ForwardHealth
Wisconsin serving you

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Affected Programs: BadgerCare Plus, Medicaid
To: Individual Medical Supply Providers, Medical Equipment Vendors, Physical Therapists, Podiatrists, Rehabilitation Agencies, Therapy Groups, HMOs and Other Managed Care Programs

New Coverage and Prior Authorization Policy for Orthopedic or Corrective Shoes and Foot Orthotics

This *ForwardHealth Update* provides a comprehensive overview and announces new policy regarding ForwardHealth's coverage of orthopedic or corrective shoes and foot orthotics effective for dates of service on and after September 1, 2015.

General Coverage Information

ForwardHealth has changed its coverage policy for orthopedic or corrective shoes and foot orthotics. Effective for dates of service (DOS) on and after September 1, 2015, ForwardHealth requires prior authorization (PA) for all orthopedic or corrective shoes and foot orthotics.

Covered Services

Per Wis. Admin. Code § DHS 107.24(4)(f), ForwardHealth covers orthopedic or corrective shoes and foot orthotics in the following situations:

- Postsurgery conditions.
- Gross deformities.
- When attached to a bar or brace.

Per Wis. Admin. Code § DHS 107.24(2)(c)2, the following shoes are covered:

- Mismatched shoes involving a difference of a full size or more.
- Modified shoes to take into account discrepancy in limb length.

Orthopedic or corrective shoes and foot orthotics are covered when medically necessary, as defined in Wis. Admin. Code § DHS 101.03(96m). Orthopedic or corrective shoes and foot orthotics are considered medically necessary by ForwardHealth when the member is ambulatory and/or routinely and consistently performs standing pivot transfers.

Note: If the member requires diabetic shoes and/or inserts, refer to the August 2015 *ForwardHealth Update* (2015-38), titled "New Policy Regarding Diabetic Shoes and Inserts."

Noncovered Services

Per Wis. Admin. Code § DHS 107.24(5), ForwardHealth does not cover the following:

- Orthopedic or corrective shoes or foot orthotics for the following conditions:
  - ✓ Flattened arches, regardless of the underlying pathology.
  - ✓ Incomplete dislocation or subluxation metatarsalgia with no associated deformities.
  - ✓ Arthritis with no associated deformities.
  - ✓ Hypoallergenic conditions.
- Services denied by Medicare for lack of medical necessity.
- Delivery or set-up charges for equipment as a separate service.

- Fitting, adapting, adjusting, or modifying a prosthetic or orthotic device or corrective or orthopedic shoes as a separate service.

Per Wis. Admin. Code § DHS 101.03(50), durable medical equipment (DME) is defined as equipment which can withstand repeated use, is primarily used for medical services, is generally not useful to a person in the absence of illness or injury, and is appropriate for use in the home.

ForwardHealth does not cover the following models, types, and styles of orthopedic or corrective shoes:

- Sandals or other open-toed models.
- Models requested to accommodate seasonal or weather conditions.
- Models to accommodate work situations or recreational purposes.
- Athletic shoes.

Prior Authorization Requirements

Providers are reminded that PA requirements are listed in the PDF version of the DME Index (available on the ForwardHealth Portal at *www.forwardhealth.wi.gov/WIPortal/content/provider/medicaid/MedicalEquipmentVendor/resources_25.htm.spage*).

Note: Prior authorization is not always required for some procedure codes (for example, minor repairs or additions to orthopedic shoes).

Prior Authorization Documentation

ForwardHealth requires the following documentation be submitted with PA requests for orthopedic or corrective shoes or foot orthotics:

- A completed Prior Authorization Request Form (PA/RF), F-11018 (05/13).
- A completed Prior Authorization/Durable Medical Equipment Attachment (PA/DMEA), F-11030 (07/12).
- A physician's prescription for orthopedic or corrective shoes and/or foot orthotics.
- The member's *International Classification of Diseases* (ICD) diagnosis (or diagnoses) and any other co-morbid conditions that support the condition for the requested services.
- If present, the objective measurement of specific foot deformity.
- The member's height and weight.
- The shoe brand, model number, and size(s).
- Medical records from the prescribing provider that support the PA request.
- The written report of the member's podiatry exam and results.
- The member's ambulatory status and/or transfer abilities.
- The member's use of any ambulation aids for mobility, if applicable.
- Information regarding the member's functional daily routine (e.g., place of residence, caregiver type, and level of assistance, if applicable).
- Specific reason for the requested service, date of initial issue of the requested service to the member, or the reason for replacement and the last DOS to member, if known.
- If new equipment is requested to replace current items, the estimate of charges to repair the member's current equipment and/or the reason repair is not possible or cost-effective.
- If mismatched shoes are requested, documentation of the foot size discrepancy.
- If custom services are requested, documentation of the services or equipment that have been tried by the member and results indicating what specific medical needs of the member were not met.

