MEDICAL POLICY

Medical Policy Title	**Foot Orthotics**
Policy Number	**1.01.41**
Current Effective Date	**January 1, 2027**
Next Review Date	**July 2027**

Our medical policies are guides to evaluate technologies or services for medical necessity. Criteria are established through the assessment of evidence based, peer-reviewed scientific literature, and national professional guidelines. Federal and state law(s), regulatory mandates and the member's subscriber contract language are considered first in the determination of a covered service. (Link to Product Disclaimer)

POLICY STATEMENT(S)

I. Foot orthotics are considered **medically appropriate** when **ALL** the following criteria are met:

A. The patient must have symptoms associated with the particular foot condition;

B. The patient has failed to respond to a course of appropriate conservative treatment (e.g., physical therapy, injections, strapping, anti-inflammatory medications). Orthotics should not be considered first line therapy;

C. Patient has **ANY** of the following conditions:

1. Adults (skeletally mature feet):

a. Plantar fasciitis;

b. Calcaneal spurs (heel spurs);

c. Calcaneal bursitis (acute or chronic);

d. Neurologically impaired feet, including neuroma, tarsal tunnel syndrome, ganglionic cyst, and neuropathies involving the feet, including those associated with peripheral vascular disease, diabetes, carcinoma, drugs, toxins, and chronic renal disease;

e. Inflammatory conditions (e.g., sesamoiditis, submetatarsal bursitis, synovitis, tenosynovitis, synovial cyst, osteomyelitis, and plantar fascial fibromatosis);

f. Sports-related injuries, including diagnoses related to inflammatory problems (e.g., bursitis, tendonitis);

g. Musculoskeletal/arthropathic deformities, including deformities of the joint or skeleton that impair walking in a normal shoe (e.g., bunions, hallux valgus, talipes deformities, pes deformities (other than pes planus), anomalies of toes);

h. Vascular conditions, including ulceration, poor circulation, peripheral vascular disease, Buerger's disease/thromboangitis obliterans, and chronic thrombophlebitis;

i. Conditions related to diabetes.

2. Children (skeletally immature feet):

a. Torsional conditions (e.g., metatarsus adductus, tibial torsion, femoral torsion);
b. Structural deformities (e.g., tarsal coalitions);
c. Hallux valgus deformities;
d. In-toe or out-toe gait;
e. Musculoskeletal weakness (e.g., pronation, pes planus). Before age three, all children have flat feet. The arch at the inside of the foot does not begin to develop until about 3 years of age. Children with flexible flat feet generally do not have foot pain.

II. Only one (1) orthotic per foot is considered **medically necessary**.

III. Duplicate orthotics or separate orthotics for each pair of a patient's shoes are considered **not medically necessary**, as more than one (1) orthotic device per body part used for the same function is considered a matter of convenience for the member.

IV. Foot orthotics are considered **not medically necessary** when the foot condition does not cause symptoms.

RELATED POLICIES

Corporate Medical Policy

1.01.25 Orthotics

POLICY GUIDELINE(S)

I. Coverage for foot orthotics is contract dependent. Most contracts exclude coverage for foot orthotics or other supportive devices of the feet, except in the following situations:

A. A shoe insert may be **eligible for coverage** if the shoe is an integral part of a leg brace, and the expense of the insert is included as part of the cost of the brace.

B. Rehabilitative foot orthotics prescribed as part of post-surgical or post traumatic casting care may be **eligible for coverage** under the patient's medical benefits, if dispensed at the time of surgery or casting.

II. Orthopedic footwear is not considered a foot orthotic (HCPCS L3140-L3265 or L3300-L3334).

III. Due to wear and tear with normal use, orthotics may need refurbishing periodically, every one (1) or two (2) years. Replacement of orthotics should not be necessary more often than every two (2) years.

IV. Over-the-counter orthotics are **ineligible for coverage** under any circumstance, for any condition.

V. Foot orthotics for corns, calluses, hammertoes, flat feet, pronation, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet are **ineligible for coverage**.

DESCRIPTION

Foot orthotics, or orthoses, are mechanical devices that are placed in a shoe (e.g., shoe inserts, arch supports) to assist in restoring or maintaining normal alignment of the foot and to relieve stress from strained or injured soft tissues, bony prominences, deformed bones, and joints, and inflamed or chronic bursae. Removable foot supports are placed inside the shoe to manage different foot symptoms and deformities. The devices can be made of several different types of materials and are usually designed to the measurement, plaster models and patterns of the foot and leg. They may be available commercially or may be custom-made.

The usual indications for foot orthotics are to relieve pressure on areas that are painful, ulcerated, scarred, or callused; to support weak or flat longitudinal or transverse foot arches; or to control foot positions and, thus, affect the alignment of other lower limb joints. All are concerned with improving foot function, controlling foot motion, reducing shock absorption, and minimizing stress forces that could ultimately cause foot deformity and pain.

