

LCD for Therapeutic Shoes for Persons with Diabetes (L11535)

Contractor Information

Contractor Name

[NHIC, Corp.](#)

Contractor Number

16003

Contractor Type

DME MAC

LCD Information

LCD ID Number

L11535

LCD Title

Therapeutic Shoes for Persons with Diabetes

Contractor's Determination Number

TSD20070701

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CMS National Coverage Policy

Medicare Benefit Policy Manual (IOM 100-02), Chapter 15, Section 140

Primary Geographic Jurisdiction

Connecticut
District of Columbia
Delaware
Massachusetts
Maryland
Maine
New Hampshire
New Jersey
New York - Entire State
Pennsylvania
Rhode Island
Vermont

LCD Information

Oversight Region

Region I

DME Region LCD Covers

Jurisdiction A

Original Determination Effective Date

For services performed on or after 05/01/1993

Original Determination Ending Date

Revision Effective Date

For services performed on or after 08/01/2009

Revision Ending Date

Indications and Limitations of Coverage 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 illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements. For the items addressed in this medical policy, the criteria for "reasonable and necessary" are defined by the following indications and limitations of coverage and/or medical necessity.

The statutory coverage criteria for therapeutic shoes including the requirement for an order are specified in the related Policy Article.

Separate inserts may be covered and dispensed independently of diabetic shoes if the supplier of the shoes verifies in writing that the patient has appropriate footwear into which the insert can be placed. This footwear must meet the definitions found in this policy for depth shoes or custom-molded shoes.

A custom molded shoe (A5501) is covered when the patient has 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 and available upon request. 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 least costly medically appropriate alternative, A5500.

Coding Information

CPT/HCPCS Codes

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:

A5500 FOR DIABETICS ONLY, FITTING (INCLUDING FOLLOW-UP), CUSTOM PREPARATION AND SUPPLY OF OFF-THE-SHELF DEPTH-INLAY SHOE MANUFACTURED TO ACCOMMODATE MULTI-DENSITY INSERT(S), PER SHOE

A5501 FOR DIABETICS ONLY, FITTING (INCLUDING FOLLOW-UP), CUSTOM PREPARATION AND SUPPLY OF SHOE MOLDED FROM CAST(S) OF PATIENT'S FOOT (CUSTOM MOLDED SHOE), PER SHOE

A5503 FOR DIABETICS ONLY, MODIFICATION (INCLUDING FITTING) OF OFF-THE-SHELF DEPTH-INLAY SHOE OR CUSTOM-MOLDED SHOE WITH ROLLER OR RIGID ROCKER BOTTOM, PER SHOE

A5504 FOR DIABETICS ONLY, MODIFICATION (INCLUDING FITTING) OF OFF-THE-SHELF DEPTH-INLAY SHOE OR CUSTOM-MOLDED SHOE WITH WEDGE(S), PER SHOE

A5505 FOR DIABETICS ONLY, MODIFICATION (INCLUDING FITTING) OF OFF-THE-SHELF DEPTH-INLAY SHOE OR CUSTOM-MOLDED SHOE WITH METATARSAL BAR, PER SHOE

A5506 FOR DIABETICS ONLY, MODIFICATION (INCLUDING FITTING) OF OFF-THE-SHELF DEPTH-INLAY SHOE OR CUSTOM-MOLDED SHOE WITH OFF-SET HEEL(S), PER SHOE

A5507 FOR DIABETICS ONLY, NOT OTHERWISE SPECIFIED MODIFICATION (INCLUDING FITTING) OF OFF-THE-SHELF DEPTH-INLAY SHOE OR CUSTOM-MOLDED SHOE, PER SHOE

A5508 FOR DIABETICS ONLY, DELUXE FEATURE OF OFF-THE-SHELF DEPTH-INLAY SHOE OR CUSTOM-MOLDED SHOE, PER SHOE

A5510 FOR DIABETICS ONLY, DIRECT FORMED, COMPRESSION MOLDED TO PATIENT'S FOOT WITHOUT EXTERNAL HEAT SOURCE, MULTIPLE-DENSITY INSERT(S) PREFABRICATED, PER SHOE

