

REIMBURSEMENT POLICY STATEMENT

Ohio Medicaid

Policy Name & Number	Date Effective
Orthotics-OH MCD-PY-1151	05/01/2024
Policy Type	
REIMBURSEMENT	

Reimbursement Policies prepared by CareSource and its affiliates are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function,



A. Subject
Orthotics

B. Background

Orthotics are braces, splints, casts, and supports that may be utilized to align, prevent, or correct deformities or to improve the function of movable parts of the body.

Reimbursement policies are designed to assist providers when submitting claims to CareSource. These are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and office staff are encouraged to use self-service channels to verify member's eligibility.

It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT/HCPCS code(s) for the product or service that is being provided. The inclusion of a code in this policy does not imply any right to reimbursement or guarantee claims payment.

The purpose of this policy is to reinforce CareSource's ability to audit post-payment claims and ensure that reimbursement was justified by reviewing a provider's documentation to confirm medical necessity.

C. Definitions

- Certificate of Medical Necessity (CMN) – A written statement by a practitioner attesting that a particular item or service is medically necessary for an individual.
- Orthotics – The evaluation, measurement, design, fabrication, assembly, fitting, adjusting, servicing, or training in the use of an orthotic device, or the repair, replacement, adjustment, or service of an existing orthotic device.
- Orthotic Device – A custom fabricated or fitted medical device used to support, correct, or alleviate neuromuscular or musculoskeletal dysfunction, disease, injury, or deformity. The device is dispensed to an eligible CareSource member by an appropriate provider and can be considered for back, spinal (lumbar, cervical, and/or thoracic), foot, ankle, and knee indications.

D. Policy

- I. CareSource may request documentation from the ordering physician and the dispensing durable medical equipment (DME) provider to confirm medical necessity of the orthotic device.
 - A. The orthotic device must be a covered orthotic device and ordered and furnished by an eligible provider to an eligible CareSource member.

The REIMBURSEMENT Policy Statement detailed above has received due consideration as defined in the REIMBURSEMENT Policy Statement Policy and is approved.



2. a podiatrist
 3. an advanced practice registered nurse with a relevant specialty (eg, clinical nurse specialist, certified nurse practitioner)
 4. a physician assistant
- B. CareSource may request the CMN after the claim has been submitted.
- C. An illegible CMN will not be accepted.
- II. The following criteria for reimbursement must be included:

The REIMBURSEMENT Policy Statement detailed above has received due consideration as defined in the REIMBURSEMENT Policy Statement Policy and is approved.



G. Review/Revision History

DATE		ACTION
Date Issued	06/10/2020	
Date Revised	11/10/2021 04/12/2023 01/31/2024	Revised Policy language. Approved at PGC. Added additional background information. Updated references. Approved at Committee. Annual review. Updated references. Approved at Committee.
Date Effective	05/01/2024	
Date Archived		

H. References

1. Device-Related and Scope of Practice Definitions, OHIO ADMIN. CODE 4755-62-02 (2020).
2. Durable Medical Equipment, Prostheses, Orthoses, and Supplies (DMEPOS): General Provisions, OHIO ADMIN. CODE 5160-10-01 (2024).
3. DMEPOS: Footwear and Foot Orthoses, OHIO ADMIN. CODE 5160-10-31 (2024).

Approved by ODM on 2/22/2024

The REIMBURSEMENT Policy Statement detailed above has received due consideration as defined in the REIMBURSEMENT Policy Statement Policy and is approved.