Fax Transmission Cover Sheet

Date 12/8/11

You should receive (1) page(s) including this cover sheet, if you do not receive all of the pages, please contact the above number.

CERT Nurse Reviewer Comments

CID# 1207059

Received from Supplier:

- Proof of delivery;
- An order signed by the podiatrist, who is also the supplier /billing provider;
- Statement of Certifying Physician addressed to Dr. Xxxxx Xxxxx but signed by Dr. Xxxxxxx Xxxxx:
- A form from the podiatrist with multiple dates at the top which have been crossed out; last visible date is 3/10/11;
- Progress note dated 4/1/2011, after billed date of service, which supports medical management of beneficiary's diabetes, but does not include all exam of the feet or need for diabetic shoes.

Missing:

- Critical documentation from the treating physician documentable need for diabetic shoes, obtained within six months prior to delivery of shoes/inserts;
- Clinical documentation concerning the condition listed on the Statement of the Certifying Physician, which qualifies beneficiary for diabetic shoes.

08/15/2011 -call to Treating Physician requesting:

1) Clinical documentation from the physician managing beneficiary diabetes, documenting that the beneficiary is being treated under a comprehensive plan of care and needs diabetic shoes. This information must have been obtained within 6 months prior to delivery of the shoes/inserts;

2) Clinical documentation about the condition that qualifies beneficiary for coverage of diabetic shoes, as listed on the Statement of the Certifying Physician.

Response from Ordering Physician's Office:

- A progress note doted 4/l /2011, after billed date of service, which supports medical management of beneficiary's diabetes, but does not include on exam of the feet or need for diabetic shoes.

NOTE: Please ensure all progress notes, reports or orders hove a legible signature or provide a signature log or an attestation of your medical record entries if the office/progress notes or other medical record documentation is not signed or if the signature(s) ore not clearly legible. In order to be considered valid for Medicare medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary.

Reference Supplier Manual, Chapter I0 -page 83 (or signature requirements: httP://www.rnedicarenhic.f&QI/dme/drnernaca SJD_y_Q0q.J2Of

Please reference the LCD for:

> Therapeutic Shoes for Persons with Diabetes (L11535) and the accompanying article for coverage criteria:

http://wwyv.medicarenhic.c2m/dm Lmedical reviewLmr lcds/mr led current/L11464 20_U-01-0_LJ_ev 2011_-04PA 2011-01 rv 2011-0Acl

Appeals Information

Redeterminations

Redetermination requests may be faxed to **781-741-3118.**

The cover sheet for redetermination requests can be found on the CMN and Forms page.

You may also mail your Redetermination to the following addresses.
Please be sure to use the 9 digit zip code.

DME – Redeterminations
P.O. Box 9150
Hingham, MA 02043-9150

Redetermination Street Address for Overnight Mailings:
NHIC DME MAC Jurisdiction A
Appeals
75 William Terry Drive
Hingham, MA 02044

A redetermination req1.1est must be made within 120 days from the date of denial on the Medic;; re Remittance Advice (RA) otherwise it will be denied as untimely. For assistance in calculating this date visit the Self-Service Tools section of our web site and click on t11e *Redetem1inalion Request Calculator.*

3'1<)

PLACE THIS BAR COOED COVRR SHRET IN FRONT 01" THE RECORD

Medicare CERT Documentation Contractor
CMS 500-99-0019/0002 PSC CERT

Due D:ate: S/6/20J 1

Request Dat; 07122/11

Claim Control NnrrtbeJ":
NJ?J/Prcvlcler ;-.l11mber:

Contractot·Numhtr #:
Patient Name:

Contr.!ctor Ty]:le: DME
Date(') or Scrrt<o' 03/24/U-Ol/Z4/Il
CID Number.
Date o!Birti:lo 02102145

* c D c 1 2 0 7 9 *

Let.t.e1' Se:qnCTice.:
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03125/11