Strains, aches, and pains in the legs, thighs, and lower back may be due to abnormal function of the foot or a slight difference in the length of the legs. In such cases, orthotics may improve or eliminate these symptoms, which, at first, may seem only remotely connected to foot function.

Soft or flexible foot orthotics/orthoses are made from soft compressible materials such as leather, cork, rubber, soft plastics, or plastic foam (Spenco, PPT, pelite). Many of these are commercially available and used for simple problems.

I. Soft orthotics help to absorb shock, increase balance, and take pressure off uncomfortable or sore spots.

II. Soft foot orthotics are worn against the sole of the foot and are usually fabricated in full length from heel to toe with increased thickness where weight bearing is indicated and relief where no or little pressure should occur.

III. Plastic foam orthotics are available in different densities and thicknesses and are commonly used for ischemic, insensitive, ulcerated, and arthritic feet.

The advantage of any soft orthotic is that it may be easily adjusted to changing weight-bearing forces. The disadvantage is that it must be replaced more often than rigid orthotics. A soft orthotic is particularly effective for diabetes, the arthritides, and grossly deformed feet where there is the loss of protective fatty tissue on the side of the foot. Soft orthotics are also widely used in the care of healing ulcers in the insensitive foot.

Semirigid and rigid orthotics/orthoses come in a variety of materials such as leather, cork, and metals, but most commonly they are made of solid plastics, which allow minimal flexibility. These orthotics generally extend from the posterior end of the heel to the metatarsal heads (e.g., three-quarter length), and may have medial or lateral flanges. They are molded to provide support under the longitudinal arch and metatarsal area and to provide relief for painful or irritated areas.

Semirigid orthotics provide for dynamic balance of the foot while walking or participating in sports. Each sport has its own demands, and each orthotic must be constructed appropriately with the sport and the athlete taken into consideration.

The most rigid foot orthotics (e.g., Whitman, Mayer, and Shaffer plates; Boston arch supports) are

made of metal (usually steel or duralumin) and are covered with leather. Rigid orthotics are designed to control function. They are made of a firm material such as plastic, leather, fiberglass, or acrylic polymer. The finished device normally extends along the sole of the heel to the ball or toes of the foot. It is worn mostly in closed shoes with a heel height under two inches. Rigid orthotics are chiefly designed to control motion in two major foot joints, which lie directly below the ankle joint. These devices are long-lasting, do not change shape, and are usually unbreakable.

Molded polypropylene orthotics/orthoses (foot/ankle/leg) are used to manage spastic and flaccid paralysis due to neurodeformities (e.g., cerebral palsy).

Functional dynamic orthotics help guide the foot through proper functions, allowing the muscles and tendons to perform more efficiently. The classic, semirigid orthotics are constructed using laminations of leather and cork, reinforced by a material called silastic. They may also be made of polymer composites. Strappings, paddings, and appliances may be applied directly to the foot and toes, to correct deformities and protect tender areas such as corns, calluses, ulcers, nails, and bony outgrowths, from excessive friction or pressure.

SUPPORTIVE LITERATURE

Evans AM et al (2022) published a Cochrane Review assessing the benefits and harms of foot orthoses for treating pediatric flat feet. Sixteen randomized controlled trials including 1,058 children, aged 11 months to 19 years, with flexible flat feed were included. Three comparisons were evaluated across trials: CFO versus shoes; PFO versus shoes; CFO versus PFO. Low to very low-certainty evidence shows that the effect of customized foot orthotics (CFOs) (high cost) or prefabricated foot orthotics (PFOs) (low cost) versus shoes, and CFOs versus PFOs on pain, function and health related quality of life is uncertain. This is pertinent for clinical practice, given the economic disparity between CFOs and PFOs. Foot orthotics may improve pain and function, versus shoes in children with juvenile idiopathic arthritis, with minimal delineation between costly CFOs and generic PFOs. The authors concluded this review confirms that in the absence of pain, the use of high-cost CFOs for healthy children with flexible flat feet has no supporting evidence and draws very limited conclusions about foot orthotics for treating pediatric flat feet.

