SHOES AND FOOT ORTHOTICS

Covered benefits are listed in three (3) Sections - A, B and C. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations and exclusions as stated in the member’s Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member’s EOC/SOB, the member’s EOC/SOB provision will govern.

Essential Health Benefits for Individual and Small Group
For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits (“EHBs”). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage for benefits which are deemed EHBs (such as maternity benefits), the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute EHBs is made on a state by state basis. As such, when using this guideline, it is important to refer to the member specific benefit document to determine benefit coverage.

A. FEDERAL/STATE MANDATED REGULATIONS

OKLAHOMA:
Oklahoma Statutes Insurance Code §36-6060.2: Every health benefit plan issued or renewed on or after November 1, 1996, shall, subject to the terms of the policy contract or agreement, include coverage for the following equipment, supplies and related services for the treatment of Type I, Type II, and gestational diabetes, when medically necessary and when recommended or prescribed by a physician or other licensed health care provider legally authorized to prescribe under the laws of this state:

- Podiatric appliances for prevention of complications associated with diabetes.

Shoes and Foot Orthotics: Benefit Interpretation Policy (Effective 05/01/2018)
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OREGON:
OR §743A.144 Prosthetic and orthotic devices
(1) All individual and group health insurance policies providing coverage for hospital, medical or surgical expenses, other than limited benefit coverage, shall include coverage for prosthetic and orthotic devices that are medically necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities and that are not solely for comfort or convenience. The coverage required by this subsection includes all services and supplies medically necessary for the effective use of a prosthetic or orthotic device, including formulating its design, fabrication, material and component selection, measurements, fittings, static and dynamic alignments, and instructing the patient in the use of the device.

(2) As used in this section:
   a) Orthotic device means a rigid or semirigid device supporting a weak or deformed leg, foot, arm, hand, back or neck, or restricting or eliminating motion in a diseased or injured leg, foot, arm, hand, back or neck
   b) Prosthetic device means an artificial limb device or appliance designed to replace in whole or in part an arm or a leg.

(3) The Director of the Department of Consumer and Business Services shall adopt and annually update rules listing the prosthetic and orthotic devices covered under this section. The list shall be no more restrictive than the list of prosthetic and orthotic devices and supplies in the Medicare fee schedule for Durable Medical Equipment, Prosthetics, Orthotics and Supplies, but only to the extent consistent with this section.

(4) The coverage required by subsection (1) of this section may be made subject to, and no more restrictive than, the provisions of a health insurance policy that apply to other benefits under the policy.

(5) The coverage required by subsection (1) of this section shall include any repair or replacement of a prosthetic or orthotic device that is determined medically necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities and that is not solely for comfort or convenience.

(6) If coverage under subsection (1) of this section is provided through a managed care plan, the insured shall have access to medically necessary clinical care and to prosthetic and orthotic devices and technology from not less than two distinct Oregon prosthetic and orthotic providers in the managed care plans provider network.

TEXAS:
28 TAC § 21.2605 Diabetes:
A health benefit plan shall provide coverage for equipment and supplies for the treatment of diabetes for which a physician or practitioner has written an order, including:
12) podiatric appliances, including up to two pairs of therapeutic footwear per year, for the prevention of complications associated with diabetes

TIC Section 1358.051, 1358.054 and 1358-056
Sec. 1358.051. DEFINITIONS. In this subchapter:
(1) "Diabetes equipment" means:
   a) Blood glucose monitors, including noninvasive glucose monitors and glucose monitors designed to be used by blind individuals;
   b) Insulin pumps and associated appurtenances;
   c) Insulin infusion devices; and
   d) Podiatric appliances for the prevention of complications associated with diabetes.

Sec 1358.054 COVERAGE REQUIRED
a) A health benefit plan that provides coverage for the treatment of diabetes and conditions associated with diabetes must provide to each qualified enrollee coverage for:
   1. diabetes equipment;
2. diabetes supplies; and
3. diabetes self-management training in accordance with the requirements of

Sec 1358.056 COVERAGE FOR NEW OR IMPROVED EQUIPMENT AND SUPPLIES. A health benefit plan must provide coverage for new or improved diabetes equipment or supplies, including improved insulin or another prescription drug, approved by the United States Food and Drug Administration if the equipment or supplies are determined by a physician or other health care practitioner to be medically necessary and appropriate.