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]'lemscopy biJih sidnf ;1ch Pt\i=!nnd] leAse .l.lO r"--l0l' \'lll l>ll' p:1!8 cdp5 whn c0pyin. Plerlse send the ori!?,lnal c:opy oftltis br coc1 (1 c.ovr shttt with copy of the medical record doCl1mc.ntnotccl <lbL1\', 'l he l\:: 1'1"11 ()(h: lliiCm l\1l\Ql be with !he orip.inRl cm'tr sht ln. 0rdcr to cnsurr.: f.lropcvalidation of l"Ct i.pt by the CE..'R.T f)(')("Umcnt fir,n Offi.:.-c. Jlk:.'"lr.e. f :-; rl(ll:lliTl lll:lt.i-ltl to :(140) ::68-62221]' unnhk j() radocum l\[:1;, ¢ -= end inli mHIli "VIl](l 1ht:: :lddrc.-;s nctd b]l)W.

PATIENT ,\{l'J'HORIZAT/(I,V Nln' REQUIRED TO RESPOND TO THIS REQUEST

P'mvldl'r1g me<lical rcconlr. crf Medic:m:pai"ietlb"; t("ll)w (illllprehem;ive E1ror Rate Testing (CER'f) cootra.ctor] within the. scope. i'lf complhmc.e with Lhe Hc lth ln&u.l'i.'ll.ll: Pnrlability "l1ld ..\(,'i"iiiiTiabil.ity Ac.t tHJtAAl.

CERT Document<ltfon Office ₌ Attn: CID # t.Zii70S9, 909Q .function D11ve, S dt.e 9, Annapolis ,J1 .ncl.ionMD .10701
JIAX 1240) >MJ.-!1222 PH (SS8J779-7477nr (301) 957-2380

NOTE: Beginning in the. Spt:ing of 01 I, CERT will hq .i11 :wc.ep1 ing <locumcnl alion from provider.li.ent via llle El :trnnic S11brnission of Medic] J)or::umcntation (C .MD} rntc.haj1JSitn..Pr:rr m··1:_· i11l'1'i'ln:'ll'i0n :: h(m.1' c:1MD. see www.cm!>.p;ov/csMD.

12 pages

faxed 3/10/11 8mm

TRANSMISSI

tOTAL NU:MllBlt OF PAGES (JNILUDINQ Tfn:l SRtlEl") J_____

RegOU"dlng Your .fnllrnt1.

We have prescribed therapeutic shoes and inlays for your patient. He or obe q11nlln•• undor the Medlcnre Dlnbotk Shoe prog•um. MedlcRre rulu reqnh,th•t yoti, "'the pntlent'r plty ltiRn, certify that the pQ!lent meet! the crller.ln for the prugrom. Tlte crllerln nre lmll nted on the form ••nl w.il.h lhb fBl. flme rlgn the "Stntementll' CeJ Ufylng Physlclnn for Thcrapruth: SqoeB" nd f•xlt hcl< to"" · Thnnl1 yuu.

CON IDEtjT!AUTX NOTICE

Thl• """""""" lranomf••lon [!l jnlended only lor """ uoe.•r lho i11dlvldl/ol or enllly lo \'hlloh R I••ddre•o•d, and *moy* conloln oonndenllol i,rormoUon belonging lo lhB oondet l'l oh r.t'f'Oiecl•d by low ondlor by Ute ptllclllllunor dl""l JlllYffeg.. It you Stlmllhelni Bmled ro<iplenl, you em lteruby noUned Jh•lony dl,oloouro, oop)'fng, dlolribuflon, ot lhol klng oJ All)' oollon In rellllnoQn lhe conlenl! or lhl• lnlormotton '" oltlclly ptohlblt.d. rr you hov• r•••lvod lhhl lnlnomr••r.. In emn-, pi•••• fmmedlelefy nottfy U9 by lelophone!o arrange ror.d1c telum ol *lho* dorumen!(a)

Rx ep .li:.oes – 1 pair / Inserts – 3 pair

Pati*lat:' Per Statement of the c ilifying l'hysiciarl, lhe patient ba;s one or more o{the followin foot condition:

_Previous Amputation _:.Peripb ral Nl'ltlropatby _Previous Ulceration
_foot D.:fur.mity _Pre-Ul10erative Callus X Poor Circulation

