input type="checkbox"/> M20.41	<input type="checkbox"/> M20.42
Hallux rigidus	<input type="checkbox"/> M20.21	<input type="checkbox"/> M20.22
Hallux varus	<input type="checkbox"/> M20.31	<input type="checkbox"/> M20.32
Flat foot [pes planus]	<input type="checkbox"/> M21.41	<input type="checkbox"/> M21.42
Charcot's joint ankle and foot	<input type="checkbox"/> M14.671	<input type="checkbox"/> M14.672
Other acquired deformities of foot	<input type="checkbox"/> M21.6X1	<input type="checkbox"/> M21.6X2

## Foot ulceration

	Right	Left
pressure ulcer of heel	<input type="checkbox"/> L89.61	<input type="checkbox"/> L89.62
ulcer of other site	<input type="checkbox"/> L89.899	<input type="checkbox"/> L89.899
midfoot	<input type="checkbox"/>	<input type="checkbox"/>
sub metatarsal	<input type="checkbox"/>	<input type="checkbox"/>
sub hallux	<input type="checkbox"/>	<input type="checkbox"/>
1st toe	<input type="checkbox"/>	<input type="checkbox"/>
2nd toe	<input type="checkbox"/>	<input type="checkbox"/>
3rd toe	<input type="checkbox"/>	<input type="checkbox"/>
4th toe	<input type="checkbox"/>	<input type="checkbox"/>
5th toe	<input type="checkbox"/>	<input type="checkbox"/>
heel	<input type="checkbox"/>	<input type="checkbox"/>
styloid	<input type="checkbox"/>	<input type="checkbox"/>
medial longitudinal arch	<input type="checkbox"/>	<input type="checkbox"/>

## Poor circulation

Unspecified atherosclerosis of native arteries of the extremities	<input type="checkbox"/> I70.201	<input type="checkbox"/> I70.202	<input type="checkbox"/> I70.203
Atherosclerosis of native arteries of extremities with intermittent claudication	<input type="checkbox"/> I70.211	<input type="checkbox"/> I70.212	<input type="checkbox"/> I70.213
with rest pain	<input type="checkbox"/> I70.221	<input type="checkbox"/> I70.222	<input type="checkbox"/> I70.223
diminished dorsalis pedis pulse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
diminished posterior tibial pulse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
increased capillary refill time (> 3 sec.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Atherosclerosis of native arteries of the leg <b>with ulceration</b> of heel and midfoot	<input type="checkbox"/> I70.234	<input type="checkbox"/> I70.244	
Atherosclerosis of native arteries of leg <b>with ulceration</b> of other parts of foot	<input type="checkbox"/> I70.235	<input type="checkbox"/> I70.245	

## History of partial or complete amputation of the foot

	Right	Left
Acquired absence of great toe	<input type="checkbox"/> Z89.411	<input type="checkbox"/> Z89.412
Acquired absence of other toe(s)	<input type="checkbox"/> Z89.421	<input type="checkbox"/> Z89.422
Acquired absence of foot	<input type="checkbox"/> Z89.431	<input type="checkbox"/> Z89.432

## Peripheral neuropathy with evidence of callus formation

*(Both conditions must be present. Neuropathy alone is not enough.)*

- Type I diabetes mellitus with diabetic polyneuropathy (unspecified E10.40)
- Type II diabetes mellitus with diabetic polyneuropathy (unspecified E11.40)
  - loss of vibratory sensation
  - loss of protective sensation
  - loss of deep tendon reflexes
  - loss of sharp / dull perception
- Diabetes mellitus with polyneuropathy (E13.42)

## History of preulcerative callus

- Corn / Callus (L84)
  - sub metatarsal  right  left
  - sub hallux  right  left
  - 1st toe  right  left
  - 2nd toe  right  left
  - 3rd toe  right  left
  - 4th toe  right  left
  - 5th toe  right  left
  - heel  right  left
  - styloid  right  left
  - medial longitudinal arch  right  left

**Order online at [SafeStep.net](http://SafeStep.net) or call 866.712.STEP (7837)**