A5512 FOR DIABETICS ONLY, MULTIPLE DENSITY INSERT, DIRECT FORMED, MOLDED TO FOOT AFTER EXTERNAL HEAT SOURCE OF 230 DEGREES FAHRENHEIT OR HIGHER, TOTAL CONTACT WITH PATIENT'S FOOT, INCLUDING ARCH, BASE LAYER MINIMUM OF 1/4 INCH MATERIAL OF SHORE A 35 DUROMETER OR 3/16 INCH MATERIAL OF SHORE A 40 DUROMETER (OR HIGHER), PREFABRICATED, EACH

A5513 FOR DIABETICS ONLY, MULTIPLE DENSITY INSERT, CUSTOM MOLDED FROM MODEL OF PATIENT'S FOOT, TOTAL CONTACT WITH PATIENT'S FOOT, INCLUDING ARCH, BASE LAYER MINIMUM OF 3/16 INCH MATERIAL OF SHORE A 35 DUROMETER OR HIGHER), INCLUDES ARCH FILLER AND OTHER SHAPING MATERIAL, CUSTOM FABRICATED, EACH

ICD-9 Codes that Support Medical Necessity

For ICD-9 codes relating to statutory coverage, see Policy Article.

Coding Information

Diagnoses that Support Medical Necessity

Not specified

ICD-9 Codes that DO NOT Support Medical Necessity

Not specified.

ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation

Diagnoses that DO NOT Support Medical Necessity

Not specified.

General 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 patient's medical records will reflect the need for the care provided. The patient's medical records include the physician'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.

An order for each item billed must be signed and dated by the prescribing physician, kept on file by the supplier, and made available upon request. Items billed before a signed and dated order has been received by the supplier must be submitted with an EY modifier added to each affected HCPCS code.

If the prescribing physician is the supplier, a separate order is not required, but the item provided must be clearly noted in the patient's record.

A new order is not required for the replacement of an insert or modification within one year of the order on file. However, the supplier's records should document the reason for the replacement. A new order is required for the replacement of any shoe. A new order is also required for the replacement of an insert or modification more than one year from the most recent order on file.

The supplier must obtain a signed statement from the physician who is managing the patient's systemic diabetes condition (i.e., the certifying physician) specifying that the patient has diabetes mellitus, has one of conditions 2a-2f listed in the related Policy Article, is being treated under a comprehensive plan of care for his/her diabetes, and needs diabetic shoes. The certifying physician must be an M.D. or D.O and may not be a podiatrist, physician assistant, nurse practitioner, or clinical nurse specialist. The "Statement of Certifying Physician for Therapeutic Shoes" form (see LCD Attachments section below) is recommended. Whatever form is used must contain all of the elements contained on the recommended form attached to this LCD. This statement must be completed, signed, and dated by the certifying physician. A new Certification Statement is required for a shoe, insert or modification provided more than one year from the most recent Certification Statement on file.

The ICD-9 code that justifies the need for these items must be included on the claim.

KX AND GY MODIFIERS:

Suppliers must add a KX modifier to codes for shoes, inserts, and modifications only if criteria 1, 2, and 3 in the Non-Medical Necessity Coverage and Payment Rules section of the related Policy Article have been met. This documentation must be available upon request. The Statement of Certifying Physician form is not sufficient to meet this requirement.

General Information

If criteria 1, 2, and 3 in the Non-Medical Necessity Coverage and Payment Rules section of the related Policy Article have not been met, 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.

Refer to the Supplier Manual for more information on documentation requirements

Appendices

Utilization Guidelines

Refer to Indications and Limitations of Coverage and/or Medical Necessity.

Sources of Information and Basis for Decision

Advisory Committee Meeting Notes

Start Date of Comment Period

05/01/1993

End Date of Comment Period

06/14/1993

Start Date of Notice Period

07/01/1993

Revision History Number

TSD009

Revision History Explanation

Revision Effective Date: 08/01/2009

CMS NATIONAL COVERAGE POLICY:

Added: Benefit Policy Manual reference.

HCPCS CODES AND MODIFIERS:

Added: GY modifier.