Typ of Shoe Presciibe: {

tdded D h - ·: : ustmn-Molded Shoes

lfcustom-moldeli shoes < re requil'!'ld, tl1e foot d!!form.jty *ot* ICD 9 code:----

Custom-molded shoes were required due to:

AdditiomLI Shoe M dlifi '" 'tion':

-lcat-molded devict::! 1:.;;ll.ylThis patient is sufficiently at hiBh rb.k to wamnt a heat-lllOldsd custoD:!ized iDsee, but not sufficiently l!llOUgh at-risk or have a fixed or gross defurmity to wmant a c ::touNnade insert. The defomlity and at-risk statlls is $.ignificant meugh to pret.lude tbu&.of pre-made, non-hes.t-custo:mizable i!1 irts.
Th= pm wml o>:<l'"tt?d'

_For otlllltom, devices QI'I, y: A r:ru;t impl'eooiorJ or scan was taken so that cTJatom illserts, with cu. Ettlcrunni()dB.tiO!ll'l integral to lhc insert:!, could bto fabrh::lrted (see sh.oe order form). Tlul!e pain; wl!re otd.ered, This patiel'lt tequltes custom insms because the defomdties are oo fixed +:,d so sew:re that tbe patient c m11t be aeoommodated in the heat-mt.lld.:d imerts ;md/r previ0\15 attanpts ill heat-molded insetts faild to alleviate the patie.nt's palllllllldlor at :r1i .k cODditia J..
'th rapmtle objectN'•("if·

- Prevent pedal \llo:.,l"ations
- fll<lilil.:te gait
- Maxlmally distri utll plantar pressure

SignAtur ------- Date: 3 l'()-t{

Rx Depth Shoes – 1 pair / Inserts – 3 pair

Patient:. Date:. ___ 1

Per Statement of the CertifYing l'hysician, the patient has o.ne or more of the following foot condition:

_Previous Amputation _Peripheral Neuropathy ,_)'rovipus Ulceration
Foot Deformity Pre-Ulcerative Callus)!,.Pdor Circulation

Type of Shoe Prescribed:

?<'Added Depth _Custom-Molded Shoes

If cust01n"molded shoes are required, the foot deformity or ICD-9 code: _____
_____

Custom-molded"shoes were required due to:

_____
_____

Additional Shoe Modifications:- ----------

i:eat-molded devices only: This patient is sufficiently at high risk to warrant a heat-molded customized insert, but not sufficiently enough at-risk or have a fixed or gross 'deformity to Wliltran.t a custom-made insert. The deformity and at-risk stliltus is significant enough to preclude the use of pre-made, non-heat-customizable inserts.
Three pairs were ordered.

_For custom devices only: A cast impression or scan was taken so that custom inserts, with customized. acconunodations integral to the inserts, could be fabricated (see shoe order form). Three P'"-irs were ordered. This patient requires custom inserts because the deformities are so fixed and so severe that the patient cannot be acconunodated in the heat-molded inserts and/or previous attempts at heat-molded inserts failed to alleviate the patient's pain and/or at risk condition.
Therapeutic ob,jective(s):

- Prevent pedal ulcerations
- Facilitate g'"-it
- Maximally distribute plantar pressure

Signatur Dati): 2>jl1)-l(

D.P.M

Statement of Cartlf1r ,ng for Th•rapeutic Foo"'ear

Patient Nome:

Phone:

HICN: __006:____}___!– - -_

rrognoslGood
ourclllon of uscge: IZ Moi1lhs

Please complete and sign thil; lOITI'I. 1\tlf c:licore's Therapeutic Shoe Program proVides annual vercge for shoes andinsem for polients with diabetl"$ at risk f?r vlcero1i_on. O e ?/the progrc 's objeefiveis to ensum that potierit with dlobe!es hove o Pl"IY51fiOn who!S moi10gIng their d1obetes. 1'hot r,; WhY a requirement fa1 · po!let"lt a glbllily is that!here be a signe•<'S1dlemenl of Cerlifying Physician" from the pofient's diabetes dor br. Be sure to indicate the checked dlagnc•i;,ls in your own patienI record.

