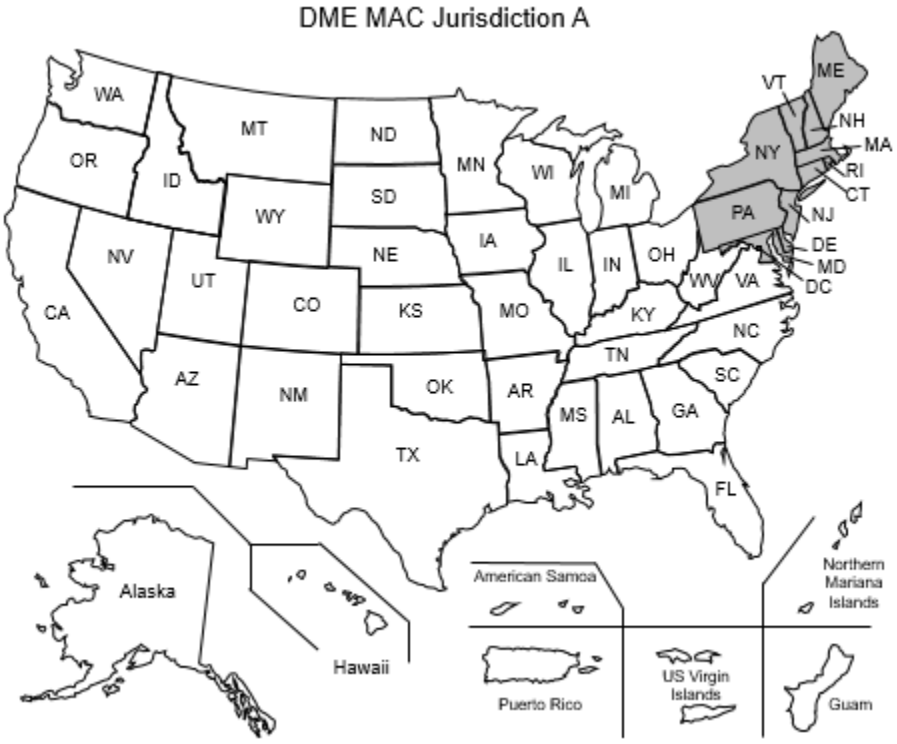
NCPDP Diabetic Footwear Billing Instructions: MEDICARE

Medicare:

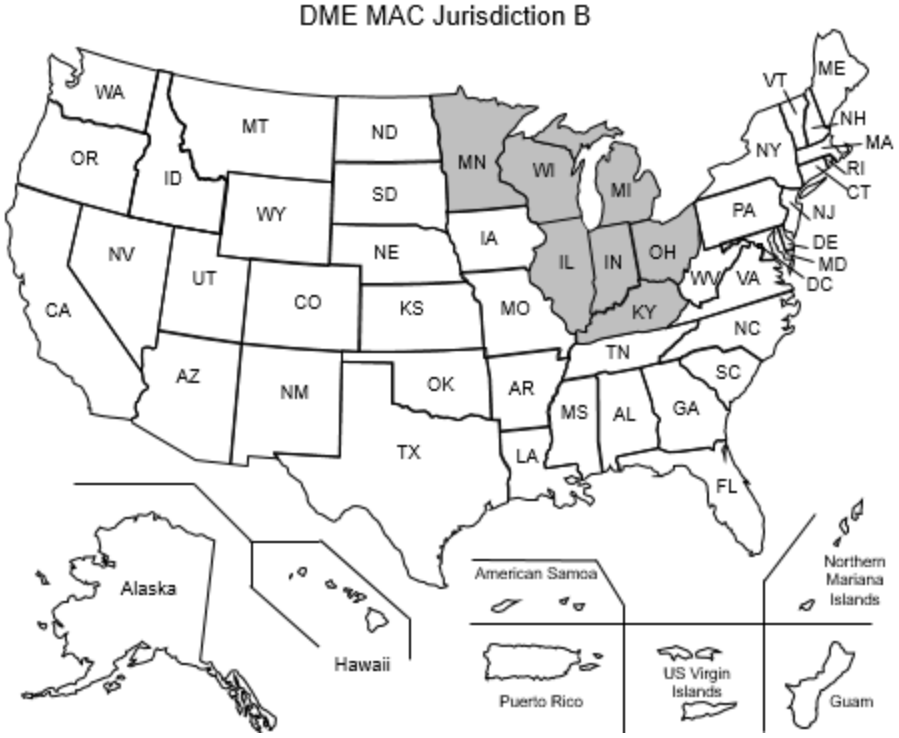
Medicare patient's either have Medicare Part A (which does not cover diabetic footwear), but may also have Medicare Part B (which DOES cover diabetic footwear) or Medicare C (which is treated like any other commercial insurance EXCEPT…they are required to follow Medicare Part B coverage guidelines. In and out of network benefits still apply.).

