Local Coverage Determination (LCD): Orthopedic Footwear (L33641)

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Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
CGS Administrators, LLC	DME MAC	17013 - DME MAC	J-B	Illinois Indiana Kentucky Michigan Minnesota Ohio Wisconsin
CGS Administrators, LLC	DME MAC	18003 - DME MAC	J-C	Alabama Arkansas Colorado Florida Georgia Louisiana Mississippi New Mexico North Carolina Oklahoma Puerto Rico South Carolina Tennessee Texas Virgin Islands Virginia West Virginia
Noridian Healthcare Solutions, LLC	DME MAC	16013 - DME MAC	J-A	Connecticut Delaware District of Columbia Maine Maryland Massachusetts New Hampshire New Jersey New York - Entire State Pennsylvania Rhode Island Vermont

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
Noridian Healthcare Solutions, LLC	DME MAC	19003 - DME MAC	J-D	Alaska American Samoa Arizona California - Entire State Guam Hawaii Idaho Iowa Kansas Missouri - Entire State Montana Nebraska Nevada North Dakota Northern Mariana Islands Oregon South Dakota Utah Washington Wyoming

LCD Information

Document Information

LCD ID
L33641

LCD Title
Orthopedic Footwear

Proposed LCD in Comment Period
N/A

Source Proposed LCD
N/A

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For services performed on or after 10/01/2015

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N/A

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CMS National Coverage Policy

CMS Manual System Pub. 100-03, Medicare National Coverage Determinations Manual, Chapter 1, Section 280.10

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

For any item to be covered by Medicare, it must (1) be eligible for a defined Medicare benefit category, (2) be reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member, and (3) meet all other applicable Medicare statutory and regulatory requirements.

The purpose of a Local Coverage Determination (LCD) is to provide information regarding "reasonable and necessary" criteria based on Social Security Act § 1862(a)(1)(A) provisions.

In addition to the "reasonable and necessary" criteria contained in this LCD there are other payment rules, which are discussed in the following documents, that must also be met prior to Medicare reimbursement:

- The LCD-related Standard Documentation Requirements Article, located at the bottom of this policy under the Related Local Coverage Documents section.

- The LCD-related Policy Article, located at the bottom of this policy under the Related Local Coverage Documents section.
- Refer to the Supplier Manual for additional information on documentation requirements.
- Refer to the DME MAC web sites for additional bulletin articles and other publications related to this LCD.

For the items addressed in this LCD, the “reasonable and necessary” criteria, based on Social Security Act § 1862(a)(1)(A) provisions, are defined by the following coverage indications, limitations and/or medical necessity.

Statutory coverage criteria for orthopedic footwear are specified in the related Policy Article.

Prosthetic shoes (L3250) are covered if they are an integral part of a prosthesis for a beneficiary with a partial foot amputation (refer to the ICD-10 Codes section in the LCD-related Policy Article). Claims for prosthetic shoes for other diagnosis codes will be denied as not medically necessary.

GENERAL

A Standard Written Order (SWO) must be communicated to the supplier before a claim is submitted. If the supplier bills for an item addressed in this policy without first receiving a completed SWO, the claim shall be denied as not reasonable and necessary.

For Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) base items that require a Written Order Prior to Delivery (WOPD), the supplier must have received a signed SWO before the DMEPOS item is delivered to a beneficiary. If a supplier delivers a DMEPOS item without first receiving a WOPD, the claim shall be denied as not reasonable and necessary. Refer to the LCD-related Policy Article, located at the bottom of this policy under the Related Local Coverage Documents section.

For DMEPOS base items that require a WOPD, and also require separately billed associated options, accessories, and/or supplies, the supplier must have received a WOPD which lists the base item and which may list all the associated options, accessories, and/or supplies that are separately billed prior to the delivery of the items. In this scenario, if the supplier separately bills for associated options, accessories, and/or supplies without first receiving a completed and signed WOPD of the base item prior to delivery, the claim(s) shall be denied as not reasonable and necessary.

An item/service is correctly coded when it meets all the coding guidelines listed in CMS HCPCS guidelines, LCDs, LCD-related Policy Articles, or DME MAC articles. Claims that do not meet coding guidelines shall be denied as not reasonable and necessary/incorrectly coded.

Proof of delivery (POD) is a Supplier Standard and DMEPOS suppliers are required to maintain POD documentation in their files. Proof of delivery documentation must be made available to the Medicare contractor upon request. All services that do not have appropriate proof of delivery from the supplier shall be denied as not reasonable and necessary.

Summary of Evidence

NA

Analysis of Evidence
(Rationale for Determination)

NA

Coding Information

CPT/HCPCS Codes

Group 1 Paragraph:

The appearance of a code in this section does not necessarily indicate coverage.

