DMSI CHECKLIST

1. Certifying MD documentation for diabetes management

The MD or DO must see the patient. If both a PA/NP/ARNP and the MD/DO see the patient, the records must indicate that the MD/DO performed the diabetic management portion of the visit. This portion cannot be co-signed by the MD/DO.

- ☐ Patient's diabetes is under control and noted in the chart note
- ☐ A1c Level/Lab results reviewed within the chart notes and/or ordered within the chart note
- ☐ Patients home glucose levels reviewed
- ☐ MD/DO discusses diet and/or exercise
- ☐ Medication list documented in the chart note
- ☐ Plan of care documented

  Example: Patient's DM is under control. Continue checking sugar level once daily, no change in medication. Diet and exercise plan discussed. Return to office in 3 months.

2. Information needed on the TSF

- ☐ Is the certifying physician an MD or DO?
- ☐ Is the DM visit within 6 months of the shoe delivery? Expiration date_____
- ☐ Is the TSF signed within 3 months of shoe/insert delivery? Expiration date_____

3. Documentation neeDED for the Foot Examination

This part of the examination (foot examination only) can be performed by a NP, PA, ARNP, or DPM. However, their notes must be signed by the certifying MD agreeing with the NP, PA, ARNP, or DPM evaluation on the same date as the TSF is signed.*** **FOOT EXAM MUST BE WITHIN 6 MONTHS OF THE SHOE/INSERT DELIVERY.*****

- ☐ Is there **detailed** information regarding the diagnosis listed on the TSF?
  - History of partial or complete amputation of the foot (*What type of amputation? Was there one toe amputated? Multiple toes? Which one(s)? Great toe? Forefoot? Etc.)*
  - History of previous foot ulceration *(Where was the ulcer (s)?)*
  - History of pre-ulcerative callus (*Where was the callus?)*
  - Peripheral neuropathy with evidence of callus formation *(Must state peripheral neuropathy and location of the callus.)*
  - Foot deformity *(Does the patient have hammer toes, bunions, pes planus, valgus/varus deformity? DX needs to be specific.)*
  - Poor circulation (*What tests were performed? Pedal pulses, Dopler, objective.)* Diagnosis such as hypertension, coronary artery disease, congestive heart failure or the presence of edema are not by themselves sufficient. Documentation must include objective and quantifying information such as pedal pulses or clearly indicate the condition of the foot/feet.

☐ Do the medical records state that the patient needs shoes and Inserts? Custom shoes, inserts and/or modifications must also be documented.

DMSI BILLING CHECKLIST

1. INFORMATION REQUIRED PRIOR TO PO BEING ISSUED

☐ Valid TSF

☐ Medical records supporting TSF

☐ Detailed Rx

☐ Completed practitioner evaluation form. Must not contradict the information in the medical records

2. INFORMATION REQUIRED TO BILL

☐ Everything listed above

☐ Delivery notes, signed POD, ABN as needed