Putting the pieces together for clinicians

Understanding Medicare Coverage for Lymphedema Garments

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March 6th & 8th, 2024

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Today's Agenda

- What we've learned about the new LTA Medicare coverage guidelines
- What changed from 2023 to 2024 for therapists and what they need to understand with respect to clinical guidelines and requirements- how to help suppliers help patients.
- Our experiences thus far
- What is still unknown
- Questions and (some) Answers and Opinions

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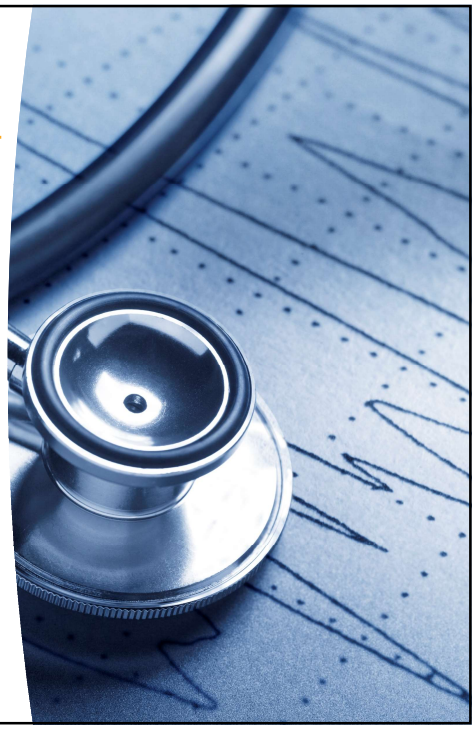
Baseline Terminology and FYI



- Medical/Clinical Record vs. Prescription
- Phase 1 (Treatment)
- Phase 2 (Maintenance)
- Staging of Lymphedema (you all know this!)
- Items (actual products to be ordered, including manufacturer, model, compression)
- HCPCS code- products match Medicare codes
- Medicare Fee For Service (FFS)-billed directly to CMS
- Medicare Advantage- billed to insurance company

During this presentation:

- Topics in green apply to DME in general and are not specific to LTA or compression
- Topics in blue are SunMED's OPINION right now and could change as guidance becomes more clear

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2023 vs 2024 for Medicare and Medicare Advantage plans: No More Benefit Checks

- A benefit check is when the therapist has NOT submitted items
- In 2023, this was needed given the variation in payer coverage guidelines
- These will now only apply (and hopefully temporarily) to commercial plans and work comp plans
- For Medicare and Medicare Advantage plans, your patients are covered at least at 80%.
- The vast majority will have a secondary or supplemental plan that will pick up the remaining 20%.

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What we know thus far about billing Medicare FFS (Traditional Medicare)

- Makes up about 50% of the US Medicare population.
- Clinical and Coverage policies have been released.
- Fee schedule has been released.
- Codes have been established.
- Much easier than Medicare Advantage plans to process for right now.
- Approximately 65% of the Medicare orders we have received have been Medicare FFS.
- SunMED has received payments from all four regions.

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Medicare Advantage Plans: What we've learned thus far:

Each plan needs to decide how (not if) they will cover these items	They can continue using miscellaneous codes, but we anticipate they will eventually adopt Medicare codes.	Over 8,000 different Medicare Advantage plans and growing.
Very few plans have released any updated coverage information, and when they do it is up to the DME provider to find that out on their own.	Early indications are pointing towards every insurance provider adopting Medicare codes.	Reimbursements will be lower then Medicare.

SunMED is currently processing Advantage orders not knowing what the reimbursement rates will be until the claim adjudicates.

