



IEHP UM Subcommittee Approved Authorization Guideline			
<b>Guideline</b>	Foot Orthotics	<b>Guideline #</b>	UM_ORT 03
		<b>Original Effective Date</b>	01/20/2005
<b>Section</b>	Orthopedic	<b>Revision Date</b>	01/09/2019

**COVERAGE POLICY**

- A. Foot orthotics are considered **medically necessary** for Members who meet all of the following selection criteria:
1. Symptoms present that are caused by a particular foot condition (conditions listed below)
  2. Members fail to respond to a course of appropriate conservative treatment (i.e. physical therapy, injections, strapping, anti-inflammatory medications, over the counter remedies).
  3. Member has any of the following conditions
    - a. Adults
      - i. Chronic Plantar fasciitis
      - ii. Calcaneal spurs (heel spurs)
      - iii. Chronic Calcaneal bursitis
      - iv. Neurologically impaired feet (including neuroma, tarsal tunnel syndrome, ganglionic cyst, and neuropathies involving the feet, including those associated with peripheral vascular disease, diabetes, carcinoma, drugs, toxins, and chronic renal disease)
      - v. Inflammatory conditions (including sesamoiditis, submetatarsal bursitis, synovitis, tenosynovitis, synovial cyst, osteomyelitis, and plantar facial fibromatosis).
      - vi. Chronic sport-related injuries (including diagnoses related to inflammatory problems such as bursitis, tendonitis).
      - vii. Musculoskeletal/arthropathic deformities (including deformities of the joint that impairs walking in a normal shoe, (bunions, hallux valgus, talipes deformities, pes deformities, anomalies of toes).
      - viii. Vascular conditions (including ulceration, poor circulation, peripheral vascular disease, Buerger’s disease [Thromboangiitis obliterans], chronic thrombophlebitis).

- ix. Conditions related to diabetes such as:
  - A. History of partial or complete foot amputation
  - B. History of previous foot ulceration
  - C. History of preulcerative callus
  - D. Diminished blood supply to the foot
  - E. Foot deformity
  - F. Current treatment under a comprehensive diabetic care plan that requires therapeutic shoes and/or inserts because of diabetes-related foot conditions.

b. Children

- i. Structured deformities (e.g. tarsal conditions)
- ii. Hallux valgus deformities
- iii. In toe or out toe gait (diagnosis of tibial torsion, femoral anteversion, genu valgum or varus should be evaluated by a pediatric orthopedist prior to ordering orthotics).

B. Replacement Frequency

Replacement of orthotics is not considered medically necessary more often than one every 12 months.

**COVERAGE LIMITATIONS AND EXCLUSIONS**

- A. IEHP may, at its discretion, redirect the production of custom orthotics to a contracted prosthetic company. Separate compensation will not be made for fitting, measuring, training or delivery of the item.
- B. Coverage will not be approved if the Member's condition does not meet the above guidelines.
- C. Foot orthotics have no proven value for back pain, knee pain (other than medial osteoarthritis), hip osteoarthritis and lower leg injuries.
- D. Separate orthotics for each pair of the Member's shoes are not considered medically necessary.
- E. Over the counter supplies, inserts, or shoes are generally sufficient to control symptoms for the following disorders:
  - 1. Pes Planus or Flat Foot (unless documentation of a fixed arch or severe ankle varus is supplied)
  - 2. Foot pronation
  - 3. Corns or Calluses
  - 4. Metatarsus adductus and hammertoes
  - 5. Heel Spurs

**ADDITIONAL INFORMATION**

None

## CLINICAL/REGULATORY RESOURCE

### A. **Center for Medicare & Medicaid Services (CMS)**

1. For any item to be covered by Medicare, it must meet the following:
  - a. Be eligible for a defined Medicare benefit category
  - b. Be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.
2. 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”) (Local coverage article A52481, 2017).

B. **Medicare Benefit Policy Manual** states that “Orthopaedic shoes and other supportive devices for the feet generally are not covered. However, the exclusion does not apply to such a shoe if it is an integral part of the leg brace, and its expense is included as part of the cost of the brace. Also, this exclusion does not apply to therapeutic shoes furnished to diabetics.”

C. **CMS Local Coverage Article**, “Orthopaedic Footwear – Policy Article (A52481)” notes that with the exception of when shoes are an integral part of a covered leg brace, orthopaedic footwear using codes L3000-L3649 are not covered. These codes include removable foot inserts molded to patient model longitudinal arch supports.

D. **Medi-Cal Provider Manual** states that removable foot inserts molded to patients may be covered if the recipient has a medical condition of the foot (feet) that requires custom fitted inserts to decrease pain, increase functional capacity and/or prevent or ameliorate further injury.

E. **MCG:** Foot orthotics are indicated with select foot conditions including diplegic cerebral palsy, juvenile rheumatoid arthritis, pes cavus, rheumatoid arthritis or plantar fasciitis which has not improved with conservative therapy or prefabricated orthotics.

### F. **Apollo Medical Review Criteria Guidelines**

In general, foot orthotics, orthopedic shoes, or other supportive devices are not covered except under the following conditions:

1. Shoes are an integral part of a leg brace and their expense is included as part of the cost of the brace
2. Therapeutic shoes that are furnished to selected diabetic members of plans where state diabetic mandates apply.
3. Rehabilitative foot orthotics that are prescribed as part of post-surgical or post-traumatic casting care
4. Prosthetic shoes

### G. **The American College of Foot and Ankle Orthopedics and Medicine**

The use of Prescription Custom Foot Orthosis (PCFO) is appropriate for patients demonstrating signs and/or symptoms related to patho-mechanical etiologies when the patients also present with one or more of the following circumstances:

1. Prior failed attempts to treat the condition with over-the-counter devices.
2. Deformity or forces that are too great to be managed with over-the-counter devices.
3. Prior successful use of PCFOs for the condition

## DEFINITION OF TERMS

- A. **Pre-fabricated** (off the shelf): Orthosis that require “Minimal Self Adjustment” for fitting. The item does not require trimming, bending, molding, assembling or customizing to fit an individual by a certified orthotist or an individual with specialized training.
- B. **Custom-fabricated** (custom-made): Customized products made for specific Members. Devices may require “substantial modification” at the time of delivery by a certified orthotist or individual with specialized training to obtain an individualized fit.
- C. **Certified Orthotist:** Individual who is certified by the American Board of Certifications in Orthotics and Prosthetics, Inc. or by the Board of Orthotist/Prosthetist Certification.

## REFERENCES

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**DISCLAIMER**

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