Quantity,Product and HCPC CCid"s

I A550CJ Dep!l1Shoes.pair

3 AS51:2 Insffis – rnwltiple den5l!y.eli, F'cl formed. molded to loot wilh exlemal heal source {i.e. heat gun). prefdblicoted, per shoe

Ox: *(check* <:lll *thol* ·apply)

Cl Peripheral n uropothy With ca!us fomllllli'.; n
a Fool deb'rr.ity
o Pre-- . lcerotlvs c::<;>Tius
tJ History of prevlo0•foolvlcercllon .
o Portia!or Cdlflplete foot amputation
P<.Jor circulaMon
))illbel<3 Typo
DType11. ControTied
nType l. Conkolled
LJ Type ll, Uncontrolled
a Type l. Uncontrolled
Pdmory O!agno s:
o Diabetes with neurulogicol manlfestalion ;
o Oiabef()wi11'1 peripheralcill:ula!ay discm:ler
o Diobeles wtthovt neL.rovo;culor manifes :rtlons c: nc:l WJ1h c1ura1 defoJmity
s..c:ondmy DlaQH > b:

CJ Claw toe [7.3S.!l)
o Hollvx t1glcM (735.21
o Hcrnux valgus (7I5.0)
::l Hammer toe [735.4)
o 1-rotorv of pre-Uic:erotlve c::dllu• (707.\>)
q l.c:>W!9r lirnb ompulaffon, foe:>(V49.73)
o Lo-ver limb amputcrfion.graot toe (Y.49.71)
o L<.:>werllmb ampvl n.lessertoe/s) (V49.72)
1:1 UlGer of heel and mldfoot /707.141
a Ulcer otl1er port of l'ool(707.15)
IJ lJnspecilied deformity of ankle a11d foot. oc(:lrJiret..l (736}0)
IJ UnspeciRed acquired defOrmity of 1oe (73.5.)

1 c rtiry 11101 this potiE>nl i! t:relng treme"' under o comprer;en ive plan of core tor diat:retes ond reqvire• accommodative depth footwearondl1pserts.The patient's medical nacotd Indicates that ll'll$ patient hl:l> dlat:>e!es <lnd one or more of these.::: .!dory diagnoses Indlcl')tec:l above. I retdin the original of this foriTI rn th tient chari.

DL

)•

Signature:

0H,]:3.L3dJ.S\13 6rL069SL *TL*

PT. NAME

VASCULAR FINDINGS: (need !A, ZB, IIi +2C)

_Pt. aware and Lllfnrllllf non-covered servic

AOt _N011,:lbl.Umatic an1_9.|J.f.aftpp
BOI_-6s<lll*PT* pulse oap. Refill ____sooS.
02 ";!J1.DPpulse(L R)
OJ n rophie Cbonges (3 req\lil od)
04_halt groWth (.doc :ease/
05 thickening ..
06___n@nentary changes (hemosiderin)
07_....._;;_s k'i"n texture (1h >lhY
08_skh1 color (depe en or I cyanosis)
C09_Claudicotion (potient t port)
IO_._Temperature (coolness)
Il_EdeiJJa: _mild _mod. _severe
17. Paresthesia
13_Buming

DERMATOLOGIC EX,AM
I. Pinch callus - R I 2 3 4 5 L I 2 3 4 5
2. Plantar lesions R 1 2 3 4 5 L 1 2 3 4 5
3. Dm sol lesions (HD)" R 12 j 4 5 L I 2 3 4 5
4. Distollesions (HD). R I 2 3 4 5 L I 2 3 4 5
5. Web sp._Jesimls (HM) R I 2.3 4 5 L I 2 3 45

■ evidence ofn1ycotic nails includes:
--mi1 discoloration (whit't(
_onychalysis
'gual debris
___aci,iyY"ungal skin in . .
ened ua!:fl;._ 31\un 3-6Jrun
of.n•ils R (j)) 4 L@ 3 4 5

TREATMENT
,_.-IJebtidedmycotic nails X nlJled/removed d<bns
_,,,;d bridod hype11tophied nails X
_Debrided hypetkerntotic lesions.

PT. NAME__ DATE_____

Pt. .Pn:sents with c/o__ hype!"'U"ophicd _thickened _discolored _lifting_ painful nails

Pt. qualifies fOI" care because of:__ PVD PAIN in nails

Pt. presents with c/o painful hyperkeratotic lesion __.