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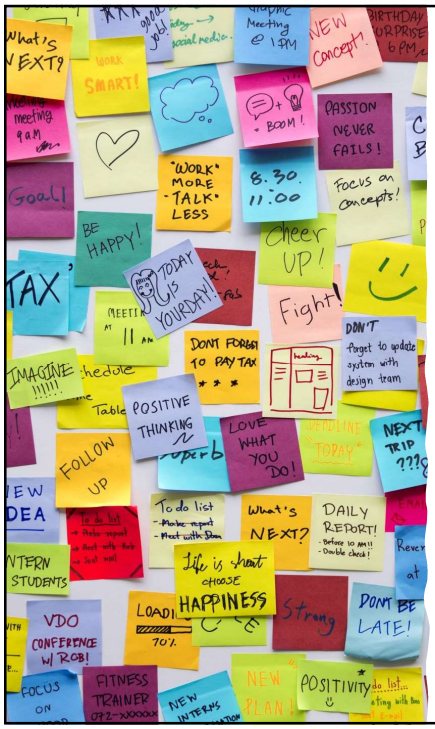

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Clinical Notes and Rx in 2023

- Not every insurance plan required them
- Diagnosis codes were required, especially with a breast cancer diagnosis when UE garments were ordered.
- The Rx could be generic- "compression garments" was sufficient
- The Rx did not need to "exactly" support the clinical notes.
- Mentioning the products in the clinical notes was acceptable documentation
- Almost NONE of this applies in 2024!!!

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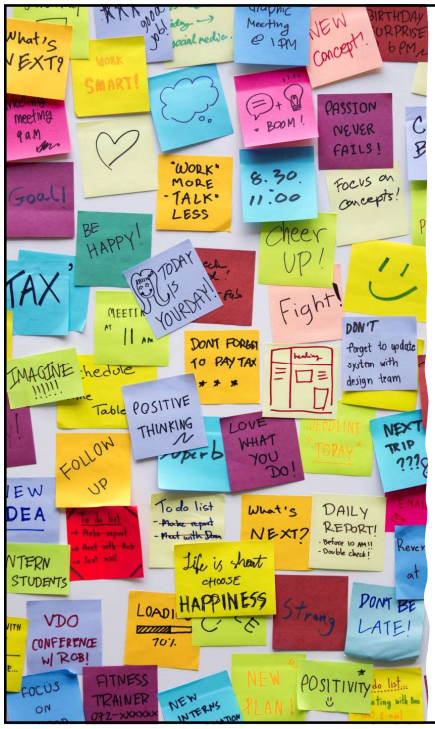

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Clinical Notes in 2024

- The Prescription is NOT a part of the clinical record.
- The Prescription *must* support the clinical notes
- For Medicare/Advantage patients, must include one of the four covered Dx codes approved by CMS for coverage. (Lipedema is not covered)
- The items ordered must be included in the medical record now (garment type, RTW vs Custom, compression rating, and accessories or options)
- If bandaging is ordered, notes should include if these are being used for Phase I (treatment) or Phase II (maintenance)
- The ***WHY*** is critically important to the clinical notes!!!

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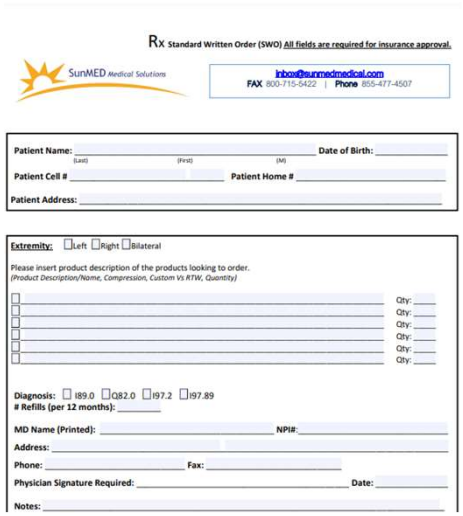
Prescriptions in 2024



Rx Standard Written Order (SWO) All fields are required for insurance approval.