Following are the instructions for Medicare Part B:

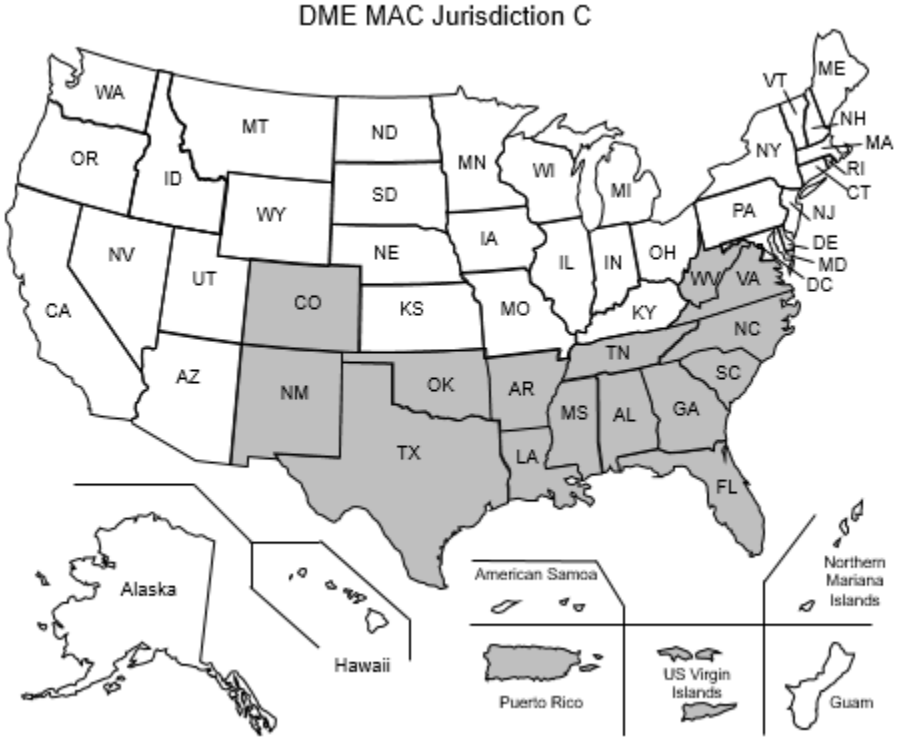
1. Use **BIN 610160** The Payer Sheet can be found here
2. Choose the PCN for **DMERC - (Region where the patient lives (see below maps)** from the EBS PCN List. The EBS PCN list can be found here

