Priority Health	BILLING POLICY No. 163
Therapeutic Shoes Diabetes	
Date of origin: Sept 2025	**Review dates: 06/2026**

DEFINITIONS

Therapeutic shoes are shoes that are either custom-molded or extra-depth, designed to reduce the risk of foot ulceration in individuals with diabetes. They are intended to provide protection for insensitive feet, relieve pressure, and accommodate foot deformities.

MEDICAL POLICY

Orthotics: Shoe Inserts, Orthopedic Shoes #91420

For Medicare

For indications that do not meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Click here for additional details on PSOD.

POLICY SPECIFIC INFORMATION

Documentation requirements

1. Treating Physician Certification Statement (MD/DO responsible for managing diabetes):

- Confirms diagnosis of diabetes.
- Identifies at least one qualifying foot condition.
- Certifies medical necessity for therapeutic shoes.

2. Clinical Records documenting:

- Date and results of foot exam.
- Relevant history (ulcer, amputation, deformity, neuropathy, circulation status).
- Justification for custom-molded vs. depth-inlay shoe, if applicable.

3. Supplier Records (for DME providers):

- Proof of delivery
- Fabrication/molding documentation

Reimbursement specifics

Coverage is provided for the following items when all medical necessity criteria are met:

- Custom-molded shoes (HCPCS: A5501, A5502)
- Depth-inlay shoes (HCPCS: A5500)
- Inserts (HCPCS: A5512 – A5513)
- Modifications to shoes (HCPCS: A5503 – A5507)

Frequency Limitations

Please consult medical policy 91420 for frequency limitations and allowances.

Additional pairs are only covered when medically justified (e.g., significant foot deformity or wear).

Coding specifics

- The HCPCS codes for therapeutic shoes and inserts are generally considered stand-alone supply/DME codes.
- CMS does not bundle A5500–A5513 together in NCCI edits.
- A custom-molded shoe (A5501/A5502) cannot be billed together with a depth-inlay shoe (A5500) for the same foot at the same time.

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. The modifier list below may not be an all-inclusive list. Please see our provider's manual page for modifier use here.
For these CPT codes:

- LT/RT modifiers are required — if missing, denials often occur.
- Use KX modifier to indicate that specific items or services meet all medical policy coverage criteria and to attest documentation on file (treating physician certification, qualifying condition, etc.).

Place of Service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Click here for additional information.

Reimbursement rates

Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. Go to the fee schedules (login required).

REFERENCES

LCA A52501 - https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=52501

LCD L33369 - https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=33369&ContrId=389

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures,

DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Sept 2025	New policy – effective October 16, 2025
June 2026	Added associated medical policy and updated language to consult medical policy for frequency and limitations.