HCPCS MODIFIERS:

EY – No physician or other licensed health care provider order for this item or service
GY - Item or service statutorily excluded or does not meet the definition of any Medicare benefit
KX - Requirements specified in the medical policy have been met
LT - Left side
RT - Right side

HCPCS CODES

Group 1 Codes:

CODE	DESCRIPTION
A9283	FOOT PRESSURE OFF LOADING/SUPPORTIVE DEVICE, ANY TYPE, EACH
L3000	FOOT, INSERT, REMOVABLE, MOLDED TO PATIENT MODEL, 'UCB' TYPE, BERKELEY SHELL, EACH
L3001	FOOT, INSERT, REMOVABLE, MOLDED TO PATIENT MODEL, SPENCO, EACH
L3002	FOOT, INSERT, REMOVABLE, MOLDED TO PATIENT MODEL, PLASTAZOTE OR EQUAL, EACH
L3003	FOOT, INSERT, REMOVABLE, MOLDED TO PATIENT MODEL, SILICONE GEL, EACH
L3010	FOOT, INSERT, REMOVABLE, MOLDED TO PATIENT MODEL, LONGITUDINAL ARCH SUPPORT, EACH
L3020	FOOT, INSERT, REMOVABLE, MOLDED TO PATIENT MODEL, LONGITUDINAL/ METATARSAL SUPPORT, EACH
L3030	FOOT, INSERT, REMOVABLE, FORMED TO PATIENT FOOT, EACH
L3031	FOOT, INSERT/PLATE, REMOVABLE, ADDITION TO LOWER EXTREMITY ORTHOSIS, HIGH STRENGTH, LIGHTWEIGHT MATERIAL, ALL HYBRID LAMINATION/PREPREG COMPOSITE, EACH

CODE	DESCRIPTION
L3040	FOOT, ARCH SUPPORT, REMOVABLE, PREMOLDED, LONGITUDINAL, EACH
L3050	FOOT, ARCH SUPPORT, REMOVABLE, PREMOLDED, METATARSAL, EACH
L3060	FOOT, ARCH SUPPORT, REMOVABLE, PREMOLDED, LONGITUDINAL/ METATARSAL, EACH
L3070	FOOT, ARCH SUPPORT, NON-REMOVABLE ATTACHED TO SHOE, LONGITUDINAL, EACH
L3080	FOOT, ARCH SUPPORT, NON-REMOVABLE ATTACHED TO SHOE, METATARSAL, EACH
L3090	FOOT, ARCH SUPPORT, NON-REMOVABLE ATTACHED TO SHOE, LONGITUDINAL/METATARSAL, EACH
L3100	HALLUS-VALGUS NIGHT DYNAMIC SPLINT, PREFABRICATED, OFF-THE-SHELF
L3140	FOOT, ABDUCTION ROTATION BAR, INCLUDING SHOES
L3150	FOOT, ABDUCTION ROTATION BAR, WITHOUT SHOES
L3160	FOOT, ADJUSTABLE SHOE-STYLED POSITIONING DEVICE
L3170	FOOT, PLASTIC, SILICONE OR EQUAL, HEEL STABILIZER, PREFABRICATED, OFF-THE-SHELF, EACH
L3201	ORTHOPEDIC SHOE, OXFORD WITH SUPINATOR OR PRONATOR, INFANT
L3202	ORTHOPEDIC SHOE, OXFORD WITH SUPINATOR OR PRONATOR, CHILD
L3203	ORTHOPEDIC SHOE, OXFORD WITH SUPINATOR OR PRONATOR, JUNIOR
L3204	ORTHOPEDIC SHOE, HIGHTOP WITH SUPINATOR OR PRONATOR, INFANT
L3206	ORTHOPEDIC SHOE, HIGHTOP WITH SUPINATOR OR PRONATOR, CHILD
L3207	ORTHOPEDIC SHOE, HIGHTOP WITH SUPINATOR OR PRONATOR, JUNIOR
L3208	SURGICAL BOOT, EACH, INFANT
L3209	SURGICAL BOOT, EACH, CHILD
L3211	SURGICAL BOOT, EACH, JUNIOR
L3212	BENESCH BOOT, PAIR, INFANT
L3213	BENESCH BOOT, PAIR, CHILD
L3214	BENESCH BOOT, PAIR, JUNIOR
L3215	ORTHOPEDIC FOOTWEAR, LADIES SHOE, OXFORD, EACH
L3216	ORTHOPEDIC FOOTWEAR, LADIES SHOE, DEPTH INLAY, EACH
L3217	ORTHOPEDIC FOOTWEAR, LADIES SHOE, HIGHTOP, DEPTH INLAY, EACH
L3219	ORTHOPEDIC FOOTWEAR, MENS SHOE, OXFORD, EACH
L3221	ORTHOPEDIC FOOTWEAR, MENS SHOE, DEPTH INLAY, EACH
L3222	ORTHOPEDIC FOOTWEAR, MENS SHOE, HIGHTOP, DEPTH INLAY, EACH