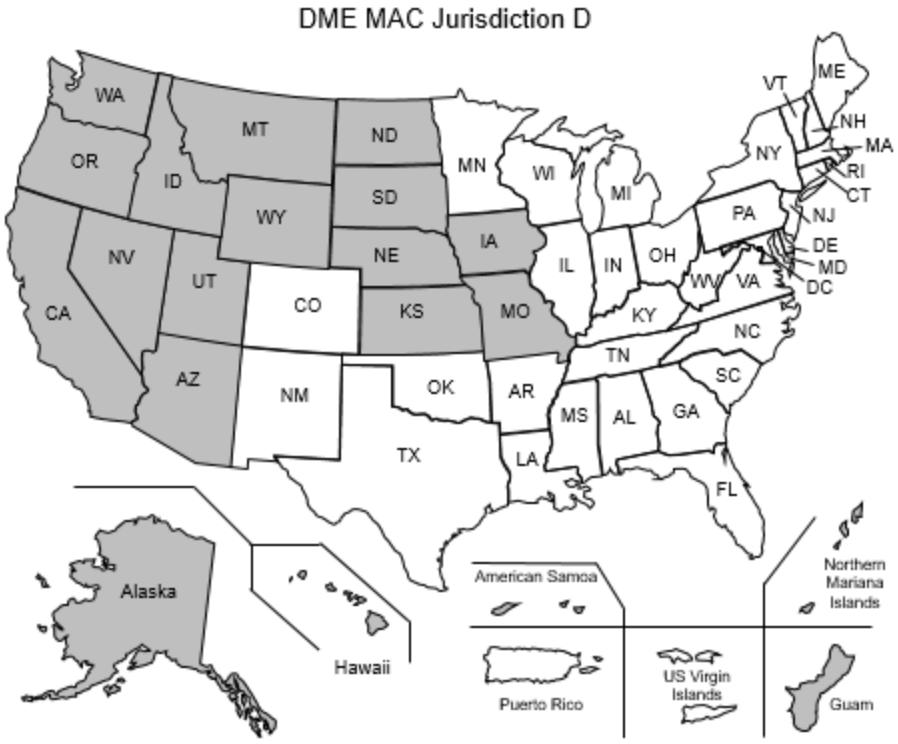


DME MAC Jurisdiction B

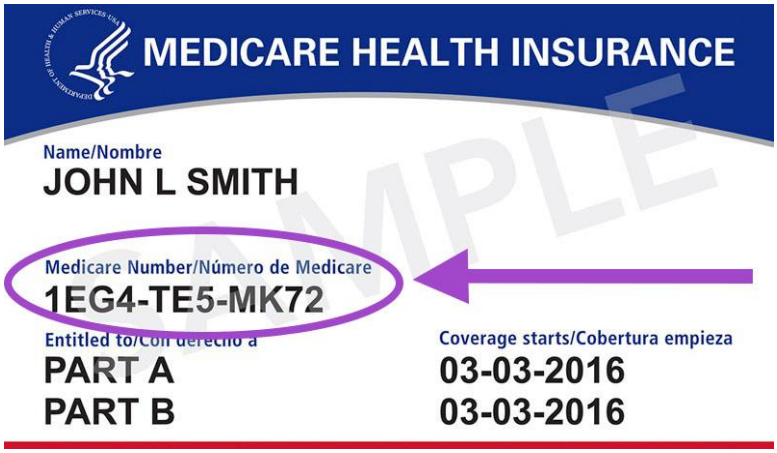


DME MAC Jurisdiction C





3. Use the **Medicare MBI** number from their red, white and blue card.



4. Instead of using an NDC, you will want to refer to page 3 of the EBS payer sheet for instructions on entering the HCPCS code. The Payer Sheet can be found here. You may need to contact your pharmacy software vendor to determine where these fields are found in your software system.
    a. NCPDP Field “436-E1-Product/Service ID Qualifier” is where you will use the code “09” to indicate the use of a HCPCS code.
    b. NCPDP Field “407-D7-Product/Service ID” is where you will indicate the

- ➔ HCPCS code of **A5500** - Diabetic Footwear-Non-Custom per shoe
  - ◆ Up to 2 total per calendar year (1-RT and 1-LT)
- ➔ HCPCS code of **A5512** - Inserts: Heat Molded per insert
- ➔ HCPCS code of **A5513** - Inserts: Custom Molded (Box Molded from Pt) per insert
- ➔ HCPCS code of **A5514** - Inserts: Custom Molded (CAD/CAM Scan) per insert
  - ◆ Up to 6 total per year (3 LT and 3 RT)

It is important to enter these as individual orders (ie. A5500 RT Qty 1, A5500 LT Qty 1, A5512 RT Qty 3, and A5512 LT Qty 3)

436-E1	Product/Service ID Qualifier	M	03 = NDC 09 = HCPCS or CPT	
407-D7	Product/Service ID	M		11-digit NDC HCPCS or CPT code

5. Add the appropriate modifier in NCPDP field 459-ER.

459-ER	Procedure Modifier Code	O		Submit the RR modifier for any Rental.