R12345 L12345

VASCULAR l'INlJINGS: (need !A, 2B, IB +2C)

"_Pt. aware and inforln<d of non-covered service

A01_Non-trau)llatic amputation
BOl Absent PT pulse (L R) cop. Refill ____sees.
02_Absent DP pulse (L R)
03_Advanced Trophic Changes (J roqt1ired)
04_1tair gl"'I'>\l ,l, (dccroaselabsence)
05_nail thickenil'tg
06__pigmentary changes (he!llosidel"in)
07_skin texture (Ulill, shiny)
08_skin color (depe11dent rubor / cyanosis)
C09 Claudicalion (pal:ient report)
IO_Temper ture (coolness)
II Edema: mild mod. _severe
12 ParestheSia ___
13_Burning

DF-RMATOLOG!C EXAM
I. Pinch callu' R 1 2 3-4 5 .L12345
2. Piontar lesions R I 2 J: 4 5 L12345
3. Dorsal lesions (1:-lD) R I 2 3 4 5 L12345
4. Distal lesions (l-ID) R I 2 3 4"5 L 1230
5. Web sp. lesions (Hrvt) R 1 2 3 4 5 L12H5

TREATMENT
_Debrided mycotic nails X__ (thiltned/removed debris)
Debrided hypertrophied noils X__.
_Debrided hJ•perkeratot.ic lesions.
_A Jllied lnpiMI gentian violet.
-R com n ndF.d r.opical ru1tifimgals.

-- clinical evid.ence of mycotic nails inclllde:s:c
l1ai_l discoh)ralio >'(white / yellow)
onycholysis
subtlllgua!debris
_active fu11gal skin intect.i.lm
___thickened nails <3null _.3 6mm
of nails R I 2 3 4 5 L 1 2 3 4 5

SigJWur<_____

Patient Aut/wrizatirm {Or Parmellt

Patiellt

.i I hBve received.b)_ individual "extra depth" shoe3 and budividual.full .;outset custoln heat molded inserts. l am satisfied with the fit and authorize Medicare an.d my supplemental ittsuranc.e cHrrier to pay Dr. Henderson directly. Lunderstand th .t Medicare pays for tip to one pair of shoes (2 individual shoes) and 3 pair *of* inserts(6 individual) per calendar year. I understand that I am responsible for any deductible and unpaid balance that Medicare or *my* coinsmance does not cover.

I have not received any other shoes or in erl.s under this plan from allY other supplier in the pa.st year,

. l UJ1derstand that should I retu111 the shoes without all exchange or if tbe fit is cm:red and change of style is the rea. on for exchange a $18.00 re-stocking fee wi.ll be. charged to the patient.

DIAUETIC SHOES

1:1:\11__3p_Lf_;{(_

Futient retll.lllc I(IIIw \tiTir:.e ilriz; d:tlc (r_tlr_lq!er,:serneitl rJl. Ll.tci.r c. .lra dc[_dlr diallelic shoes nnd dunltkll;;iLv illsr_lles l11e slwc.:: /ll. rhc pcl.i.E'n.l wr-/1 -,It" irJsolesure fuJI l'UIJ.I:KIIrl ilw p;llicrrl's r cel. I':tlicltl. ill,•:l.rucl.ecl.i.n fJI"[:""" ." flJld rol tiUJJ ofinsu/e_,_ I':JlieLtl nl_rk l, , '-'l'l--'-'" ,s[wE'G cr.rr.r r:-1/y 1lretiL381'-"C ,_,,,_1 to ontiJulsle irts.lws wilill'UI dislno:oo. l'>tLk'tiL it.tslnwlnl.i.t_J I rt eak-itt lJ r ir <l Rlld relu.rn policy .ti.Jt·.sl.ttte,s llltrl itt'<ulr:'.S l'_lty. ici:"tl',s C<'Jhfy_il'l'- . lal. r<r rtl '-'" Gk. Pal.ienl is in8Lntcle.d ll' c"ll_lltc rol.'lirT .ifn11y queslit>ll,or prol:•k"l', PnLier1t .sigrtet:l receil-'1 urrd l'8lur_lll'r.'li<:y ,•:;rtuec' ute ni-'lH<:l(.niate eut.d Wtl_ su1_:,3la1i<18nl, ral.inll. wngivcrll_ll1\i(·,liuli e- <:l'llll ·'ln.irtl.l-'colicy. -'lll)]'lic(•: ,5laucbrds. :llld WLille_ll iu·lr-ucli,_uts fliJr_l ll'iltT:ttllv irtfctl'lll:Jiinn