CODE	DESCRIPTION
L3224	ORTHOPEDIC FOOTWEAR, WOMAN'S SHOE, OXFORD, USED AS AN INTEGRAL PART OF A BRACE (ORTHOSIS)
L3225	ORTHOPEDIC FOOTWEAR, MAN'S SHOE, OXFORD, USED AS AN INTEGRAL PART OF A BRACE (ORTHOSIS)
L3230	ORTHOPEDIC FOOTWEAR, CUSTOM SHOE, DEPTH INLAY, EACH
L3250	ORTHOPEDIC FOOTWEAR, CUSTOM MOLDED SHOE, REMOVABLE INNER MOLD, PROSTHETIC SHOE, EACH
L3251	FOOT, SHOE MOLDED TO PATIENT MODEL, SILICONE SHOE, EACH
L3252	FOOT, SHOE MOLDED TO PATIENT MODEL, PLASTAZOTE (OR SIMILAR), CUSTOM FABRICATED, EACH
L3253	FOOT, MOLDED SHOE PLASTAZOTE (OR SIMILAR) CUSTOM FITTED, EACH
L3254	NON-STANDARD SIZE OR WIDTH
L3255	NON-STANDARD SIZE OR LENGTH
L3257	ORTHOPEDIC FOOTWEAR, ADDITIONAL CHARGE FOR SPLIT SIZE
L3260	SURGICAL BOOT/SHOE, EACH
L3265	PLASTAZOTE SANDAL, EACH
L3300	LIFT, ELEVATION, HEEL, TAPERED TO METATARSALS, PER INCH
L3310	LIFT, ELEVATION, HEEL AND SOLE, NEOPRENE, PER INCH
L3320	LIFT, ELEVATION, HEEL AND SOLE, CORK, PER INCH
L3330	LIFT, ELEVATION, METAL EXTENSION (SKATE)
L3332	LIFT, ELEVATION, INSIDE SHOE, TAPERED, UP TO ONE-HALF INCH
L3334	LIFT, ELEVATION, HEEL, PER INCH
L3340	HEEL WEDGE, SACH
L3350	HEEL WEDGE
L3360	SOLE WEDGE, OUTSIDE SOLE
L3370	SOLE WEDGE, BETWEEN SOLE
L3380	CLUBFOOT WEDGE
L3390	OUTFLARE WEDGE
L3400	METATARSAL BAR WEDGE, ROCKER
L3410	METATARSAL BAR WEDGE, BETWEEN SOLE
L3420	FULL SOLE AND HEEL WEDGE, BETWEEN SOLE
L3430	HEEL, COUNTER, PLASTIC REINFORCED
L3440	HEEL, COUNTER, LEATHER REINFORCED

CODE	DESCRIPTION
L3450	HEEL, SACH CUSHION TYPE
L3455	HEEL, NEW LEATHER, STANDARD
L3460	HEEL, NEW RUBBER, STANDARD
L3465	HEEL, THOMAS WITH WEDGE
L3470	HEEL, THOMAS EXTENDED TO BALL
L3480	HEEL, PAD AND DEPRESSION FOR SPUR
L3485	HEEL, PAD, REMOVABLE FOR SPUR
L3500	ORTHOPEDIC SHOE ADDITION, INSOLE, LEATHER
L3510	ORTHOPEDIC SHOE ADDITION, INSOLE, RUBBER
L3520	ORTHOPEDIC SHOE ADDITION, INSOLE, FELT COVERED WITH LEATHER
L3530	ORTHOPEDIC SHOE ADDITION, SOLE, HALF
L3540	ORTHOPEDIC SHOE ADDITION, SOLE, FULL
L3550	ORTHOPEDIC SHOE ADDITION, TOE TAP STANDARD
L3560	ORTHOPEDIC SHOE ADDITION, TOE TAP, HORSESHOE
L3570	ORTHOPEDIC SHOE ADDITION, SPECIAL EXTENSION TO INSTEP (LEATHER WITH EYELETS)
L3580	ORTHOPEDIC SHOE ADDITION, CONVERT INSTEP TO VELCRO CLOSURE
L3590	ORTHOPEDIC SHOE ADDITION, CONVERT FIRM SHOE COUNTER TO SOFT COUNTER
L3595	ORTHOPEDIC SHOE ADDITION, MARCH BAR
L3600	TRANSFER OF AN ORTHOSIS FROM ONE SHOE TO ANOTHER, CALIPER PLATE, EXISTING
L3610	TRANSFER OF AN ORTHOSIS FROM ONE SHOE TO ANOTHER, CALIPER PLATE, NEW
L3620	TRANSFER OF AN ORTHOSIS FROM ONE SHOE TO ANOTHER, SOLID STIRRUP, EXISTING
L3630	TRANSFER OF AN ORTHOSIS FROM ONE SHOE TO ANOTHER, SOLID STIRRUP, NEW
L3640	TRANSFER OF AN ORTHOSIS FROM ONE SHOE TO ANOTHER, DENNIS BROWNE SPLINT (RIVETON), BOTH SHOES
L3649	ORTHOPEDIC SHOE, MODIFICATION, ADDITION OR TRANSFER, NOT OTHERWISE SPECIFIED

General Information

Associated Information

DOCUMENTATION REQUIREMENTS

Section 1833(e) of the Social Security Act precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider." It is expected that the beneficiary's medical records will reflect the need for the care provided. The beneficiary's medical records include the treating practitioner's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be available upon request.

GENERAL DOCUMENTATION REQUIREMENTS

In order to justify payment for DMEPOS items, suppliers must meet the following requirements:

- SWO
- Medical Record Information (including continued need/use if applicable)
- Correct Coding
- Proof of Delivery

Refer to the LCD-related Standard Documentation Requirements article, located at the bottom of this policy under the Related Local Coverage Documents section for additional information regarding these requirements.