DOCUMENTATION REQUIREMENTS:

Revised: Instructions for certification statement to indicate that it must be completed by the certifying physician.

Revised: Instructions concerning KX modifier to refer to the Policy Article.

Clarified: Information documenting that KX modifier requirements have been met must be in the records of the certifying physician.

General Information

Added: Instructions for use of GY modifier.

03/01/2008

In accordance with Section 911 of the Medicare Modernization Act, this policy was transitioned to DME MAC NHIC (16003) LCD L11535 from DME PSC TriCenturion (77011) LCD L11535.

Revision Effective Date: 07/01/2007

INDICATIONS AND LIMITATIONS OF COVERAGE:

Moved: Requirement for an order to the Policy Article.

Moved: Statement about coverage of modifications to the Policy Article.

Removed: DMERC references.

DOCUMENTATION REQUIREMENTS:

Removed: DMERC references.

06/01/2007

In accordance with Section 911 of the Medicare Modernization Act of 2003, Virginia and West Virginia were transitioned from DME PSC TriCenturion (77011) to DME PSC TrustSolutions (77012).

03/01/2006

In accordance with Section 911 of the Medicare Modernization Act of 2003, this policy was transitioned to DME PSC TriCenturion (77011) from DMERC Tricenturion (77011).

Revision Effective Date: 01/01/2006 (March 2006 publication)

HCPCS CODES AND MODIFIERS:

Added: A5512 and A5513.

Deleted: K0628 and K0629.

Revision Effective date: 01/01/2006

LMRP converted to LCD and Policy Article

DOCUMENTATION REQUIREMENTS:

Removed the requirement for additional documentation to be submitted with the claim.

Removed the requirement for a narrative description to be included on a claim with code A5507.

Removed claim form completion reference for the CMS-1500 form or the electronic equivalent.

Revision Effective Date: 04/01/2004

HCPCS CODES AND MODIFIERS:

Added: K0628 and K0629.

Deleted: A5509 and A5511.

CODING GUIDELINES: Added definitions for codes K0628 and K0629.

Revision Effective Date: 04/01/2003

POLICY TITLE:

Retitled policy to reflect current American Diabetes Association nomenclature.

HCPCS CODES AND MODIFIERS:

Added: EY modifier.

INDICATIONS AND LIMITATIONS OF COVERAGE:

Added standard language concerning coverage of items without an order.

Clarified the term "calendar year" to mean the period from January through December.

DOCUMENTATION REQUIREMENTS:

Added standard language concerning use of the EY modifier for items without an order.

The revision dates listed below are the dates the revisions were published and not necessarily the effective dates for the revisions.

04/01/2002 – Crosswalked HCPCS code A5502 to A5509, A5510 and A5511. Added non-coverage statement for A5510. Updated ICD-9 code range for diabetes mellitus in Coverage and Payment

General Information

Rules section. Added RT and LT modifiers. Replaced ZX with KX modifier. Clarified that code A5507 can be used for repairs to diabetic shoes. Clarified that the certifying physician may not be a podiatrist.

12/01/2000 – Revised Statement of Certifying Physician for Therapeutic Shoes form adding “Circle all that apply” for all questions and statement that person signing the form must be an M.D. or D.O.

03/01/1998 – Removed HCPCS L3649, added HCPCS K0401. Added definitions for certifying physician, prescribing physician, and supplier in the Definitions section.

04/01/1995 – Revised definition of ZX modifier in Documentation section.

Reason for Change

Last Reviewed On Date

Related Documents

Article(s)

[A37218 - Therapeutic Shoes for Persons with Diabetes - Policy Article - Effective September 2009](#)

LCD Attachments

[Statement of Certifying Physician](#) (10,913 bytes)

Article for Therapeutic Shoes for Persons with Diabetes - Policy Article - Effective September 2009 (A37218)

Contractor Information

Contractor Name

[NHIC, Corp.](#)

Contractor Number

16003

Contractor Type

DME MAC

Article Information

Article ID Number

A37218

Article Type

Article

Key Article

Yes

Article Title

Therapeutic Shoes for Persons with Diabetes - Policy Article - Effective September 2009

Primary Geographic Jurisdiction

Connecticut
District of Columbia
Delaware
Massachusetts
Maryland
Maine
New Hampshire
New Jersey
New York - Entire State
Pennsylvania
Rhode Island
Vermont

DME Region Article Covers

Jurisdiction A

Original Article Effective Date

01/01/2006

Article Information

Article Revision Effective Date

09/01/2009

Article Text

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES

For an item addressed in this policy to be covered by Medicare, a written signed and dated order must be received by the supplier prior to claim submission. If the supplier bills for an item without first receiving the completed order, the item will be denied as noncovered.

