LIMBIONICS
prosthetics and orthotics

Dear Patients,

In order to receive your Insurance benefits for therapeutic footwear, you will need to schedule an appointment with the Physician that treats you for diabetes.

Please take this packet to your appointment and have your Physician complete all required paperwork. Thank you

Dear Physician,

Please assist us in providing our mutual patient with diabetic shoes and orthoses. Medicare/ Insurance states that they need the following documentation from the certifying Physician. ***All completed originals must be kept in your patients' chart per insurance guidelines

The 4 steps that are required

1. A signed detailed written order
   -we have provided this
   -must be complete with ICD-10

2. Completed Diabetic Verification Form
   -we have provided this
   -must be complete with ICD-10

3. Annual Foot Examination
   -we have provided this form

4. M.D. or D.O. face to face progress note from patients current visit

Please fax all paperwork back to
Limbionics Prosthetics & Orthotics at (919) 869-1987

All forms and progress notes must be signed and dated by an M.D. or D.O. If forms and progress notes are done by a P.A. or N.P. they must be cosigned and dated by an M.D. or D.O.

This Documentation is for Durham, Chatham/ Chapel Hill, Henderson Locations

Contact Phone Numbers: (919) 908-8975 and (252) 430-6538

www.limbionics.com

Diabetic Verification

Patient Name:	Patients Phone #:	Patient DOB:
Device Type: Bilateral Diabetic Shoes w/ Inserts	**Diagnosis Code (ICD-10)** _____	**Visit Date:**

The physician listed below certifies that all of the following statements are true:
(Physician must be an MD or DO)

1. **This patient has diabetes mellitus. ICD-10 _____ Date of Onset _____**
2. **This patient has the following conditions (please check all that apply):**
   - History of partial or complete amputation of the foot: ***ICD-10*** **_____**
   - History of previous foot ulceration: ***ICD-10*** **_____**
   - History of pre-ulcerative callus: ***ICD-10*****_____**
   - Peripheral neuropathy with evidence of callus formation: ***ICD-10*****_____**
   - Foot deformity: ***ICD-10*** **_____**
   - Poor circulation: ***ICD-10*** **_____**
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.**
5. **I have seen this patient within the past six months.**

Physician Name:	Physician UPIN:	Physician NPI:	Insurance Info:
Physician Address:			
Physician Work Phone:		**Physician Fax:**	

The above procedures and any repair and/or parts to maintain proper fit and function are appropriate for this patient, and are deemed medically necessary.

_____ _____

Physician Signature **Date**

_____

Print Name

Comprehensive Diabetes Foot Examination Form

Adapted from the National Diabetes Education Program's Foot Screening Form

Name: **Date:** **Age:**

Onset Date:

I. Medical History
(Check all that apply.)

- ☐ Peripheral Neuropathy
- ☐ Cardiovascular Disease
- ☐ Nephropathy
- ☐ Retinopathy
- ☐ Peripheral Vascular Disease

II. Current History

1. Any change in the foot or feet since the last evaluation?
   ☐ Yes ☐ No
2. Current ulcer or history of a foot ulcer?
   ☐ Yes ☐ No
3. Is there pain in the calf muscles when walking that is relieved by rest?
   ☐ Yes ☐ No

III. Foot Exam

1. Are the nails thick, too long, ingrown or infected with fungal disease?
   ☐ Yes ☐ No

2. Note foot deformities.
   ☐ Toe deformities ☐ Bunions ☐ Charcot foot ☐ Foot drop
   ☐ Prominent metatarsal heads
   ☐ Amputation (Specify date, side and level.)
   _____

