

Therapeutic Shoe and Insert Claim Form Preparation

NOTE: Claims cannot be submitted until AFTER the shoe has been dispensed.

Claims for DME supplies cannot be billed paper based or electronic to your regular Medicare carrier. Claims must be submitted to the DME regional carrier. Special software must be used to file electronically. Contact SureFit regarding our EDI service.

The SureFit Medicare Resource Center has prepared these guidelines to assist your practice in the successful completion of your Therapeutic Footwear claims. When reviewing these guidelines refer to the attached sample claim form. If you have further questions please contact our resource center at (800) 298-6050.

Reading The Sample Claim

There are several different conventions used on the sample claim to represent the type of information to enter in each box. The four conventions are as follows:

- 1) **XXXX's** In boxes that contain X's enter the information that is pertinent to your patient or practice.
- 2) **Blank Space** In boxes that are left blank it is necessary to leave these boxes blank on your claim form.
- 3) **(Brackets)** Information within brackets lets you know what type of information to place in that box. Instructions for the completion of these boxes can be found below.
- 4) **Text** Any box that contains text represents the actual text that should be placed in that box. Instructions for the completion of these boxes can be found below.

Submitting Claims

Effective 1/1/2010 all claims must be submitted within one year of the date of service.

Each claim must be submitted to the carrier that handles the region where the patient's permanent address is registered with Medicare. Below is a chart to assist you in selecting the proper carrier for claims submission.

All paper claims are now scanned through an optical character recognition (OCR) process. To allow successful scanning of your claims, please refer to the Palmetto GBA attachment, Reminder for Proper Submission of Paper Claims. Claims that are not able to be scanned may be returned.

Chart 1

<p>REGION Region A Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island and Vermont</p>	<p>DMERC National Heritage Ins. Co. Customer Service DME – Specialty Claims 866-590-6731 P.O. Box 9165 IVR 866-419-9458 Hingham, MA 02043-9165</p>
<p>Region B Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, and Wisconsin</p>	<p>National Government Services Participating: CS 866-590-6727 DMEPOS Assigned IVR(877) 299-7900 P.O. Box 7027 Indianapolis, IN 46207-7027 Non-Participating: DMEPOS Non-Assigned P.O. Box 7031 Indianapolis, IN 46207-7031</p>
<p>Region C Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, Virgin Islands, Virginia, and West Virginia</p>	<p>Cigna Government Services P.O. Box 20010 Nashville, TN 37202 Customer Service 866-270-4909 IVR 866-238-9650</p>
<p>Region D Alaska, Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, Nevada, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming, Northern Mariana Islands or American Samoa.</p>	<p>Noridian Administrative Services P.O. Box 6727 Fargo, ND 58108-6727 Custom Service 866-243-7272 IVR 877-320-0390</p>

Box 1 – Boxes Carrier Type

Check the Medicare box

Box 9, 9A, 9B – Other Insured’s Name, Policy or Group Number, Date of Birth

Make sure you complete the insured’s information for any secondary carrier, which may be different than your patient.

Box 9C – (Secondary Carrier Address)

If the patient has a secondary insurance plan enter the carrier’s address, otherwise leave blank.

Box 9D – (Secondary Carrier)

If the patient has a secondary insurance plan enter the carrier’s name and/or Medigap number (OCNA), otherwise leave blank.

Box 10A, 10B, 10C – Patient’s Condition Related to

Check No for all three questions.

Box 11 – None

Enter the word NONE

Box 11C – (Carrier Name)

Enter the carrier that handles the region where the patient’s permanent address is registered with Medicare (See chart 1 on page 2).

- Region A: National Heritage Ins. Co.
- Region B: National Government Services
- Region C: Cigna Government Services
- Region D: Noridian Administrative Services

Box 11D – Another Health Benefit Plan

Check Yes if there is a secondary carrier, otherwise check No.

Box 17 – (Prescribing Physician)

Enter the name of the prescribing physician that ordered the shoes and inserts. Usually this is the podiatrist.

Box 17A – Leave Blank**Box 17B – (NPI #)**

Enter the prescribing physician’s 10 digit National Provider Identifier number.

Box 19 – Leave Blank**Box 21 – Diagnosis**

The first code must indicate the patient has diabetes (e.g. 250.00, 250.01, 250.60, 250.61, 250.70, 250.71). Some codes can be used by themselves and other codes require two codes to be used.