The Certifying Physician is defined as a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) who is responsible for diagnosing and treating the patient's diabetic systemic condition through a comprehensive plan of care. The certifying physician may not be a podiatrist, physician assistant, nurse practitioner, or clinical nurse specialist.

The Prescribing Physician is the person who actually writes the order for the therapeutic shoe, modifications and inserts. This physician must be knowledgeable in the fitting of diabetic shoes and inserts. The prescribing physician may be a podiatrist, M.D., D.O., physician assistant, nurse practitioner, or clinical nurse specialist. The prescribing physician may be the supplier (i.e., the one who furnishes the footwear).

The Supplier is the person or entity that actually furnishes the shoe, modification, and/or insert to the beneficiary and that bills Medicare. The supplier may be a podiatrist, pedorthist, orthotist, prosthetist or other qualified individual. The Prescribing Physician may be the supplier. The Certifying Physician may only be the supplier if the certifying physician is practicing in a defined rural area or a defined health professional shortage area.

Therapeutic shoes, inserts and/or modifications to therapeutic shoes are covered if the following criteria are met:

1. The patient has diabetes mellitus (ICD-9 diagnosis codes 249.00-250.93); and
2. The certifying physician has documented in the patient's medical record one or more of the following conditions:
 - a. Previous amputation of the other foot, or part of either foot, or
 - b. History of previous foot ulceration of either foot, or
 - c. History of pre-ulcerative calluses of either foot, or
 - d. Peripheral neuropathy with evidence of callus formation of either foot, or
 - e. Foot deformity of either foot, or
 - f. Poor circulation in either foot; and
3. The certifying physician has certified that indications (1) and (2) are met and that he/she is treating the patient under a comprehensive plan of care for his/her diabetes and that the patient needs diabetic shoes.

If criteria 1, 2 or 3 are not met, the therapeutic shoes, inserts and/or modifications to therapeutic

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shoes will be denied as noncovered. When codes are billed without a KX modifier (see Documentation Requirements section in the accompanying Local Coverage Determination), they will be denied as noncovered.

In order to meet criterion 2, the certifying physician must either:

- i. Personally document one or more of criteria a – f in the medical record prior to signing the certification statement; or
- ii. Obtain, initial, date (prior to signing the certification statement), and indicate agreement with information from the medical records of a podiatrist, other M.D or D.O., physician assistant, nurse practitioner, or clinical nurse specialist that documents one or more of criteria a – f.

Note: The certification statement is not sufficient to meet the requirement for documentation in the medical record.

For patients meeting the coverage criteria, coverage is limited to one of the following within one calendar year (January – December):

One pair of custom molded shoes (A5501) (which includes inserts provided with these shoes) and 2 additional pairs of inserts (A5512 or A5513); or

One pair of depth shoes (A5500) and 3 pairs of inserts (A5512 or A5513) (not including the non-customized removable inserts provided with such shoes).

A modification of a custom molded or depth shoe may be covered as a substitute for an insert. Although not intended as a comprehensive list, the following are the most common shoe modifications: rigid rocker bottoms (A5503), roller bottoms (A5503), wedges (A5504), metatarsal bars (A5505), or offset heels (A5506). Other modifications to diabetic shoes (A5507) include, but are not limited to flared heels.

Quantities of shoes, inserts, and/or modifications greater than those listed above will be denied as noncovered.

Items represented by code A5510 reflect compression molding to the patient's foot over time through the heat and pressure generated by wearing a shoe with the insert present. Since these inserts are not considered total contact at the time of dispensing, they do not meet the requirements of the benefit category and will be denied as noncovered.