TIC Section 1371.001 and 1371.003
Sec. 1371.001. DEFINITIONS. In this chapter:
   a) "Enrollee" means an individual entitled to coverage under a health benefit plan.
   b) "Orthotic device" means a custom-fitted or custom-fabricated medical device that is applied to a part of the human body to correct a deformity, improve function, or relieve symptoms of a disease.
   c) "Prosthetic device" means an artificial device designed to replace, wholly or partly, an arm or leg.

Sec. 1371.003. REQUIRED COVERAGE FOR PROSTHETIC DEVICES, ORTHOTIC DEVICES, AND RELATED SERVICES.
   a) A health benefit plan must provide coverage for prosthetic devices, orthotic devices, and professional services related to the fitting and use of those devices that equals the coverage provided under federal laws for health insurance for the aged and disabled under Sections 1832, 1833, and 1834, Social Security Act (42 U.S.C. Sections 1395k, 1395i, and 1395m), and 42 C.F.R. Sections 410.100, 414.202, 414.210, and 414.228, as applicable.
   b) Covered benefits under this chapter are limited to the most appropriate model of prosthetic device or orthotic device that adequately meets the medical needs of the enrollee as determined by the enrollee's treating physician or podiatrist and prosthetist or orthotist, as applicable.
   c) Subject to applicable copayments and deductibles, the repair and replacement of a prosthetic device or orthotic device is a covered benefit under this chapter unless the repair or replacement is necessitated by misuse or loss by the enrollee.
   d) Coverage required under this section:
      1. must be provided in a manner determined to be appropriate in consultation with the treating physician or podiatrist and prosthetist or orthotist, as applicable, and the enrollee;
      2. may be subject to annual deductibles, copayments, and coinsurance that are consistent with annual deductibles, copayments, and coinsurance required for other coverage under the health benefit plan; and
      3. may not be subject to annual dollar limits.
   e) Covered benefits under this chapter may be provided by a pharmacy that has employees who are qualified under the Medicare system and applicable Medicaid regulations to service and bill for orthotic services. This chapter does not preclude a pharmacy from being reimbursed by a health benefit plan for the provision of orthotic services.

WASHINGTON:
RCW 48.44.315, Diabetes Coverage – Definitions: All health benefit plans offered by health care Service contractors shall provide benefits for at least the following services and supplies for persons with diabetes:
   a. For health benefit plans that include coverage for pharmacy services, appropriate and medically necessary equipment and supplies, as prescribed by a health care provider, that includes but is not limited to insulin, syringes, injection aids, blood glucose monitors, test strips for blood glucose monitors, visual reading and urine test strips, insulin pumps and accessories to the pumps, insulin devices, prescriptive oral agents for controlling blood sugar levels, foot care appliances for prevention of complications associated with diabetes, and glucagon emergency kits.
B. STATE MARKET PLAN ENHANCEMENTS

Foot Orthotics/Footwear Coverage for specialized footwear for foot disfigurement may be available if the Subscriber’s employer purchased a footwear supplemental benefit. If your Health Plan includes a footwear supplemental benefit, a brochure describing it will be enclosed with these materials.

C. COVERED BENEFITS

IMPORTANT NOTE: Covered benefits are listed in Sections A, B and C. Always refer to Sections A and B for additional covered benefits not listed in this Section.

NOTE: Specialized Footwear, including Foot Orthotics and custom-made or standard orthopedic shoes, is ONLY COVERED for members with diabetic foot disease or when an orthopedic shoe is permanently attached to a Medically Necessary orthopedic brace.

1. Prosthetic Shoe when used as a structural device to replace all of a foot or when a large portion of the member's forefoot (front part) is missing.

