Non-Physician Supplier Medicare Compliance Documentation Guide

Shoe Fitter Responsibility/Actions

1. Complete “Patient Evaluation Prior to Shoe Selection”.

2. Select Shoe Size and Style.
   • Measure feet and use display stand to select shoe according the 4 S’s: Size, Shape, Stability, Style.

3. Print up “Physician’s Packet” at Apexfoot.com/dealer-resources and complete:
   • Prescription.
   • Physician Notes on Qualifying Condition(s).
   • Statement of Certifying Physician.

   Give customized forms to patient to be signed by Certifying Physician.
   Make appointment for patient with MD / DO.

4. Alternatively, print out in advance, “Physician’s Packet” from “Forms” section of Apexfoot.com/dealer-resources

5. Click on “Dispensing Docs” to print out “Patient Receipt”, “Dispensing Chart Notes” and “Supplier Standards”. Save in patient's chart until patient returns to pick up shoes.

Patient Responsibility/Actions

6. Patient visits MD / DO, has foot evaluation with discussion of diabetes management.
   • Following evaluation, physician completes forms, signs, dates and faxes to supplier.

Supplier Responsibility/Actions

7. Supplier evaluates forms, reviews to ensure Medicare compliance and orders shoes and inserts.
   • If compliance forms incomplete or inaccurate, supplier follows up with certifying physician.
   • Once forms determined to be accurate and complete, non-physician supplier places order for shoes and inserts with apex via phone or fax. Shoes and inserts shipped.

Shoe Fitter Responsibility/Actions

8. Supplier contacts patient, fits shoes and signs compliance documentation.

9. Supplier goes to Apexfoot.com to print out Medicare compliance documentation including: Patient Receipt, Supplier Standards and Dispensing SOAP Note.

Medicare Compliance Documentation Pointers:

• Save the “Patient Evaluation” as required by Medicare. It may be requested in event of audit.

• Give patient: Physician Notes of Qualifying Condition(s), Statement of Certifying Physician, and Prescription for Therapeutic Shoes and Inserts. Tell patient to bring forms to MD/DO managing their diabetes.

Questions?
Contact
Customer Support - 800-252-2739
Patient Evaluation Prior to Shoe Selection

- Ensure that patient is eligible for coverage for shoes and inserts by Medicare, Medicaid or a private insurer
- Ensure that patient has qualifying risk factor for therapeutic shoes

Patient Name: ______________________________________________    HICN: _____________________ DOB: ______/______/______

Does the patient have Medicare as the primary insurance?:  
- Yes  
- No

Has the patient received shoes under the Medicare Therapeutic Shoe Program this calendar year?:  
- Yes  
- No

### Assessment

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<tr>
<th>Feature</th>
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<td>Callus</td>
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<td>Amputation</td>
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<td>Deformities</td>
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<td>Edema</td>
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<td>Fat Pads</td>
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<td>Cognitive Awareness</td>
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Has patient worn therapeutic footwear?  
- Yes  
- No

### Functional goals for patient services (check all that apply)

- Protection of sensation-compromised foot
- Provision of appropriate footwear for protection, support, stability, and comfort
- Refer to MD/DO follow-up
- Other: ___________________________________________

### Neurological (Use Y or N)

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<thead>
<tr>
<th>Neurological Feature</th>
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<tbody>
<tr>
<td>Loss of Vibration Perception</td>
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<td>Loss of Protective Sensation</td>
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### 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)

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 Ordering Information

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

- Length: ________________ Width: ________________
- Selected Shoe Brand:  
  - Selected Shoe Model / Sku: __________________________
- Selected Inserts:  
  - Prefabricated heat molded  
  - Custom milled  
  - Insert Quantity (Prs):  
    - 3  
    - 2  
    - 1
- If Partial Foot Filler is required:  
  - 1 Left Partial Foot Filler (L5000)  
  - 3 Right Inserts  
  - 1 Right Partial Foot Filler (L5000)  
  - 3 Left Custom Inserts

Qualified Fitter’s Signature: ___________________________________________  Date: _______ / _______ / _______

Qualified Fitter’s Name (Printed): ________________________________

Document created exclusively by Apex  
Signed by supplier, save in patient’s chart