Inserts used in noncovered shoes are noncovered.

Deluxe features of diabetic shoes (A5508) will be denied as noncovered.

There is no separate payment for the fitting of the shoes, inserts or modifications or for the certification of need or prescription of the footwear. Claims for unrelated evaluation and management services provided by the physician are processed by the local carrier.

Shoes are also covered if they are an integral part of a covered leg brace. However, different codes are used for footwear provided under this benefit. See the medical policy on Orthopedic Footwear for details.

Article Information

CODING GUIDELINES

A depth shoe (A5500) is one that:

1. Has 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
2. Is made from leather or other suitable material of equal quality; and
3. Has some form of shoe closure; and
4. Is 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. (The American last sizing schedule is the numerical shoe sizing system used for shoes in the United States.)
The shoe may or may not have an internally seamless toe.

A custom-molded shoe (A5501) is one that:

1. Is constructed over a positive model of the patient's foot; and
2. Is made from leather or other suitable material of equal quality; and
3. Has removable inserts that can be altered or replaced as the patient's condition warrants; and
4. Has some form of shoe closure.
The shoe may or may not have an internally seamless toe.

Code A5512 describes a total contact, multiple density, prefabricated removable inlay that is directly molded to the patient's foot. Direct molded means it has been conformed by molding directly to match the plantar surface of the individual patient's foot. Total contact means it makes and retains actual and continuous physical contact with the weight-bearing portions of the foot, including the arch throughout the standing and walking phases of gait.

The insert must retain its shape during use for the life of the insert. The layer responsible for shape retention is called the "base layer" in the code descriptor. This material usually constitutes the bottom layer of the device and must be of a sufficient thickness and durometer to maintain its shape during use (i.e., at least ¼ inch of 35 Shore A or higher or at least 3/16 inch of 40 Shore A or higher). The material responsible for maintaining the shape of the device must be heat moldable. The specified thickness of the base layer must extend from the heel through the distal metatarsals and may be absent at the toes.

Code A5513 describes a total contact, custom fabricated, multiple density, removable inlay that is molded to a model of the patient's foot so that it conforms to the plantar surface and makes total contact with the foot, including the arch. A custom fabricated device is made from materials that do not have predefined trim lines for heel cup height, arch height and length, or toe shape.

The insert must retain its shape during use for the life of the insert. The base layer of the device must be at least 3/16 inch of 35 Shore A or higher material. The base layer is allowed to be thinner in the custom fabricated device because appropriate arch fill or other additional material will be layered up individually to maintain shape and achieve total contact and accommodate each patient's specific needs. The central portion of the base layer of the heel may be thinner (but at least 1/16 inch) to allow for greater pressure reduction. The specified thickness of the lateral portions of the base layer must extend from the heel through the distal metatarsals and may be absent at the toes. The top layer of the device may be of a lower durometer and must also be heat moldable. The materials used should be suitable with regards to the patient's condition.

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Rigid rocker bottoms (A5503) are exterior elevations with apex position for 51 percent to 75 percent 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. Rigidity is ensured by the steel in the shoe. 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) (A5503) are the same as rocker bottoms, but the heel is tapered from the apex to the front tip of the sole.

Wedges (posting) (A5504) 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.

Metatarsal bars (A5505) are exterior bars which 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 (A5506) 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.

A deluxe feature (A5508) does not contribute to the therapeutic function of the shoe. It may include, but is not limited to style, color, or type of leather.

Code A5507 is only to be used for not otherwise specified therapeutic modifications to the shoe or for repairs to a diabetic shoe(s).

Deluxe features must be coded using code A5508.

Codes for inserts or modifications (A5503 – A5508, A5510, A5512, A5513) may only be used for items related to diabetic shoes (A5500, A5501). They must not be used for items related to footwear coded with codes L3215 - L3253. Inserts and modifications used with L coded footwear must be coded using L codes (L3000 - L3649).

The right (RT) and/or left (LT) modifiers must be used when billing shoes, inserts, or modifications. If bilateral items are provided on the same date of service, bill for both items on the same claim line using the RTLT modifiers and 2 units of service. Claims billed without modifiers RT and/or LT will be rejected as incorrect coding.