   Use modifiers **RT** for the shoe/inserts for the right foot, and **LT** for shoe/inserts for the left foot. Medicare will not cover a diabetic shoe for a prosthetic foot. If the patient has a prosthetic foot, you will need to complete a valid ABN for that shoe, as well as any inserts that will be used for that shoe, and the patient would be required to pay cash for those services.
6. Insert the **qualifying diagnosis.** See information below regarding Medicare Coverage Criteria. The link to the ICD10 diagnosis codes can be found by clicking here
7. Your pharmacy system as a default place of service as **12 (home)**. However if you provide the services in a facility, you will need to add the appropriate place of service code. Please note these services are NOT payable in a place of service 31 (Skilled Nursing) or 32 (Nursing) facilities. You can access the complete place of service code list by clicking here
8. Add the practitioner that ordered/certified the daibetic footwear. This should be the practitioner that is treating their diabetic condition.

Medicare Coverage Criteria:

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

1. The beneficiary has diabetes mellitus; **and**
2. The certifying physician has documented in the beneficiary's medical record one or more of the following conditions:
    - Previous amputation of the other foot, or part of either foot, or
    - History of previous foot ulceration of either foot, or
    - History of pre-ulcerative calluses of either foot, or
    - Peripheral neuropathy with evidence of callus formation of either foot, or
    - Foot deformity of either foot, or
    - 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 beneficiary under a comprehensive plan of care for his/her diabetes and that the beneficiary needs diabetic shoes. For claims with dates of service on or after 01/01/2011, the certifying physician must:
    - Have an in-person visit with the beneficiary during which diabetes management is addressed within 6 months prior to delivery of the shoes/inserts; **and**
    - Sign the certification statement on or after the date of the in-person visit and within 3 months prior to delivery of the shoes/inserts.
4. Prior to selecting the specific items that will be provided, the supplier must conduct and document an in-person evaluation of the beneficiary.
5. At the time of in-person delivery to the beneficiary of the items selected, the supplier must conduct an objective assessment of the fit of the shoe and inserts and document the results. A beneficiary’s subjective statements regarding fit as the sole documentation of the in-person delivery does not meet this criterion.

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 of an in-person visit within 6 months prior to delivery of the shoes/inserts and prior to or on the same day as 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 an in-person visit with a podiatrist, other M.D or D.O., physician assistant, nurse practitioner, or clinical nurse specialist that is within 6 months prior to delivery of the shoes/inserts, and that documents one of more of criteria a – f.

The requirement that the in-person visit(s) be within 6 months prior to delivery of the shoes/inserts is effective for claims with dates of service on or after 1/1/2011.

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

NCPDP Diabetic Footwear Billing Instructions: COMMERCIAL

ALL commercial plans are either an HMO or PPO plan.

HMO plans REQUIRE you to be IN NETWORK with their plan OR have an out of network prior authorization. Network providers will be paid at the rate they agreed to in their contract. This is why it is important to make sure you negotiate good contracts.

PPO plans will allow any willing provider to bill claims for their members, HOWEVER, claims payment will be based on the patient's In and Out of Network benefits. Their out of network deductible could be twice as high as their in network deductible, and the benefits could be much less. However, the only way to know is to contact the payer. The EBS Eligibility Team can assist. Please allow them plenty of time to respond, as these answers are not real time responses.

You can contact the **EBS Eligibility Team** at 573-472-3613 Option 1, email eligibility@ebsservice.com, or their fax number is 573-481-2576.

Best Practices: You must check eligibility to determine coverage and benefits. If the patient is **not willing to wait** for an eligibility response, and you are out of network with the plan, that will be **"Cash, Check, or Credit Card"** and provide them with a receipt for them to submit to their plan. You can also choose to offer a "Courtesy Billing", which means you will send the claim to EBS as a NON-assigned claim, and we will file the claim to be reimbursed to the patient. This option is NOT available if you are IN-NETWORK with the commercial medical plan.

If you are IN NETWORK with the plan on the medical side (requires a separate agreement from your prescription drug network), you will **follow the Medicare instructions** (on the Medicare instruction sheet). You will **replace #2** by using the PCN for the Commercial insurance based on the **EBS PCN List**.