Refer to the Supplier Manual for additional information on documentation requirements.

Refer to the DME MAC web sites for additional bulletin articles and other publications related to this LCD.

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS

Items covered in this LCD have additional policy-specific requirements that must be met prior to Medicare reimbursement.

Refer to the LCD-related Policy article, located at the bottom of this policy under the Related Local Coverage Documents section for additional information.

Miscellaneous

Appendices

Utilization Guidelines

Refer to Coverage Indications, Limitations and/or Medical Necessity

Sources of Information

N/A

Bibliography

NA

Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
01/01/2020	R6	**Revision Effective Date: 01/01/2020** COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Revised: Statement to refer to ICD-10 code list in the LCD-related Policy Article GENERAL: Revised: Order information as a result of Final Rule 1713 CODING INFORMATION: Removed: Field titled “Bill Type” Removed: Field titled “Revenue Codes” Removed: Field titled “ICD-10 Codes that Support Medical Necessity” Removed: Field titled “ICD-10 Codes that DO NOT Support Medical Necessity” Removed: Field titled “Additional ICD-10 Information” DOCUMENTATION REQUIREMENTS: Revised: “physician’s” to “treating practitioner’s” GENERAL DOCUMENTATION REQUIREMENTS: Revised: “Prescriptions (orders)” to “SWO” *02/20/2020: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because they are due to non-discretionary coverage updates reflective of CMS FR-1713.*	• Provider Education/Guidance • Other
01/01/2019	R5	**Revision Effective Date: 01/01/2019** COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY: Removed: Statement to refer to diagnosis code section below Added: Refer to Covered ICD-10 Codes in the LCD-related Policy Article ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY: Moved: All diagnosis codes to the LCD-related Policy Article diagnosis code section per CMS instruction ICD-10 CODES THAT DO NOT SUPPORT MEDICAL NECESSITY: Moved: Statement about noncovered diagnosis codes moved to LCD-related Policy Article	• Other (ICD-10 code relocation per CMS instruction)

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
		noncovered diagnosis code section per CMS instruction	
01/01/2017	R4	**Revision Effective Date: 01/01/2017** COVERAGE INDICATIONS, INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Removed: Standard Documentation Language Added: New reference language and directions to Standard Documentation Requirements Added: General Requirements DOCUMENTATION REQUIREMENTS: Removed: Standard Documentation Language Added: General Documentation Requirements Added: New reference language and directions to Standard Documentation Requirements POLICY SPECIFIC DOCUMENTATION REQUIREMENTS: Removed: Standard Documentation Language Added: Direction to Standard Documentation Requirements Removed: Information under Miscellaneous and Appendices RELATED LOCAL COVERAGE DOCUMENTS: Added: LCD-related Standard Documentation Requirements article	• Provider Education/Guidance
07/01/2016	R3	Effective July 1, 2016 oversight for DME MAC LCDs is the responsibility of CGS Administrators, LLC 18003 and 17013 and Noridian Healthcare Solutions, LLC 19003 and 16013. No other changes have been made to the LCDs.	• Change in Assigned States or Affiliated Contract Numbers
10/01/2015	R2	**Revision Effective: 10/01/2015** ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY Added: Inadvertently omitted ICD10's subsequent visit	• Typographical Error • Revisions Due To ICD-10-CM Code Changes
10/01/2015	R1	**Revision Effective Date: 10/01/2015** COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Added: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility Removed: ICD-9 references DOCUMENTATION REQUIREMENTS: Revised: Standard Documentation Language to add	• Provider Education/Guidance

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
		covered prior to a beneficiary's Medicare eligibility Added: Instructions for Equipment Retained from a Prior Payer	

Associated Documents

Attachments

N/A

Related Local Coverage Documents

Article(s)
A52481 - Orthopedic Footwear - Policy Article
A55426 - Standard Documentation Requirements for All Claims Submitted to DME MACs

Related National Coverage Documents

N/A

Public Version(s)

Updated on 02/14/2020 with effective dates 01/01/2020 - N/A
Updated on 02/22/2019 with effective dates 01/01/2019 - 12/31/2019
Some older versions have been archived. Please visit the MCD Archive Site to retrieve them.

Keywords

N/A

END OF LOCAL COVERAGE DETERMINATION

Per the Code of Federal Regulations, 42 C.F.R § 426. 325, only those portions of the currently effective Local Coverage Determination (LCD) that are based on section 1862(a)(1)(A) of the Social Security Act, may be challenged through an acceptable complaint as described in 42 C.F.R § 426.400. Also, per 42 C.F.R § 426.325 items that are not reviewable, and therefore cannot be challenged, include the Policy Article. Please note the distinction of the documents when reviewing the materials.