3. Pedal Pulses
   (Fill in the blanks with a "P" or an "A" to indicate present or absent.)

Posterior tibial:	Dorsalis pedis:
Left	Left
Right	Right

4. Skin Condition (Measure, draw in and label the patient's skin condition using the key and foot diagram to the right.)

C = Callus R = Redness W = Warmth

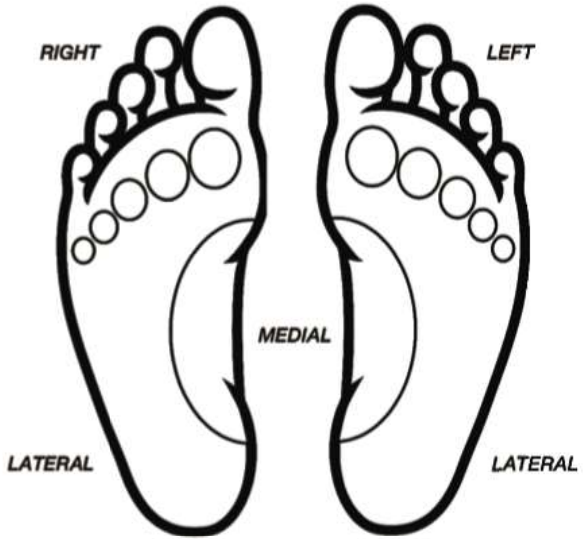
F = Fissure S = Swelling U = Ulcer

M = Maceration PU = Pre-ulcerative lesion D = Dryness

IV. Sensory Foot Exam

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

Notes:



V. Risk Categorization (Check appropriate item.)

Low-Risk Patient
All of the following:

- ☐ Intact protective sensation ☐ No severe deformity
- ☐ No prior foot ulcer ☐ Pedal pulses present
- ☐ No severe deformity ☐ No amputation

High-Risk Patient
One or more of the following:

- ☐ Loss of protective sensation
- ☐ Absent pedal pulses
- ☐ Severe foot deformity
- ☐ History of foot ulcer

VI. Footwear Assessment

1. Does the patient wear appropriate shoes?
   ☐ Yes ☐ No
2. Does the patient need inserts/orthotics?
   ☐ Yes ☐ No

VII. Education

1. Has the patient had prior foot care education?
   ☐ Yes ☐ No
2. Can the patient demonstrate appropriate self-care?
   ☐ Yes ☐ No

VII. Management Plan (Check all that apply.)

☐ Provide patient education for preventive foot care. ☐ Refer to Orthotist for proper footwear

Date:_____ Provider Signature:_____

LIMBIONICS

PROSTHETICS & ORTHOTICS

Prescription for Diabetic Shoes and Inserts SWO/ LMN

Patient Name: _____. **DOB**:_____

Patient Phone #: _____

Projected Monthly Frequency: Daily **Estimated Length of Need**: Lifetime

ICD 10 DM Dx (E08.00-13.9):_____

Please select Shoe Type:

____ **A5500 Extra Depth (unit 2): For Diabetics Only, Fitting (Including follow up), custom preparation and supply of Off-The Shelf Depth- Inlay Shoe Manufactured to Accommodate Multi-Density Inserts per shoe.** (Patient is diabetic and would benefit from extra depth and extra width shoes to protect his/her feet. The shoes will also give extra room for the use of diabetic inserts to protect the bottom of his/her feet.)

Please select Insert Type:

____ **A5513 Custom Fabricated, (Unit 3 per side): For Diabetics Only Multiple Density Inserts, custom molded form model of patient's foot, total contact with patient's foot** (Patient is diabetic and would benefit from custom diabetic inserts to prevent specific pressures on the bottom of the feet. Inserts should be custom to correct patients' foot and ankle alignment and provide medial longitudinal arch support.)

____ **L5000 Toe filler (unit 1 per side): Partial Foot, Shoe Insert with Longitudinal Arch, Toe Filler.** (Patient is a partial foot amputee and would benefit from a toe filler for increased balance and to prevent shear forces on the foot caused by shifting and migration in the shoe.)

Physician Signature: _____

Physician Name (Printed): _____

NPI#: _____ Date: _____

Physicians Address: _____

_____

Physician Phone: _____