Submission Options

Providers may submit PA requests for orthopedic or corrective shoes and foot orthotics via any of the following:

- Portal.
- Fax.
- Mail.
- 278 Health Care Services Review — Request for Review and Response transaction.

For specific information about each of these submission options, providers should refer to the Submission Options chapter of the Prior Authorization section of the Durable

Medical Equipment service area of the ForwardHealth Online Handbook.

Other Documentation

Per Wis. Admin. Code § DHS 105.02(4), providers are required to maintain medical records for no less than five years from the date of reimbursement. The billing provider's record of service for orthopedic or corrective shoes or foot orthotics must include all of the following:

- A copy of the completed PA request and all records submitted for the service.
- Written confirmation of delivery of the service to the member, which includes the following:
  - ✓ Date of delivery.
  - ✓ Member's printed name.
  - ✓ Member's acknowledgment of receipt with member's signature and member's entry of date signed.
  - ✓ If member is not able to sign, the printed name of the person accepting delivery, signature, date signed, and relationship to the member.
  - ✓ Brand, model, and sizes issued to the member.
  - ✓ Quantity dispensed.
- Written instruction to the member for the use and care of the items dispensed.
- All information to support both PA requests and claims.

Physician Prescription Requirements

A prescription for orthopedic or corrective shoes or foot orthotics, and for all related services (modifications, repair, etc.), must meet the requirements stated in Wis. Admin. Code § DHS 107.02(2m)(b) and include the following:

- An ICD diagnosis that supports the medical need for the requested orthopedic or corrective shoes or foot orthotics.
- If present, an ICD diagnosis of any other co-morbid conditions of the member that support the medical need for the requested orthopedic or corrective shoes or foot orthotics.
- If present, an ICD diagnosis of the member's gross foot deformity and/or other conditions that justify the medical need for the orthopedic or corrective shoes or foot orthotics.
- The quantity to be dispensed and the length of need.

If a billing provider receives an initial prescription for a service, but after assessing the member, the physician's prescription does not completely and accurately represent all of the services and items that will be issued to the member, the billing provider is responsible for obtaining a new prescription. A prescription that indicates only "refill," "verbal order," or "orthopedic shoes," even if signed by a physician, does not meet this requirement. Wisconsin Medicaid does not accept verbal orders for orthopedic or corrective shoes or foot orthotics. A billing provider is required to have a current and valid written prescription on file before the service may be issued to the member. These prescription requirements must be present on every prescription used to support the billing provider's submission of a claim.

Member Responsibility

A member may request a noncovered service, a covered service for which PA was denied (or modified), or a service that is not covered under the member's limited benefit category. The charge for the service may be collected from the member if both of the following conditions are met **prior** to the delivery of that service:

- The member accepts responsibility for payment.
- The provider and member make payment arrangements for the service.

Providers are strongly encouraged to obtain a **written** statement in advance documenting that the member has accepted responsibility for the payment of the service.

The amounts allowed as payment for covered services must be accepted as payment in full. As a result, providers may not collect payment from a member, or authorized person acting on behalf of the member, for the difference between their usual and customary charge and the allowed amount for a service (i.e., balance billing).

Procedure Codes

Providers are reminded to request PA and submit claims for services with the most accurate procedure codes for all

services and equipment. Review the DME Index for procedure code information.

Claims Submission

When submitting claims and PA requests, providers are required to record each procedure code representing the shoe or unit as a separate line item. Refer to the specific procedure code description to determine the number of units:

- If code description indicates "each," indicate the RT (right side) or LT (left side) modifier, as appropriate, on separate line items of the claim or PA request.
- If the code description indicates "pair," indicate no modifier. Submit as one line item as a unit of one on the claim or PA request.

Copayments

Providers should refer to the Copayment chapter of the Reimbursement section of the Online Handbook at *www.forwardhealth.wi.gov/* for information about copayments.

Information Regarding Managed Care Organizations

This *Update* contains fee-for-service policy and applies to services members receive on a fee-for-service basis only. For managed care policy, contact the appropriate managed care organization. Managed care organizations are required to provide at least the same benefits as those provided under fee-for-service arrangements.

The *ForwardHealth Update* is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). The Wisconsin AIDS Drug Assistance Program and the Wisconsin Well Woman Program are administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at 800-947-9627 or visit our website at *www.forwardhealth.wi.gov/*.

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This *Update* was issued on 08/26/2015 and information contained in this *Update* was incorporated into the Online Handbook on 09/01/2015.