

Orthopedic Shoe Dealer

Provider Manual



Iowa Department
of Human Services



Iowa
Department
of Human
Services

Provider
Orthopedic Shoe Dealer

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CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. ESTABLISHMENTS ELIGIBLE TO PARTICIPATE

Retail dealers in orthopedic shoes and shoe repair shops specializing in orthopedic work (padding, wedging, metatarsal bars, built-up soles or heels, etc.) are establishments eligible to participate in Medicaid.

B. COVERAGE OF SERVICES

Orthopedic shoes, inserts, arch supports and modifications are covered when:

- ◆ A written prescription by a doctor of medicine, podiatry or osteopathy, physician assistant or advanced registered nurse practitioner includes the date, diagnosis, reason the orthopedic shoes are needed, probable duration of need and specific description of any modification the shoes must include, and
- ◆ The diagnosis indicates an orthopedic, neuromuscular, vascular or insensate foot condition.

NOTE: A diagnosis of flat feet is **not** covered.

Therapeutic shoes for persons with diabetes are covered according to Medicare criteria.

1. Definitions

Depth shoes are shoes that:

- ◆ Have a full length, heel-to-toe filler that when removed provides a minimum of 3/16" of additional depth used to accommodate custom-molded or customized inserts, and
- ◆ Are made from leather or other suitable material of equal quality, and
- ◆ Have some form of shoe closure, and
- ◆ Are available in full and half sizes with a minimum of three widths so that the sole is graded to the size and width of the upper portions of the shoe according to the American standard last sizing schedule or its equivalent.



Custom-molded shoes are shoes that:

- ◆ Are constructed over a positive model of the member's foot, and
- ◆ Are made of leather or another suitable material of equal quality, and
- ◆ Have inserts that can be altered or replaced as the member's condition warrants, and
- ◆ Have some form of closure such as laces or Velcro.

Custom shoes are shoes that are:

- ◆ Modified with attachments, such as arch supports, lifts, wedges, and heels, specific to the individual member. Inserts and attachments may be billed separately in addition to the code for the shoe when a custom shoe is provided.
- ◆ An off-the-shelf shoe with only a premolded or molded to patient model removable insert is not a custom shoe.

Metatarsal bars are exterior bars that are placed behind the metatarsal heads in order to remove pressure from the metatarsal heads. The bars are of various shapes, heights, and construction depending on the exact purpose.

Offset heel is a heel flanged at its base either in the middle, to the side, or a combination, that is then extended upward to the shoe in order to stabilize extreme positions of the hind foot.

Rigid rocker bottoms are exterior elevations with apex position for 51% to 75% distance measured from the back end of the heel. The apex is a narrowed or pointed end of an anatomical structure. The apex must be positioned behind the metatarsal heads and tapering off sharply to the front tip of the sole.

Apex height helps to eliminate pressure at the metatarsal heads. The steel in the shoe ensures rigidity. The heel of the shoe tapers off in the back in order to cause the heel to strike in the middle of the heel.

Roller bottoms (sole or bar) are the same as rocker bottoms, but the heel is tapered from the apex to the front tip of the sole.

Wedges (posting) are either of hind foot, fore foot, or both and may be in the middle or to the side. The function is to shift or transfer weight bearing upon standing or during ambulation to the opposite side for added support, stabilization, equalized weight distribution, or balance.



2. Interpreter Services

Interpretative services may be covered, whether done orally or through sign language. Interpreters must provide only interpretation services for the agency. The services must facilitate access to Medicaid covered services.

In order for interpretation services to be covered by Iowa Medicaid, the services must meet the following criteria:

- ◆ Provided by interpreters who provide only interpretive services
- ◆ Interpreters may be employed or contracted by the billing provider
- ◆ The interpretive services must facilitate access to Medicaid covered services

Providers may only bill for these services if offered in conjunction with an otherwise Medicaid covered service. Medical staff that are bilingual are not reimbursed for the interpretation but only for their medical services.

a. Documentation of the Service

The billing provider must document in the member's record the:

- ◆ Interpreter's name or company,
- ◆ Date and time of the interpretation,
- ◆ Service duration (time in and time out), and
- ◆ Cost of providing the service.

b. Qualifications

It is the responsibility of the billing provider to determine the interpreter's competency. Sign language interpreters should be licensed pursuant to 645 Iowa Administrative Code (IAC) 361. Oral interpreters should be guided by the standards developed by the [National Council on Interpreting in Health Care](#).

Following is the instruction for billing interpretive services when that service is provided by an outside commercial translation service:

- ◆ Bill code T1013
 - For telephonic interpretive services use modifier "UC" to indicate that the payment should be made at a per-minute unit.
 - The lack of the UC modifier will indicate that the charge is being made for the 15 minute face-to-face unit.



- ◆ Enter the number of minutes actually used for the provision of the service. The 15 minute unit should be rounded up if the service is provided for 8 minutes or more.

NOTE: Because the same code is being used but a conditional modifier may be necessary, any claim where the UC modifier is **NOT** used and the units exceed 24 will be paid at 24 units.