Inserts for missing toes or partial foot amputation should be coded L5000 or L5999, whichever is applicable.

The only products that may be billed using codes A5512 are those that are specified in the Product Classification List on the Pricing, Data Analysis, and Coding (PDAC) contractor web site.

There are two categories of products that are billed with code A5513:

- Inserts that are custom fabricated by a manufacturer/central fabrication facility and then sent to someone other than the patient. These items may be billed using code A5513 only if they are listed on the PDAC web site.
- Inserts that are custom fabricated from raw materials that are dispensed directly to the patient by the entity that fabricated the insert. These items do not have to be listed on the PDAC web site in order to be billed using code A5513. However, the supplier must provide a list of the materials that were used and a description of the custom fabrication process on

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request.

If an insert is not included in one of these categories of items, it must be billed with code A5510 or A9270 (noncovered item).

Information concerning the documentation that must be submitted to the PDAC for a Coding Verification Review can be found on the PDAC web site or by contacting the PDAC.

Coding Information

ICD-9 Codes that are Covered

The presence of an ICD-9 code listed in this section is not sufficient by itself to assure coverage. Refer to the Article Text field, Non-Medical Necessity Coverage and Payment Rules section for other coverage criteria and payment information.

[249.00](#) - SECONDARY DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, NOT STATED AS UNCONTROLLED, OR UNSPECIFIED - SECONDARY DIABETES MELLITUS WITH UNSPECIFIED COMPLICATION, UNCONTROLLED

[250.00](#) - DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II OR UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED - DIABETES WITH UNSPECIFIED COMPLICATION, TYPE I [JUVENILE TYPE], UNCONTROLLED

No Coding Information has been entered in this section of the article.

Other Information

Revision History Explanation

Revision Effective Date: 09/01/2009

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Clarified: Documentation of qualifying conditions must be in the medical records of the certifying physician. (This requirement has always been included in the national policy. The 09/01/2009 effective date does not apply.)

CODING GUIDELINES:

Revised: Billing instructions for the RT and LT modifiers.

Revised: Statement concerning which products billed with code A5513 must have PDAC Coding Verification Review.

Revision Effective Date: 10/01/2008

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: Additional diagnosis codes for diabetes.

CODING GUIDELINES:

Replaced: References to SADMERC with PDAC.

ICD-9 CODES THAT ARE COVERED:

Added: 249.00-249.91

03/01/2008

In accordance with Section 911 of the Medicare Modernization Act, this policy was transitioned to DME MAC NHIC (16003) Article A37218 from DME PSC TriCenturion (77011) Article A37218.

Revision Effective Date: 07/01/2007

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Other Information

Moved: Requirement for a physician order from the LCD and noted that absence of the order was a statutory coverage denial.

Moved: Statement about coverage of modifications from the LCD.

Clarified: Physician assistants, nurse practitioners, and clinical nurse specialists may not be the Certifying Physician but may be the Prescribing Physician.

CODING GUIDELINES:

Removed: DMERC reference.

Revised: Statement about billing for inserts based on the SADMERC Product Classification list.

06/01/2007

In accordance with Section 911 of the Medicare Modernization Act of 2003, Virginia and West Virginia were transitioned from DME PSC TriCenturion (77011) to DME PSC TrustSolutions (77012).

03/01/2006

In accordance with Section 911 of the Medicare Modernization Act of 2003, this article was transitioned to DME PSC TriCenturion (77011) from DMERC Tricenturion (77011).

Revision Effective Date: 01/01/2006 (March 2006 publication)

CODING GUIDELINES:

Added: A5512 and A5513.

Deleted: K0628 and K0629.

Revised requirements for Coding Verification Review by the SADMERC.

Revision Effective date: 01/01/2006

LMRP converted to LCD and Policy Article.

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: Statement clarifying Therapeutic Shoes for Persons with Diabetes codes and Orthopedic Footwear codes.

CODING GUIDELINES:

Added: Requirement for Coding Verification Review by SADMERC for codes A5500, K0628, K0629.

Related Documents

LCD(s)

[L11535 - Therapeutic Shoes for Persons with Diabetes](#)