Use of this template is voluntary / optional

Therapeutic Shoes for Persons with Diabetes

Progress Note Template Guidance

Purpose

This template is designed to assist a clinician in completing a progress note documenting an in-person visit for therapeutic shoes for persons with diabetes to meet requirements for Medicare eligibility and coverage. The clinician can keep the completed template on file within the patient’s medical record or it can be used to develop an in-person visit or encounter progress note for use with the system containing the patient’s electronic medical record.

Patient eligibility for coverage of Therapeutic Shoes for Persons with Diabetes under Medicare

Coverage of therapeutic shoes for persons with diabetes is based on Social Security Act §1862(a)(1)(A) provisions (i.e. “reasonable and necessary”) and coverage of therapeutic shoes and inserts under the Therapeutic Shoes for Individuals with Diabetes benefit (Social Security Act §1861(s)(12)). In addition, there are specific statutory payment policy requirements that must also be met.

For any item to be covered by Medicare, it must:
- Be eligible for a defined Medicare benefit category;
- Be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member; and
- Meet all other applicable Medicare statutory and regulatory requirements.

Eligibility for coverage of therapeutic shoes for persons with diabetes under Medicare requires a physician or qualified Non-Physician Practitioner (NPP)\(^1\) to establish that coverage criteria are met. This helps to ensure the therapeutic shoe, modifications and inserts provided are consistent with the practitioner’s prescription and supported in the patient’s medical record.

MEDICARE DOCUMENTATION REQUIREMENTS FOR THERAPEUTIC SHOES FOR PERSONS WITH DIABETES

(a) IN GENERAL.—Section 1861(s)(12) of the Social Security Act (42 U.S.C. 1395x(s)(12)) is amended to read as follows:

(12) subject to section 4072(e) of the Omni-bus Budget Reconciliation Act of 1987, extra-depth shoes with inserts or custom molded shoes with inserts (in this paragraph referred to as ‘therapeutic shoes’) for an individual with diabetes, if—

(A) the physician who is managing the individual’s diabetic condition—

\(^1\) A Medicare allowed NPP is defined as a nurse practitioner, clinical nurse specialist, or physician assistant (as those terms are defined in section 1861 (aa) (5) of the Social Security Act) who is working in accordance with State law.
(i) documents that the individual has diabetes;

(ii) certifies that the individual is under a comprehensive plan of care related to the individual’s diabetic condition; and

(B) The particular type of shoes are prescribed by a podiatrist or other qualified physician (as established by the Secretary); and

(C) The shoes are fitted and furnished by a podiatrist or other qualified individual (such as a pedorthist or orthotist, as established by the Secretary) who is not the physician described in subparagraph (A) (unless the Secretary finds that the physician is the only such qualified individual in the area);

Other guidance

Completing the Therapeutic Shoes for Persons with Diabetes Progress Note Template does not guarantee eligibility and coverage but does provide an area within the patient’s medical record that is readily identifiable and may support the need for the therapeutic shoes, modification, and inserts, ordered and billed to Medicare. This template may be used with the Therapeutic Shoes for Persons with Diabetes Order Template.

NOTE: The Certifying Physician is a doctor of medicine (MD) or a doctor of osteopathy (DO) who is responsible for diagnosing and treating the beneficiary’s diabetic systemic condition through a comprehensive plan of care (POC). Currently, under §1861(s)(12) of the Social Security Act (42 U.S.C. 1395x(s)(12)), a podiatrist, physician assistant, nurse practitioner, or clinical nurse specialist are not identified as a certifying physician.

Who can complete this progress note template?

A physician or allowed NPP who performs an in-person visit.

Note: If this template is used:

1) CDEs in black Calibri are required

2) CDEs in burnt orange Italics Calibri are required if the condition is met

3) CDEs in blue Times New Roman are recommended but not required
Therapeutic Shoes for Persons with Diabetes Progress Note Template

Patient information:
Last name: ______________________________________ First name: ___________________________ MI: ___
DOB (MM/DD/YYYY): ____________________________ Gender: _____M _____F _______Other  Medicare ID: ____________

Provider (physician/NPP) who performed the evaluation if different from signing provider:
Last name: __________________________ First name: _____________________________ MI: ___ Suffix: __________
NPI: ________________________________

Patient diagnoses requiring need for therapeutic shoes for persons with diabetes (for relevant Diabetes Mellitus ICD-10-CM codes see Appendix C)

<table>
<thead>
<tr>
<th>ICD-10-CM</th>
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Therapeutic shoes coverage questions:

Does the patient have one or more of the following conditions (check all that apply and document in review of systems and physical exam section)?