Local Coverage Article:
Orthopedic Footwear - Policy Article (A52481)

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Contractor Information

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CGS Administrators, LLC	DME MAC	17013 - DME MAC	J-B	Illinois Indiana Kentucky Michigan Minnesota Ohio Wisconsin
CGS Administrators, LLC	DME MAC	18003 - DME MAC	J-C	Alabama Arkansas Colorado Florida Georgia Louisiana Mississippi New Mexico North Carolina Oklahoma Puerto Rico South Carolina Tennessee Texas Virgin Islands Virginia West Virginia
Noridian Healthcare Solutions, LLC	DME MAC	16013 - DME MAC	J-A	Connecticut Delaware District of Columbia Maine Maryland Massachusetts New Hampshire New Jersey New York - Entire State Pennsylvania Rhode Island Vermont

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Noridian Healthcare Solutions, LLC	DME MAC	19003 - DME MAC	J-D	Alaska American Samoa Arizona California - Entire State Guam Hawaii Idaho Iowa Kansas Missouri - Entire State Montana Nebraska Nevada North Dakota Northern Mariana Islands Oregon South Dakota Utah Washington Wyoming

Article Information

General Information

Article ID
A52481

Original ICD-9 Article ID
A35426
A35359
A47239
A35348

Article Title
Orthopedic Footwear - Policy Article

Article Type
Article

AMA CPT / ADA CDT / AHA NUBC Copyright Statement

Original Effective Date
10/01/2015

Revision Effective Date
01/01/2020

Revision Ending Date
N/A

Retirement Date
N/A

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Article Guidance

Article Text:

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES

For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements. Information provided in this policy article relates to determinations other than those based on Social Security Act §1862(a)(1)(A) provisions (i.e. "reasonable and necessary").

Orthopedic footwear is covered under the leg, arm, back, and neck braces, and artificial legs, arms and eyes benefit (Social Security Act §1861(s)(9)). In order for a beneficiary's DME to be eligible for reimbursement, the reasonable and necessary (R&N) requirements set out in the related Local Coverage Determination must be met. In addition, there are specific statutory payment policy requirements, discussed below, that also must be met.

Shoes, inserts, and modifications are covered in limited circumstances. They are covered in selected beneficiaries with diabetes for the prevention or treatment of diabetic foot ulcers. However, different codes are used for footwear provided under this benefit. See the medical policy on Therapeutic Shoes for Persons with Diabetes for details.

Shoes are also covered if they are an integral part of a covered leg brace described by codes L1900, L1920, L1980, L1990, L2000, L2005, L2010, L2020, L2030, L2050, L2060, L2080, or L2090. Oxford shoes (L3224, L3225) are covered in these situations. Other shoes, e.g. high top, depth inlay or custom for non-diabetics, etc. (L3649), are also covered if they are an integral part of a covered brace and if they are medically necessary for the proper functioning of the brace. Heel replacements (L3455, L3460), sole replacements (L3530, L3540), and shoe transfers (L3600, L3610, L3620, L3630 and L3640) involving shoes on a covered brace are also covered. Inserts and other shoe modifications (L3000, L3001, L3002, L3003, L3010, L3020, L3030, L3031, L3040, L3050, L3060, L3070, L3080, L3090, L3100, L3140, L3150, L3160, L3170, L3300, L3310, L3320, L3330, L3332, L3334, L3340, L3350, L3360, L3370, L3380, L3390, L3400, L3410, L3420, L3430, L3440, L3450, L3465, L3470, L3480, L3485, L3500, L3510, L3520, L3550, L3560, L3570, L3580, L3590 and L3595) are covered if they are on a shoe that is an integral part of a covered brace and if they are medically necessary for the proper functioning of the brace. Shoes and related modifications, inserts, heel/sole replacements or shoe transfers billed without a KX modifier will be denied as noncovered because coverage is statutorily excluded.

According to a national policy determination, a shoe and related modifications, inserts, and heel/sole replacements, are covered only when the shoe is an integral part of a brace. A matching shoe which is not attached to a brace and items related to that shoe must not be billed with a KX modifier and will be denied as noncovered because coverage is statutorily excluded.

Shoes which are incorporated into a brace must be billed by the same supplier billing for the brace. Shoes which are billed separately (i.e., not as part of a brace) will be denied as noncovered. A KX modifier must not be used in this situation.

Shoes are denied as noncovered when they are put on over a partial foot prosthesis or other lower extremity prosthesis (L5010, L5020, L5050, L5060, L5100, L5105, L5150, L5160, L5200, L5210, L5230, L5250, L5270, L5280, L5301, L5312, L5321, L5331, L5341, L5400, L5410, L5420, L5430, L5450, L5460, L5500, L5505, L5510, L5520, L5530, L5535, L5540, L5560, L5570, L5580, L5585, L5590, L5595 and L5600) which is attached to the residual limb by other mechanisms because there is no Medicare benefit for these items.

A foot pressure off-loading/ supportive device (A9283) is denied as noncovered because there is no Medicare benefit category for these items.