Seligman DAR et al (2021) conducted a randomized controlled trial that compared the effectiveness of soft vs hard orthotics in treating heel pain and plantar fasciitis in adults. It also compared the level of function after orthotic use, cost, and number of visits for orthotics and explored whether age was a factor in orthotic effectiveness. The participants were adults aged 18 years or older (N=44) with heel pain and plantar fasciitis. Participants received hard or soft customized orthotics from an orthotic clinic in a community-based hospital and a private orthotic clinic. Participants rated their pain intensity and pain interference before and after orthotic use using subscales from the Brief Pain Inventory. Function was similarly measured using the Late Life Function and Disability Instrument: Function component. Analyses of age, cost, and number of visits were also compared. There was a reduction in pain intensity (P=.010) and pain interference (P<.001) but no change in function over time (P=.333), and no difference between the groups who received hard vs soft orthotics. Age had no effect on orthotic effectiveness. Soft orthotics were less expensive (P<.0001) and required fewer visits for fabrication (P<.0001). The authors concluded the randomized controlled trial showed both

soft and hard orthotics provided effective pain relief, but soft orthotics are less expensive.

Hawke et al (2008) published a Cochrane Review evaluating the effectiveness of custom-made foot orthoses for the treatment of foot pain (2008). Eleven trials involving 1332 participants were included: five trials evaluated custom-made foot orthoses for plantar fasciitis (691 participants); three for foot pain in rheumatoid arthritis (231 participants); and one each for foot pain in pes cavus (154 participants), hallux valgus (209 participants) and juvenile idiopathic arthritis (JIA) (47 participants). Comparisons to custom-made foot orthoses included sham orthoses; no intervention; standardized interventions given to all participants; non-custom (prefabricated) foot orthoses; combined manipulation, mobilization or stretching; night splints; and surgery. Follow up ranged from one week to three years. Custom-made foot orthoses were effective for painful pes cavus (NNTB:5), rearfoot pain in rheumatoid arthritis (NNTB:4), foot pain in JIA (NNTB:3) and painful hallux valgus (NNTB:6); however, surgery was even more effective for hallux valgus and non-custom foot orthoses appeared just as effective for JIA but the analysis may have lacked sufficient power to detect a difference in effect. It is unclear if custom-made foot orthoses were effective for plantar fasciitis or metatarsophalangeal joint pain in rheumatoid arthritis. Custom-made foot orthoses were a safe intervention in all studies. The authors concluded there is limited evidence on which to base clinical decisions regarding the prescription of custom-made foot orthoses for the treatment of foot pain. Currently, there is gold level evidence for painful pes cavus and silver level evidence for foot pain in JIA, rheumatoid arthritis, plantar fasciitis and hallux valgus.

PROFESSIONAL GUIDELINE(S)

The U.S. Department of Veterans Affairs published the Veterans Health Administration (VHA) handbook for footwear and foot orthoses (VHA 2004). This provided the following guidelines for providing footwear and foot orthoses to Veteran beneficiaries.

Footwear Prescription Guidelines

Pathology	Shoe Type	Insert Modification (As Needed)	Comments
1. Forefoot Deformities a. Hallux abducto valgus b. Hallux varus c. Hallux rigidus	1. Standard Therapeutic Oxford: dress and/or casual shoe. 2. Standard Therapeutic Oxford walking shoe. 3. Oxford style boot. 4. Depth shoe.	1. Semi-rigid or rigid functional orthosis. 2. Additional accommodative padding as needed.	The type of shoe and orthotic must be determined based on the severity of the pathology. The prescribing physician should work with the Prosthetics Service to ensure the most basic equipment to

	5. Custom molded.		manage the condition is used.
2. Midfoot Deformities a. Charcot Foot	1. Depth shoe. 2. Custom molded. 3. Oxford style boot.	1. Semi-rigid or rigid functional orthosis. 2. Additional accommodative padding as needed. 3. Ankle-foot orthosis or other stabilization and/or immobilization brace.	The type of shoe and orthotic must be determined based on the severity of the pathology. The prescribing physician should work with the Prosthetics Service to ensure the most basic equipment to manage the condition is used.
3. Rearfoot Deformities a. Symptomatic pronation b. Symptomatic supination c. Symptomatic Pes Cavus d. Symptomatic Pes Planus e. Heel Pain (1) Retrocalcaneal (2) Inferior calcaneal f. Symptomatic equines g. Tarsel coalition h. Ankle instability i. Charcot foot	1. Standard Oxford dress and/or casual shoe. 2. Standard Oxford walking shoe. 3. Oxford style boot. 4. Depth shoe. 5. Custom molded.	1. Semi-rigid or rigid functional orthosis. 2. Additional accommodative padding as needed. 3. Ankle-foot orthosis or other stabilization and/or immobilization brace. 4. Heel cup.	The type of shoe and orthotic must be determined based on the severity of the pathology. The prescribing physician should work with the Prosthetics Service to ensure the most basic equipment to manage the condition is used.
4. Diabetic Neuropathology with no concomitant deformities.	Depth shoe.	1. Over the Counter (OTC). 2. OTC Accommodation Orthoses.	As a preventive measure, this group of patients should be followed on a regular basis for the