_________ History of partial or complete amputation of the foot
_________ History of previous foot ulceration
_________ History of pre-ulcerative callus
_________ Peripheral neuropathy with evidence of callus formation
_______ Foot deformity
_______ Poor circulation

Note: The following must be supported in the medical examination/documentation

Is the patient under a comprehensive plan of care related to the diabetic condition? _____Yes _____No
Describe: __________________________________________

Are therapeutic shoes medical necessary and appropriate for the patient? _____Yes _____No
Describe: __________________________________________

Will the shoes be fitted and furnished by a podiatrist or other qualified individual? _____Yes _____No
Describe: __________________________________________

Chief complaint / history of present illness and associated signs / symptoms:
________________________________________________________________________
________________________________________________________________________

Related past medical / surgical history:
________________________________________________________________________
________________________________________________________________________

________________________________________________________________________
### Medications (Status: N=New, C=Current, M=Modified, D=Discontinued)

<table>
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<tr>
<th>RxNorm</th>
<th>Description</th>
<th>Dose</th>
<th>Frequency</th>
<th>Route</th>
<th>Status</th>
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Other medications

### Allergies (Include RxNorm if known)

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<th>RxNorm</th>
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### Review of systems (Significant as per history of present problem and need for therapeutic shoes):

**General:**
- ___weight gain, ___weight loss, ___sleeping problems, ___fatigue, ___fever,
- ___chills, ___night sweats / diaphoresis
- other:

**Skin:**
- ___pressure ulcers, ___rashes, ___changes in nails/hair, ___eczema, ___pruritus,
- other:

**Lymphatic:**
- ___swollen glands/masses: ___in the neck, ___axilla, ___groin,
- other:

**Head:**
- ___fainting, ___dizziness, ___headaches,
- other:

**Eyes:**
- ___diplopia, ___glasses/contact lenses, ___redness/discharge, ___blurred vision,
- ___glaucoma, ___cataracts,
- other:

**Ears:**
- ___tinnitus, ___discharge, ___hearing loss,
- other:

**Nose:**
- ___epistaxis, ___sinus infections, ___discharge, ___polyps,
- other:

**Oral:**
- ___dysphagia, ___hoarseness, ___teeth/dentures,
- other:

**Neck:**
- ___lumps, ___pain on movement
- other:
<table>
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<tr>
<th>System</th>
<th>Conditions</th>
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<tbody>
<tr>
<td>Breast</td>
<td>masses/tumors, tenderness, discharge, gynecomastia, other:</td>
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<tr>
<td>Pulmonary</td>
<td>cough, shortness of breath, pain, wheezing, hemoptysis, sputum production, other:</td>
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<tr>
<td>Cardiac</td>
<td>chest pain, palpitations, orthopnea, murmur, syncope, other:</td>
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<tr>
<td>Vascular</td>
<td>edema, Claudication, varicose veins, thrombophlebitis, ulcers, other:</td>
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<tr>
<td>Gastrointestinal</td>
<td>swallowing problems, abdominal pain, constipation, diarrhea, incontinence, nausea, vomiting, ulcers, melena, rectal bleeding, jaundice, heartburn, hematemesis, other:</td>
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<tr>
<td>Renal</td>
<td>dysuria, frequency, urgency, hesitation, flank pain, hematuria, incontinence, nocturia, polyuria, other:</td>
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<tr>
<td>Musculoskeletal</td>
<td>pain, swelling, stiffness, limitation of range of motion, arthritis, gout, cramps, myalgia, fasciculation, atrophy, fracture, deformity, weakness, other:</td>
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<tr>
<td>Neurologic</td>
<td>seizures, poor memory, poor concentration, numbness / tingling, pins and needles sensation, hyperpathia, dysesthesia, weakness, paralysis, tremors, involuntary movements, unstable gait, fall, vertigo, headache, stroke, speech disorders, other:</td>
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<tr>
<td>Psychiatric</td>
<td>hallucinations, delusions, anxiety, nervous breakdown, mood changes, other:</td>
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<tr>
<td>Hematology</td>
<td>anemia, bruising, bleeding disorders (conditional), other:</td>
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<tr>
<td>Endocrine</td>
<td>heat or cold intolerance, diabetes, lipid disorders, goiter, other:</td>
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<tr>
<td>Other</td>
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</table>
**Physical examination:**

Vital signs: $T=\_\_\_\_\_\_\_ P=\_\_\_\_\_\_\_ R=\_\_\_\_\_\_\_ BP=\_\_\_\_\_\_/\_\_\_\_\_\_ Height=\_\_\_\_\_\_\_ Weight=\_\_\_\_\_\_\_  

General appearance: ____________________________________________________________________  

Head and neck: ________________________________________________________________________  

Chest / lungs: __________________________________________________________________________  

Cardiovascular: _________________________________________________________________________  

Abdominal: _____________________________________________________________________________  

Musculoskeletal / extremities: ___________________________________________________________________________  

Neurological: ___________________________________________________________________________  

Psychiatric: ____________________________________________________________________________  

Visual Exam: ____________________________________________________________________________  

Other: ___________________________________________________________________________________  

**Physician/NPP assessment / summary:** ____________________________________________________________________  

**Treatment plan:** _______________________________________________________________________  

_________________________________________________________________________________________  

_________________________________________________________________________________________  

_________________________________________________________________________________________
Therapeutic shoes order:
Description (or brand name and model number) of therapeutic shoes and supplies (see Appendix A for specific HCPCS codes)

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<th>HCPCS Code</th>
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Other Orders:
Medications (other than immunosuppressive drugs):

Supplies:

Investigations (Diagnostic Testing):

Consults:

Other:

Signature, Name, Date and NPI of physician or NPP

Signature: ____________________________
Name (Printed): ____________________________
Date (MM/DD/YYYY): __________ NPI: __________