With the exception of the situations described above, orthopedic footwear billed using codes L3001, L3002, L3003, L3010, L3020, L3030, L3031, L3040, L3050, L3060, L3070, L3080, L3090, L3100, L3140, L3150, L3160, L3170, L3201, L3202, L3203, L3204, L3206, L3207, L3208, L3209, L3211, L3212, L3213, L3214, L3215, L3216, L3217, L3219, L3221, L3222, L3224, L3225, L3230, L3250, L3251, L3252, L3253, L3254, L3255, L3257, L3260, L3265, L3300, L3310, L3320, L3330, L3332, L3334, L3340, L3350, L3360, L3370, L3380, L3390, L3400, L3410, L3420, L3430, L3440, L3450, L3455, L3460, L3465, L3470, L3480, L3485, L3500, L3510, L3520, L3530, L3540, L3550, L3560, L3570, L3580, L3590, L3595, L3600, L3610 ,L3620, L3630, L3640, and L3649 will be denied as noncovered.

REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO Final Rule 1713 (84 Fed. Reg Vol 217)

Final Rule 1713 (84 Fed. Reg Vol 217) requires a face-to-face encounter and a Written Order Prior to Delivery (WOPD) for specified HCPCS codes. CMS and the DME MACs provide a list of the specified codes, which is periodically updated. The link will be located here once it is available.

Claims for the specified items subject to Final Rule 1713 (84 Fed. Reg Vol 217) that do not meet the face-to-face encounter and WOPD requirements specified in the LCD-related Standard Documentation Requirements Article (A55426) will be denied as not reasonable and necessary.

If a supplier delivers an item prior to receipt of a WOPD, it will be denied as not reasonable and necessary. If the WOPD is not obtained prior to delivery, payment will not be made for that item even if a WOPD is subsequently obtained by the supplier. If a similar item is subsequently provided by an unrelated supplier who has obtained a WOPD, it will be eligible for coverage.

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS

In addition to policy specific documentation requirements, there are general documentation requirements that are applicable to all DMEPOS policies. These general requirements are located in the DOCUMENTATION REQUIREMENTS section of the LCD.

Refer to the LCD-related Standard Documentation Requirements article, located at the bottom of this Policy Article under the Related Local Coverage Documents section for additional information regarding GENERAL DOCUMENTATION REQUIREMENTS and the POLICY SPECIFIC DOCUMENTATION REQUIREMENTS discussed below.

An order is not required for a heel or sole replacement or transfer of a shoe to a brace.

MODIFERS

KX and GY MODIFIERS:

When billing for a shoe that is an integral part of a leg brace or for related modifications, inserts, heel/sole replacements or shoe transfer, a KX modifier must be added to the code. If the shoe or related item is not an integral part of a leg brace, the KX modifier must not be used.

If the shoe and related modifications, inserts, and heel/sole replacements are not an integral part of a brace, the GY modifier must be added to each code.

If a KX or GY modifier is not included on the claim line, it will be rejected as missing information.

When billing for prosthetic shoes (L3250) and related items, diagnosis code (specific to the 5th digit), describing the condition which necessitates the prosthetic shoes, must be included on each claim for the prosthetic shoes and related items.

When code L3649 with a KX modifier is billed, the claim must include a narrative description of the item provided as well as a brief statement of the medical necessity for the item. This must be entered in the narrative field of an electronic claim.

CODING GUIDELINES

Oxford shoes that are an integral part of a brace are billed using codes L3224 or L3225 with a KX modifier. For these codes, one unit of service is each shoe. Oxford shoes that are not part of a leg brace must be billed with codes L3215 or L3219 without a KX modifier.

Other shoes (e.g., high top, depth inlay or custom shoes for non-diabetics, etc.) that are an integral part of a brace are billed using code L3649 with a KX modifier. Other shoes that are not an integral part of a brace must be billed using codes L3216, L3217, L3221, L3222, L3230, L3251, L3252, L3253, or L3649 without a KX modifier.

Depth-inlay or custom molded shoes for diabetics and related inserts and modifications are billed using A codes whether or not the shoe is an integral part of a brace. See the medical policy on Therapeutic Shoes for Persons with Diabetes for coverage, documentation, and additional coding guidelines.

Code A9283 (foot pressure off-loading/ supportive device) is used for an item that is designed primarily to reduce pressure on the sole or heel of the foot but that does not meet the definition of:

a. A therapeutic shoe for diabetics or related insert or modification; or
b. An orthopedic shoe or modification; or
c. A walking boot

It may be a shoe-like item, an item that is used inside a shoe and may or may not extend outside the shoe, or an item that is attached to a shoe. It may be prefabricated or custom fabricated.

Code L3250 may be used only for a shoe that is custom fabricated from a model of a beneficiary and has a removable custom fabricated insert designed for toe or distal partial foot amputation. The shoe serves to hold the insert on the leg. Code L3250 must not be used for a shoe that is put on other types of leg prostheses (L5010, L5020, L5050, L5060, L5100, L5105, L5150, L5160, L5200, L5210, L5230, L5250, L5270, L5280, L5301, L5312, L5321, L5331, L5341, L5400, L5410, L5420, L5430, L5450, L5460, L5500, L5505, L5510, L5520, L5530, L5535, L5540, L5560, L5570, L5580, L5585, L5590, L5595 and L5600) that are attached to the residual limb by other mechanisms.