Diagnosis	ICD-9 Code	Notes
Diabetes – Type II (non-insulin)	250.00 *	Non-insulin dependent diabetes mellitus.
Diabetes – Type I (insulin)	250.01 *	Insulin dependent diabetes mellitus
Foot Deformity	736.70	Use with either 250.00 or 250.01
History of foot ulceration	707.10	Use with either 250.00 or 250.01
Pre-ulcerative calluses	700.	Use with either 250.00 or 250.01
Neuropathy–Diabetes Type II	250.60	Can be used alone. 250.00 or 250.01 are not needed when using this code.
Neuropathy-Diabetes Type I	250.61	
Poor Circulation – Type II	250.70	Can be used alone. 250.00 or 250.01 are not

Poor Circulation – Type I	250.71	needed when using this code.
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*These codes must be used in conjunction with 736.7, 707.1 or 700.

Box 24A – Date of Service

The date of service is the date shoes/inserts are dispensed to patient.

Box 24B – Place of Service

Enter place of service as:

Home = 12 (12 is entered because the patient is using the equipment at home).

Nursing Facility = 32 (also complete Box 32 in this case).

If the patient is designated as a "Skilled Nursing Home patient", then you will not receive reimbursement.

Box 24D – (HCPCS) A5500, A5513 (Modifier) KXLT or KXRT

HCPCS

Enter procedure code A5500 for the therapeutic shoe.

Enter procedure code A5513 for the custom molded inserts.

Enter procedure code A5512 for the prefabricated heat molded inserts.

2010 Medicare Allowable

A5500 - \$133.52 per pair – off the shelf depth inlay diabetic shoes.

A5513 - \$81.30 per pair (\$243.90 for 3 pairs) – custom molded inserts.

A5512 - \$54.48 per pair (\$163.44 for 3 pairs) - prefabricated heat molded inserts.

Modifier

Enter the modifier code KX for each of the procedures which indicates statement of certifying physician is on file

Box 24E - 1, 2, 3, 4

Enter only pointer from box 21 (1 or 2 or 3 or 4). Use the pointer that corresponds to the primary reason. Code to the highest level.

Box 24F – (Shoe Charges), (Insert Charges), (Toe Filler Charges)

Enter the allowable charge for your region. You may elect to charge more than the allowable amount, however this amount becomes your minimum charge for all patients – including self-pay.

Shoe Charge (Per Shoe) – Refer to the fee schedule for your region or state. Multiply the per unit fee by two for a pair of shoes.

Insert Charge (Per Insert) – Refer to the fee schedule for your region or state. Multiply the per unit fee by the number of individual inserts.

Ex. Three pairs of inserts – multiply the amount by six

Toe Filler Charge(optional) Refer to the toe filler reimbursement section in these instructions.

Box 24G – (U)

Enter the number of units for each procedure.

Shoe

Enter a shoe on each line.

Inserts

Enter a number from 1 – 3 on each line according to the number of individual inserts dispensed.

Toe Filler

Refer to the toe filler reimbursement section in these instructions.

Box 25 – Tax ID # or SS #

Check appropriate box

Box 26 – Patient’s Account #

Box 27 – Check appropriate box if accepting assignment.

Box 28 – (Total)

Enter the total Charges for this claim.

Box 30 – (Total)

Enter the total Charges for this claim.

Box 31 – Signature

Box 32 – (Place of Service)

If the patient is in a Nursing Facility or Assisted Living Facility, complete the name and address of the facility. If not, leave blank.

Box 32A

Enter NPI # of Nursing Facility or Assisted Living Facility.

Box 32B

Enter 1C (then a space) DME # of the Nursing Facility or Assisted Living Facility.

Box 33 – (Billing Provider Info & Phone #)

Provider Information

Box 33A

Enter Group NPI #

Box 33B – Leave Blank

Toe Filler Reimbursement

Toe fillers are covered as a Medicare reimbursable item. Considered a prosthetic device, the filler is billed using the L5000 code with an allowable of \$422.63 - \$563.50 depending on your state. The prosthetic device consists of the toe filler and the insert it is attached to, therefore, replacing the need for a separate insert for the affected foot. Below is a typical example of how to prepare a claim when dispensing six inserts to a patient with three of the six containing a toe filler.

Claim Form Preparation

Three inserts with toe filler

Box 24D – Enter code L5000 for the inserts with a toe filler. In the modifier column enter a RT for the right foot or a LT for the left.

Box 24F – Enter the charge for the item (see state fee schedule).

Box 24G – Enter 1 unit (even if you dispensed three toe fillers).

Three inserts without toe filler

Box 24D – Enter code A5513 for the inserts without the toe filler. In the modifier column enter a KXRT for the right foot or a KXLT for the left. The KX modifier signifying that the certifying statement is on file.

Box 24F – Enter the charge for the items (the allowable is \$113.07 | \$37.69 per insert)

Box 24G – Enter 3 units.

Our Medicare resource department would be happy to review one of your toe filler claim forms before submission. Just fax us the completed claim form and we will contact you with the results of our review.