3. Limitations

Payment for orthopedic shoes and inserts and therapeutic shoes for members with diabetes are limited as follows:

- ◆ Only two pairs of depth shoes per member are allowed in a 12-month period unless documentation of change in size or evidence of excessive wear is submitted.
- ◆ Three pairs of inserts in addition to the non-customized removable inserts provided with depth shoes are allowed in a 12-month period.
- ◆ Only two pairs of custom-molded shoes (which include inserts provided with these shoes) per member are allowed in a 12-month period unless documentation of change in size or evidence of excessive wear is submitted.
- ◆ Two additional pairs of inserts for custom-molded shoes are allowed in a 12-month period.

EXCEPTION: Athletic shoes for school age children under age 21 are allowed in addition to orthopedic shoes when required for participation in school sports.

Custom-molded shoes, inserts, and modifications are allowed only for members with a foot deformity that cannot be accommodated by a depth shoe. The nature and severity of the deformity must be well documented in the supplier's records. If there is insufficient justification for a custom molded shoe but the general coverage criteria are met, payment will be based on the allowance for the depth shoe.

Payment will be allowed for casting an impression that is required to manufacture a custom-made shoe. **Materials and labor** required to modify orthopedic shoes and other specified foot orthotic devices are covered according to the specifications or the written prescription of a doctor of medicine, osteopathy, or podiatry, physician assistant or advanced registered nurse practitioner.



Women's and men's orthopedic shoes not attached to a brace are covered when the second shoe is attached to a brace and is covered by other third-party payment. (Coverage differs from Medicare.)

Plaster impression foot orthotics are covered when:

- ◆ Constructed of more than one layer of a material that is soft enough and firm enough to hold an impression during use, and
- ◆ Are molded to the member's foot or made over a model of the foot. (Coverage differs from Medicare.)

Molded digital orthotics are covered.

C. PRESCRIPTION REQUIREMENT

When examination by a doctor of medicine, osteopathy, or podiatry, physician assistant or advanced registered nurse practitioner indicates that orthopedic shoes and other covered services are required, the examiner shall give the member a written prescription. The prescription must include the special features required. i.e., padding, wedging, metatarsal bars, degree of built-up heels or soles, etc.

Note for custom-made shoes: In order to substantiate this expensive treatment, the prescriber must include the diagnosis on the prescription for custom-made shoes.

When a prescription presented by or on behalf of a member fails to set forth the required information, the provider shall return it to the prescriber for correction before filling it.

The physician managing the member's diabetic condition must certify the need for therapeutic shoes and that the criteria are met.



D. BASIS OF PAYMENT

The basis of payment for goods and services provided by orthopedic shoe dealers and shoe repair shops specializing in orthopedic work shall be:

- ◆ The shoe dealer's usual, customary, and reasonable charge for the type or kind of shoe prescribed.
- ◆ Up to a maximum fee for the type or kind of shoe prescribed, plus the cost of materials and labor required to modify the shoes according to the specifications of the prescription.

Payment for mismatched shoes (other than custom-made) shall be based on one and one-half the usual, customary, and reasonable charge, up to the maximum fee for a matched pair of shoes.

- ◆ The shoe repair shop's usual, customary, and reasonable charge, up to a maximum fee for materials and labor necessary to modify orthopedic shoes according to the specifications of the prescription.

E. PROCEDURE CODES AND NOMENCLATURE

Medicaid recognizes Medicare's National Level II Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes. However, all HCPCS and CPT codes are not covered.

Click [here](#) to view the fee schedule for Orthopedic Shoe Dealers.

Providers who do not have Internet access can obtain a copy of the provider-specific fee schedule upon request from the IME.

It is the provider's responsibility to select the procedure code that best describes the item dispensed. A claim submitted without a procedure code and a corresponding diagnosis code will be denied.

NOTE: Place the two position modifier "EP" after the procedure code for each service related to "Care for Kids" (EPSDT) examination.

The date of service must be the date the shoes are provided to the Medicaid member. Each shoe should be billed as one unit. A pair of shoes would be billed as two units.



Inserts and attachments for a custom orthopedic shoe may be billed separately in addition to the code for the shoe when a custom orthopedic shoe is provided.

Therapeutic shoes for members with diabetes should be billed using the appropriate "A" codes.

More than one pair of orthopedic or therapeutic shoes provided in a 12 month period for members who also receive Medicare should be billed using the "SC" modifier.

F. BILLING POLICIES AND CLAIM FORM INSTRUCTIONS

Claims for Orthopedic Shoe Dealers are billed on federal form CMS-1500, *Health Insurance Claim Form*.

Click [here](#) to view a sample of the CMS-1500.

Click [here](#) to view billing instructions for the CMS-1500.

Refer to [Chapter IV. Billing Iowa Medicaid](#) for claim form instructions, all billing procedures, and a guide to reading the Iowa Medicaid Remittance Advice statement.

The Billing Manual can be located online at:

http://www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Provman/all-iv.pdf.