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Patient Name: _____ Date of Birth: _____
(Last) (First) (MI)
Patient Cell # _____ Patient Home # _____
Patient Address: _____

Extremity: ☐Left ☐Right ☐Bilateral

Please insert product description of the products looking to order.
(Product Description/Name, Compression, Custom Vs RTW, Quantity)

☐ _____ Qty: ____
☐ _____ Qty: ____
☐ _____ Qty: ____
☐ _____ Qty: ____
☐ _____ Qty: ____
☐ _____ Qty: ____

Diagnosis: ☐ I89.0 ☐Q82.0 ☐I97.2 ☐I97.89
Refills (per 12 months): _____

MD Name (Printed): _____ NPI#: _____
Address: _____
Phone: _____ Fax: _____
Physician Signature Required: _____ Date: _____
Notes: _____

- The prescription is NOT part of the clinical record
- The prescription is valid for one year
- Must specify the product ordered, to include compression rating, body part coverage, and ready to wear vs custom
- The prescription must support the clinical notes
- The quantity ordered must be on the Rx (maximum of three for daytime, maximum of two for nighttime)
- Refills needs to be completed (maximum of two per year); otherwise only the initial quantity specified can be dispensed. Another Rx would be needed in six months if requested
- Doctor name, signature are required (electronic acceptable but not DocuSign). NPI number of MD is very helpful.

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Bandaging & Coverage

- Bandages coded by manufacturers with the CMS approved Lymphedema HCPCS codes are covered.
- Valid for Phase I and Phase II (Decongestive and Maintenance)
- Prepare more time from initial evaluation to the start of treatment to take advantage of cost savings for your clinic.
- Need Initial Evaluation Note supporting the need for short stretch bandaging as well as a valid Dr. Prescription.
- Ordering bandaging does not "use up" their first six months of products.
- Bandaging is based on Medical Necessity.
- Wrap Style Reduction supplies will be covered by Medicare and Medicare Advantage, but they are billed the same as a daytime wrap.
- Wrap Style Reduction Supplies will take up 1 set of Daytime garment quantities.

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If you have one takeaway from this presentation:

- Don't send anything until you have everything!
- All of us processing orders can move through orders much more rapidly if we have everything we need at one time. We touch it one time and then out the door.
- This is our largest challenge right now- receiving incomplete and partial orders, causing a "back and forth"

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Coverage on RTW Singles Vs. Pairs

- Only an issue for RTW Knee High and Thigh Highs; not custom
- Most RTW knee highs and Thigh highs only come in pairs.
- If patient only has LY in one leg, decide on quantities needed and product selection. If the pair isn't marked "L" and/or "R", that packaged pair counts as two items.
- 2 pair of RTW Knee Highs = 4 total knee highs. This exceeds the Medicare quantity limits.
- Supplier cannot simply bill two pair and only bill for quantity of three. That is an inducement to Medicare, legally DME's cannot provide more than what Medicare allows, even at no charge.
- One option is to order a pair (quantity 2) and one wrap style daytime garment to arrive at quantity of three.
- If ordered this way, *must be reflected in the clinical notes as well as on the Rx*

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SunMED interpretation of body part vs limb

- CMS guidance is three per six months:
  - One to wash, One to dry, One to wear
  - Published in writing
- We believe a full leg has three components, thigh, knee, calf
- We believe this isn't three items for a limb, but rather three items per body part
- A patient could get 12 items per six months.

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Ordering Frequency

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- Our interpretation is that patients can order garments at any time throughout the 6 months until they meet their quantity limits
- We can only order additional quantities 6 months from the date of service for each garment order.
- We need written consent from the patients every time we place a re-order. (Emails are more important now than ever before).

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Changes and importance of Coding (HCPCS) by Product

- Prior to 1/1/24, supplier could determine this for custom garments since most were billed as a miscellaneous code.
- Starting 1/1/24, Manufacturers have to “crosswalk” their products to the new codes so the DME’s know the suggested (eventually approved) code that matches specifically to their product(s).
- Some products have costs above allowable (gloves comes to mind)
- Manufacturers need to or have submitted their products to PDAC for coding approval
- This approval process will take some time and may cause changes to product availability based on Medicare guidance to the manufacturers on their products
- Some of the products you have worked with in the past may not have a LY HCPCS code covered for Lymphedema

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Don’t send anything until you have everything!

- That is all!

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