		3. Semi-rigid or rigid functional orthosis. 4. Additional accommodative padding as needed.	development of pathology to ensure quick interventions as needed.
5. Peripheral Vascular Disease with non-concomitant deformities (arterial or venous).	Depth shoe.	1. OTC. 2. OTC Accommodation Orthoses. 3. Semi-rigid or rigid functional orthosis. 4. Additional accommodative padding as needed.	As a preventive measure, this group of patients should be followed on a regular basis for the development of pathology.
6. Digital and Midtarsal amputations.	1. Depth shoe. 2. Custom molded.	1. Semi-rigid or rigid functional orthosis. 2. Appropriate Filler. 3. Additional accommodative padding as needed.	As a preventive measure, this group of patients should be followed on a regular basis for the development of pathology.

REGULATORY STATUS

Not Applicable

CODE(S)

- Codes may not be covered under all circumstances.
- Code list may not be all inclusive (AMA and CMS code updates may occur more frequently than policy updates).
- (E/I)=Experimental/Investigational
- (NMN)=Not medically necessary/appropriate

CPT Codes

Code	Description
No Specific Codes	

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HCPCS Codes

Code	Description
L3000	Foot, insert, removable, molded to patient model, UCB type, Berkeley shell, each
L3001	Foot, insert, removable, molded to patient model, Spenco, each
L3002	Foot, insert, removable, molded to patient model, Plastazote or equal, each
L3003	Foot, insert, removable, molded to patient model, silicone gel, each
L3010	Foot, insert, removable, molded to patient model, longitudinal arch support, each
L3020	Foot, insert, removable, molded to patient model, longitudinal/metatarsal support, each
L3030	Foot, insert, removable, formed to patient foot, each
L3031	Foot, insert/plate, removable, addition to lower extremity orthotic, high strength, lightweight material, all hybrid lamination/prepreg composite, each
L3040	Foot, arch support, removable, premolded, longitudinal, each
L3050	Foot, arch support, removable, premolded, metatarsal, each
L3060	Foot, arch support, removable, premolded, longitudinal/metatarsal, each
L3070	Foot, arch support, nonremovable, attached to shoe, longitudinal, each
L3080	Foot, arch support, nonremovable, attached to shoe, metatarsal, each
L3090	Foot, arch support, nonremovable, attached to shoe, longitudinal/metatarsal, each
S0395	Impression casting of a foot performed by a practitioner other than the manufacturer of the orthotic

ICD10 Codes

Code	Description
Multiple Codes	

REFERENCES

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Chesterton LS, et al. Self-management advice, exercise, and foot orthoses for plantar heel pain: the TREADON pilot and feasibility randomised trial. Pilot Feasibility Stud. 2021 Apr 1;7(1):92.

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Gaino JZ, et al. The effect of foot orthoses on balance, foot function, and mobility in rheumatoid arthritis: a randomized controlled clinical trial. Clin Rehabil. 2021 Jul;35(7):1011-1020.

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Matthews M, et al. Does foot mobility affect the outcome in the management of patellofemoral pain with foot orthoses versus hip exercises? A randomised clinical trial. Br J Sports Med. 2020 Dec;54(23):1416-1422.

Panski A, et al. Universal neonatal foot orthotics a novel treatment of infantile metatarsus adductus. Eur J Pediatr. 2021 Sep;180(9):2943-2949.

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Seligman DAR, et al. Treating heel pain in adults: a randomized controlled trial of hard vs modified soft custom orthotics and heel pads. Arch Phys Med Rehabil. 2021 Mar;102(3):363-370.

U.S. Department of Veterans Affairs, Veterans Health Administration (VHA). Footwear and foot orthoses. Transmittal Sheet. VHA Handbook 1173.9. Washington, DC; VHA; 2004 Oct 6.

Wyndow N, et al. Foot orthoses and footwear for the management of patellofemoral osteoarthritis: a pilot randomized trial. Arthritis Care Res (Hoboken). 2021 Feb;73(2):240-249.

SEARCH TERMS

Not Applicable

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Orthopedic Footwear (LCD L33641) [accessed 2026 Jun 11]

Orthopedic Footwear - Policy Article (Article A52481) [accessed 2026 Jun 11]

PRODUCT DISCLAIMER

- Services are contract dependent; if a product does not cover a service, medical policy criteria do not apply.
- If a commercial product (including an Essential Plan or Child Health Plus product) covers a specific service, medical policy criteria apply to the benefit.
- If a Medicaid product covers a specific service, and there are no New York State Medicaid guidelines (eMedNY) criteria, medical policy criteria apply to the benefit.

- If a Medicare product covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.

POLICY HISTORY/REVISION	
Committee Approval Dates	
01/01/27	
Date	**Summary of Changes**
01/01/27	• Original effective date