Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE PAYMENTS FOR THERAPEUTIC SHOES

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E X E C U T I V E S U M M A R Y

PURPOSE

This report assesses the propriety of billings for therapeutic footwear provided to Medicare beneficiaries.

BACKGROUND

The Medicare Part B benefit covers therapeutic footwear for beneficiaries with diabetes and one or more of six qualifying conditions. According to documentation guidelines specified by Medicare, a doctor of medicine or a doctor of osteopathy who is treating the beneficiary's systemic diabetic condition under a comprehensive plan of care must certify the need for therapeutic footwear. This physician must also attest that the beneficiary suffers from one or more of the qualifying conditions.

A podiatrist or other physician must order or prescribe the necessary footwear. The footwear then must be fitted and furnished by a podiatrist or other qualified individual, such as a pedorthist, orthotist, or prosthetist.

If the certification statement completed by the physician who is treating the patient's systemic diabetic condition indicates that all Medicare requirements are met, the billing entity submits a claim form to the Durable Medical Equipment Regional Carrier (DMERC) for reimbursement, adding a ZX modifier to the appropriate procedure code. The ZX modifier certifies that all coverage requirements have been met, and pertinent documentation reflecting this is available in the supplier's files.

Eligible beneficiaries may receive either one pair of custom-molded shoes or one pair of depth shoes per year. According to DMERC policy, the beneficiary must have a foot deformity in order to be eligible for custom-molded shoes. In addition, beneficiaries receiving custom shoes are eligible to receive two pairs of custom-molded inserts per year. Beneficiaries receiving depth shoes are allowed three pairs of custom-molded inserts.

Suppliers of therapeutic footwear are reimbursed on a reasonable-charge basis. In 1996, maximum reasonable charge limits were $368 per pair for custom shoes, $123 per pair for depth shoes, and $62 per pair for inserts. Medicare allowances for these three products doubled from 1994 to 1996, rising from $7 million to $13.9 million.

FINDINGS

Documentation for 57 percent of therapeutic shoe claims was missing or inadequate.

We found that suppliers billed Medicare for providing therapeutic footwear to beneficiaries even though they did not have the required documentation to support medical necessity. In almost all of these cases, the suppliers had used a ZX modifier indicating that the proper documentation was on file. Problems included no orders and no physician certifications, improperly completed physician certifications, and physician certifications signed by podiatrists. We calculated that $7.7

million of the $13.9 million spent on therapeutic shoes and inserts in 1996 was improper due to inadequate documentation.

Medicare guidelines do not clearly define qualifications of non-physician entities who furnish therapeutic footwear.

The only requirement with respect to footwear expertise states, "The footwear must be fitted and furnished by a podiatrist or other **qualified** (emphasis added) individual **such as** (emphasis added) a pedorthist, orthotist or prosthetist." However, the guidelines do not specify standards, training, or minimum qualifications for non-physician entities. Suppliers do not have to submit any evidence of their expertise to Medicare.

Beneficiaries' responses indicate questionable eligibility.

A few beneficiaries self-reported that they did not have diabetes or other qualifying conditions. Almost half of the beneficiaries receiving custom-molded shoes denied having the requisite foot deformity.

Some beneficiaries report problems with the footwear.

Thirteen percent of beneficiaries reported seldom or never wearing the shoes. Most did not complain to the supplier; they simply stopped wearing the footwear.

There is potential for enormous growth in the shoe program.

The potential number of therapeutic footwear beneficiaries has barely been tapped, with less than 1 in 50 Medicare-aged diabetics receiving shoes in 1996. There are undoubtedly many diabetic beneficiaries who could benefit from therapeutic footwear, yet have not taken advantage of the benefit. At the same time, ambiguous guidelines and aggressive marketing practices may cause beneficiaries who do not need shoes to receive them. As a result, allowances for therapeutic footwear could rise to hundreds of millions of dollars per year.

RECOMMENDATIONS

We believe that Medicare coverage as well as documentation requirements should be revised. The lack of specific guidelines and the existence of ambiguous requirements have unnecessarily contributed to the growth of Medicare expenditures for therapeutic footwear. Therefore, we believe it is vital for the Health Care Financing Administration (HCFA) to remedy the questionable practices and irregularities uncovered in our inspection. We recommend that HCFA, in concert with the DMERCs and concerned national organizations, devise a strategy to 1) make coverage requirements more explicit and specific, 2) eliminate the documentation problems we encountered, and 3) develop a plan to ensure that the therapeutic footwear benefit contains quality assurance safeguards.

AGENCY COMMENTS

The HCFA concurred with our recommendations. However, they indicated that implementation would be difficult owing to a lack of financial resources. In order to secure adequate funding to

oversee benefits such as therapeutic footwear, HCFA has been working with Congress to explore various options. In response, HCFA proposed using an educational approach with suppliers, emphasizing coverage requirements and the importance of proper documentation. With respect to our recommendation regarding quality assurance safeguards, HCFA said it was unclear whether assuring appropriate documentation would meet the goal of instituting quality assurance safeguards. The HCFA also provided technical comments concerning two coverage aspects of the therapeutic footwear benefit, "poor circulation" and foot deformity. Further, they also provided technical comments about our future cost projections.

We concur with HCFA's proposal to undertake an educational initiative for diabetic footwear. Still, we believe further efforts, such as those suggested in our recommendations, are needed to curb the questionable practices and irregularities detailed in our report. With regard to our recommendation on quality assurance, we would like to clarify that documentation is a separate and distinct issue. We continue to believe that HCFA should work with the DMERCs and interested national organizations to develop a plan to ensure that the therapeutic footwear benefit contains quality assurance safeguards.