The right (RT) and/or left (LT) modifiers must be used with all footwear HCPCS codes in this policy. Effective for claims with dates of service (DOS) on or after 3/1/2019, when the same code for bilateral items (left and right) is billed on the same date of service, bill each item on two separate claim lines using the RT and LT modifiers and 1 unit of service (UOS) on each claim line. Do not use the RTLT modifier on the same claim line and billed with 2 UOS. Claims billed without modifiers RT and/or LT, or with RTLT on the same claim line and 2 UOS, will be rejected as incorrect coding.

Suppliers should contact the Pricing, Data Analysis and Coding (PDAC) Contractor for guidance on the correct coding of these items.

Coding Information

CPT/HCPCS Codes

N/A

ICD-10 Codes that Support Medical Necessity

Group 1 Paragraph:

The presence of an ICD-10 code listed in this section is not sufficient by itself to assure coverage. Refer to the LCD

section on "**Coverage Indications, Limitations, and/or Medical Necessity**" for other coverage criteria and payment information.

For HCPCS code L3250:

Group 1 Codes:

ICD-10 CODE	DESCRIPTION
Q72.00	Congenital complete absence of unspecified lower limb
Q72.01	Congenital complete absence of right lower limb
Q72.02	Congenital complete absence of left lower limb
Q72.03	Congenital complete absence of lower limb, bilateral
Q72.30	Congenital absence of unspecified foot and toe(s)
Q72.31	Congenital absence of right foot and toe(s)
Q72.32	Congenital absence of left foot and toe(s)
Q72.33	Congenital absence of foot and toe(s), bilateral
Q72.70	Split foot, unspecified lower limb
Q72.71	Split foot, right lower limb
Q72.72	Split foot, left lower limb
Q72.73	Split foot, bilateral
S98.011A	Complete traumatic amputation of right foot at ankle level, initial encounter
S98.011D	Complete traumatic amputation of right foot at ankle level, subsequent encounter
S98.012A	Complete traumatic amputation of left foot at ankle level, initial encounter
S98.012D	Complete traumatic amputation of left foot at ankle level, subsequent encounter
S98.019A	Complete traumatic amputation of unspecified foot at ankle level, initial encounter
S98.019D	Complete traumatic amputation of unspecified foot at ankle level, subsequent encounter
S98.021A	Partial traumatic amputation of right foot at ankle level, initial encounter
S98.021D	Partial traumatic amputation of right foot at ankle level, subsequent encounter
S98.022A	Partial traumatic amputation of left foot at ankle level, initial encounter
S98.022D	Partial traumatic amputation of left foot at ankle level, subsequent encounter
S98.029A	Partial traumatic amputation of unspecified foot at ankle level, initial encounter
S98.029D	Partial traumatic amputation of unspecified foot at ankle level, subsequent encounter
S98.111A	Complete traumatic amputation of right great toe, initial encounter
S98.111D	Complete traumatic amputation of right great toe, subsequent encounter

ICD-10 CODE	DESCRIPTION
S98.112A	Complete traumatic amputation of left great toe, initial encounter
S98.112D	Complete traumatic amputation of left great toe, subsequent encounter
S98.119A	Complete traumatic amputation of unspecified great toe, initial encounter
S98.119D	Complete traumatic amputation of unspecified great toe, subsequent encounter
S98.121A	Partial traumatic amputation of right great toe, initial encounter
S98.121D	Partial traumatic amputation of right great toe, subsequent encounter
S98.122A	Partial traumatic amputation of left great toe, initial encounter
S98.122D	Partial traumatic amputation of left great toe, subsequent encounter
S98.129A	Partial traumatic amputation of unspecified great toe, initial encounter
S98.129D	Partial traumatic amputation of unspecified great toe, subsequent encounter
S98.131A	Complete traumatic amputation of one right lesser toe, initial encounter
S98.131D	Complete traumatic amputation of one right lesser toe, subsequent encounter
S98.132A	Complete traumatic amputation of one left lesser toe, initial encounter
S98.132D	Complete traumatic amputation of one left lesser toe, subsequent encounter
S98.139A	Complete traumatic amputation of one unspecified lesser toe, initial encounter
S98.139D	Complete traumatic amputation of one unspecified lesser toe, subsequent encounter
S98.141A	Partial traumatic amputation of one right lesser toe, initial encounter
S98.141D	Partial traumatic amputation of one right lesser toe, subsequent encounter
S98.142A	Partial traumatic amputation of one left lesser toe, initial encounter
S98.142D	Partial traumatic amputation of one left lesser toe, subsequent encounter
S98.149A	Partial traumatic amputation of one unspecified lesser toe, initial encounter
S98.149D	Partial traumatic amputation of one unspecified lesser toe, subsequent encounter
S98.211A	Complete traumatic amputation of two or more right lesser toes, initial encounter
S98.211D	Complete traumatic amputation of two or more right lesser toes, subsequent encounter
S98.212A	Complete traumatic amputation of two or more left lesser toes, initial encounter
S98.212D	Complete traumatic amputation of two or more left lesser toes, subsequent encounter
S98.219A	Complete traumatic amputation of two or more unspecified lesser toes, initial encounter
S98.219D	Complete traumatic amputation of two or more unspecified lesser toes, subsequent encounter
S98.221A	Partial traumatic amputation of two or more right lesser toes, initial encounter