2. Orthopedic Shoe is covered when it is permanently attached to a Medically Necessary orthopedic brace.

3. Therapeutic Shoe and shoe Inserts (also known as Foot Orthotics and/or modifications to Therapeutic Shoe).
   A. One pair of Depth or one pair of Custom-Molded Therapeutic Shoes per calendar year for members diagnosed with diabetes:
      1) The shoes must be prescribed, fitted and furnished by a podiatrist or other qualified individual (e.g., a pedorthist, orthotist or prosthetist);
      2) The shoes must meet this policy's definition for Depth or Custom-Molded Shoes (see Section E);
      3) The managing Physician, who is a doctor of medicine (M.D.), doctor of podiatric medicine (D.P.M.) or a doctor of osteopathy (D.O.) and who is responsible for diagnosing and treating the member's systemic condition, must do all the following:
         a) Document in the medical record that the member has diabetes;
         b) Certify that the member is being treated under a comprehensive plan of care for his/her diabetes;
         c) Certify that the member needs Therapeutic Shoes;
         d) Document in the member’s record that the member has one or more of the following conditions:
            i. Peripheral Neuropathy with the evidence of callus formation;
            ii. History of previous ulceration, pre-ulcerative calluses, foot deformity, or previous amputation of the foot or part of the foot;
            iii. Vascular Insufficiency.
   
   Note: A pair of Therapeutic Shoes is covered even if only one foot suffers from diabetic foot disease (each shoe is equally equipped so that the affected limb, as well as the remaining limb, is protected).

   B. Inserts.
      1) The member must have the appropriate footwear to accommodate the Insert.
      2) Limitations:
         a) Three (pairs) Inserts per calendar year for Custom-Molded Shoes (including Inserts provided with the shoes);
         b) Four (pairs) Inserts per calendar year for depth shoes (including the non-customized removable Inserts provided with the shoes).
C. Modifications of Custom-Molded or Depth Shoes (e.g., wedges, offset heels, Velcro closures, inserts for missing toes, etc.) instead of obtaining a pair of Inserts in any combination.

4. Replacements, repairs and adjustments to Foot Orthotics are covered when Medically Necessary and authorized by the Member’s Participating Medical Group or UnitedHealthcare.

5. One pair of Foot Orthotics is covered per calendar year, if member meets criteria. Examples include, but are not limited to:
   a. Heel cups
   b. Shoe lifts
   c. Shoe Inserts
   d. Foot pads
   e. Custom-made polypropylene with plastic or rigid plastic Foot Orthotics

Also see Foot Care and Podiatry Services, DME Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics) and Medical Supplies Grid for OK Members, OR Members, TX Members and WA Members and Diabetic Management, Services and Supplies

D. NOT COVERED

1. Foot Orthotics are not a covered benefit unless the member meets the above diabetic foot disease criteria or as required by State Mandates or Market Plan Enhancement (see Sections A, B and C).

2. Therapeutic Shoes except as described above in Section C.

3. Orthopedic Shoes or other supportive devices for the feet except as described above in Section C.

4. Orthopedic Shoes for subluxations of the foot.

5. Supportive devices for the feet other than described above in Section C.

E. DEFINITIONS

1. Custom-Molded Shoes: Shoes that are constructed over a positive model of the member’s foot; made from leather or other suitable material of equal quality, have removable inserts that can be altered or replaced as the member’s condition warrants; and have some form of shoe closure.

2. Depth Shoes: Shoes that have a full-length heel-to-toe filler that, when removed, provides a minimum of 3/16 inch of additional depth used to accommodate custom molded or customized inserts, are made of leather or other suitable material of equal quality, have some form of foot closure, and are available in full and half sizes with a minimum of 3 widths so that the sole is graded to the size and width of the upper portions of the shoes according to the American standard last sizing schedule (the numerical shoe sizing system used for shoes sold in the United States or its equivalent).

3. Foot Orthotics: Shoe inserts that are intended to correct foot function and minimize stress forces that could ultimately cause foot deformity and pain by altering slightly the angles at which foot strikes a walking or running surface.

4. Inserts: Total contact, multiple density, removable inlays that are directly molded to the patient’s foot or a model of the patient’s foot and that are made of suitable material with regard to the patient’s condition.

5. Orthopedic Shoe: Shoe that prevents or corrects foot deformity that can be altered or replaced as the member's condition warrants; and has some form of shoe closure.
6. **Peripheral Neuropathy**: A degenerative condition of the nervous system involving the skin of the extremities.

7. **Prosthetic Shoe**: A device used when all or a substantial portion of the forefoot (front part) is missing.

8. **Therapeutic Shoe**: A depth or custom-molded shoe for individuals with diabetes.

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<td>• Removed duplicative language pertaining to <em>28 TAC § 21.2605 Diabetes</em></td>
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