!Vlt Jilyn C llemlerst.:lll. l_) 1',1\l

BREAJ<:-ININSTRUCTIONS F'OR NEW SHOES

Congratulotion• on receiving your new shoes. In occotda1ice with Medicarregulations, they have ben selected froln r" q own inventory, from auother company 01' have been fabricoted to provide you with optimum comfort ""d protections, In order to receive the greal: !lt benefits from this footwear, please follow the5e suggested guidelines.

Getting used to yotu'!iho-es

People with decrea.od feeling in their feet may have a fal•e 5onsc ofscurity os to how much at ri•k their feet actua.li;,' ore" An ulcer undr the foot can develop in a, couple of hours even if the shoes are expet1:ly fit. J.n order to best avoid irritat.i ", adhere to the following break-in schedule:

FIRST DAY	Wear One Hour
SECOND DAY	Wear Two Hours-Cbeck feet a,ll:er first hour
TI-IIRD DAY	Wcr Three Hours
FOURTH DAY	Wear Four Hours-Check fee!after two hours
FIFTH DAY	Wear Full Day-Check .,fter lunch. ·

"'IF AT ANY TIME YOU SEE RED SPOTS OR DARKNESS ON THE TOE:S OR OTHER BONY AREAS DURfl\IG THE FIRST FIVE DAYS: Discontinue wearing the shoes fur the rest ofthe day and sta.rt , ro11tine again the nex.t day **beginj1ing with one hour of wear.**

•IF A RED SPOT OR DARKNESS API'EAR.S WITJ-1 EVERY WEAIUNG- DO NOT WEAR SHOES. Call **Dr. H nd rsm for El.n adju tmli:lnt appointme!nt.**

•BE SURE TO INSPECT YOUR FEET EVERY DAY.

FOLLOW-UP

You should have regularly scheduled visits wltl, Dl : Henderson. Please direct ony questions !o this office. BiJiins questions my be directed lo your Medicare catTier. Evely four montlis get rid ofthe inserts in your shoes a11d put itl new pair. In o11c year, you will receive a reminder to re!)ln' to Dr. Henderson to evaluate the condition ofthese shoes.

RETURN POLICY

Shoes that"'" UllSl!ilnble may be retmncd within one week of dispetJsing. Tho a hoes must be in good condition, i.e,, IIC• scuffm•rk5, outside dilt or obvious wear on the soles nd in original pa ka.ging. There will be an $18 restocking fee ir til; shoes are retu11ed without exchange from the same vendor. We strongly urge you to wear these shoe5 in your home for the fi• st week. Substandard shoes may be retumed 8S II warrantios, expressed and implied under applicable State law ll'i Il. be honored,

r certify that I havo t'eceived the s.hoes .in good condition. The assistant has expla.ined, in deta.il, the proper use a.nd care •>l this device nnd has fit it f:o me. I have been givenl:l'" instructions on cat e of the shoes. The assists11t has a.sked me to call the office ifi e11counter any problems with the device or ifl have any questions. I have been informed of the Medicare DMEPOS Supplier Standards, if applicabie,

DATE 3/29/11

OVERPAYMENT SERVICES REPORT 2

TYPE OF SERVICE LEGEND

TOS	DESCRIPTION
p	LUMP SUM PURCHASE OF DME
J	••UNKNOWN ·

REASON fOR OVERPAYMENT

REAS I	DESCRIPTION
$019	fhis overpayment occurred because payment ex eeded est blished

utilization parameters, including number of and/or length of service,
obecause of leek of do umentatlon to upport the cl m.

S18 1132231101,000 0000467