ICD-10 CODE	DESCRIPTION
S98.221D	Partial traumatic amputation of two or more right lesser toes, subsequent encounter
S98.222A	Partial traumatic amputation of two or more left lesser toes, initial encounter
S98.222D	Partial traumatic amputation of two or more left lesser toes, subsequent encounter
S98.229A	Partial traumatic amputation of two or more unspecified lesser toes, initial encounter
S98.229D	Partial traumatic amputation of two or more unspecified lesser toes, subsequent encounter
S98.311A	Complete traumatic amputation of right midfoot, initial encounter
S98.311D	Complete traumatic amputation of right midfoot, subsequent encounter
S98.312A	Complete traumatic amputation of left midfoot, initial encounter
S98.312D	Complete traumatic amputation of left midfoot, subsequent encounter
S98.319A	Complete traumatic amputation of unspecified midfoot, initial encounter
S98.319D	Complete traumatic amputation of unspecified midfoot, subsequent encounter
S98.321A	Partial traumatic amputation of right midfoot, initial encounter
S98.321D	Partial traumatic amputation of right midfoot, subsequent encounter
S98.322A	Partial traumatic amputation of left midfoot, initial encounter
S98.322D	Partial traumatic amputation of left midfoot, subsequent encounter
S98.329A	Partial traumatic amputation of unspecified midfoot, initial encounter
S98.329D	Partial traumatic amputation of unspecified midfoot, subsequent encounter
S98.911A	Complete traumatic amputation of right foot, level unspecified, initial encounter
S98.911D	Complete traumatic amputation of right foot, level unspecified, subsequent encounter
S98.912A	Complete traumatic amputation of left foot, level unspecified, initial encounter
S98.912D	Complete traumatic amputation of left foot, level unspecified, subsequent encounter
S98.919A	Complete traumatic amputation of unspecified foot, level unspecified, initial encounter
S98.919D	Complete traumatic amputation of unspecified foot, level unspecified, subsequent encounter
S98.921A	Partial traumatic amputation of right foot, level unspecified, initial encounter
S98.921D	Partial traumatic amputation of right foot, level unspecified, subsequent encounter
S98.922A	Partial traumatic amputation of left foot, level unspecified, initial encounter
S98.922D	Partial traumatic amputation of left foot, level unspecified, subsequent encounter
S98.929A	Partial traumatic amputation of unspecified foot, level unspecified, initial encounter

ICD-10 CODE	DESCRIPTION
S98.929D	Partial traumatic amputation of unspecified foot, level unspecified, subsequent encounter

ICD-10 Codes that DO NOT Support Medical Necessity

Group 1 Paragraph:

For the specific HCPCS code indicated above, all ICD-10 codes that are not specified in the previous section.

For all other HCPCS codes, ICD-10 codes are not specified.

Group 1 Codes:

N/A

Additional ICD-10 Information

N/A

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type.Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

N/A

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the policy, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

N/A

Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
01/01/2020	R4	**Revision Effective Date: 01/01/2020**

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
		NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Revised: Format of HCPCS code references, from code spans to individually-listed HCPCS Removed: Therapeutic Shoes for Persons with Diabetes codes, leaving reference to the policy REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 Fed. Reg Vol 217): Added: Section and related information based on Final Rule 1713 CODING GUIDELINES: Revised: Format of HCPCS code references, from code spans to individually-listed HCPCS Removed: Therapeutic Shoes for Persons with Diabetes codes, leaving reference to the policy ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY: Revised: Section header “ICD-10 Codes that are Covered” updated to “ICD-10 Codes that Support Medical Necessity” ICD-10 CODES THAT DO NOT SUPPORT MEDICAL NECESSITY: Revised: Section header “ICD-10 Codes that are Not Covered” updated to “ICD-10 Codes that DO NOT Support Medical Necessity” *02/20/2020: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.*
01/01/2019	R3	**Revision Effective Date: 01/01/2019** CODING GUIDELINES: Revised: RT and/or LT modifier instructions ICD-10 CODES THAT ARE COVERED: Added: All diagnosis codes formerly listed in the LCD ICD-10 CODES THAT ARE NOT COVERED: Added: Notation excluding all unlisted diagnosis codes from coverage *02/28/2019: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.*
01/01/2017	R2	Revision Effective Date: 01/01/2017 POLICY SPECIFIC DOCUMENTATION REQUIREMENTS: Added: Replacement order for heel or sole information and Modifiers requirements RELATED LOCAL COVERAGE DOCUMENTS: Added: LCD-related Standard Documentation Requirements Language Article
07/01/2016	R1	Effective July 1, 2016 oversight for DME MAC Articles is the responsibility of CGS

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
		Administrators, LLC 18003 and 17013 and Noridian Healthcare Solutions, LLC 19003 and 16013. No other changes have been made to the Articles.

Associated Documents

Related Local Coverage Document(s)

Article(s)
A55426 - Standard Documentation Requirements for All Claims Submitted to DME MACs
LCD(s)
L33641 - Orthopedic Footwear

Related National Coverage Document(s)

N/A

Statutory Requirements URL(s)

N/A

Rules and Regulations URL(s)

N/A

CMS Manual Explanations URL(s)

N/A

Other URL(s)

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