COMPRESSION CARE

Medicare Quick Reference Guide

General Provisions of the new Medicare Coverage for Lymphedema Garments:

- Coverage is now active.
- A quantity of three (3) daytime garments or wraps per body area are allowed once every six (6) months. (Wraps count as daytime garments)
- A quantity of two (2) nighttime garments per body area are allowed once every two (2) years (24 months).
- Medicare will pay for a new set of garments or wraps if determined to be reasonable and necessary due to a change in the beneficiary's medical or physical condition that warrants a new size or type of garment or wrap.

Our Case Managers are all Certified Fitters who have been trained to assist you in selecting garments that fall within the Medicare allowables. Please keep in mind that many garments are considered upgrades from the standard allowable, but most manufacturers have an option that fits Medicare allowables.

Our Process /What is Needed From You

1. Demo sheet & Insurance card copy (usually sent in the verification stage)
2. Physician Signature on Plan of Care OR Signed Compression RX
3. Detailed Garment Order OR Complete Custom Measurement Form
4. MEDICARE- write why you are recommending the particular garment on POC
5. Shipping Instructions (Clinic or Patient home address)

What Must the Evaluation Include?

- To be covered by Medicare, the patient needs a diagnosis of one of the following:

Code	Description
189.0	Lymphedema, not elsewhere classified
197.2	Postmastoctomy lymphedema syndrome
197.89	Other postprocedural complications and disorders of the circulatory system, not elsewhere classified
Q82.0	Hereditary lymphedema

All **SIGNED** orders (POC and Rx) should contain at least one of these diagnosis codes.

CONTINUED ON BACK

What Must the Evaluation Include? *(continued)*

- This Information **MUST** be included in **EACH** Patient evaluation:
  1. If you are treating the patient with a custom garment, the medical records must necessitate the use of a custom fitted gradient compression garment versus an off-the-shelf standard gradient compression garment.
  2. Explanation of the patient's current condition and that they would benefit from the specific garment(s) being ordered by Compression Care.
  3. Manufacturer, model and quantity you are recommending to be ordered for each patient.
  4. If we are ordering a custom garment for a patient and an accessory (i.e. silicone band, silk liner, pad) is added to the garment, please make sure verbiage regarding the accessory is present in the item description.

     The reason for this is Medicare requires us to break out all accessories added and bill them under a different code on a separate line. They have stated a narrative must be present in the medical records explaining the need for these accessories.

Documentation Requirements

No benefits check is required for traditional Medicare. If the patient has a Medicare Advantage Plan (MAP) please consult the previous chart to determine if a benefits check is necessary.

For the fastest turnaround service, please send us **EVERYTHING ALL AT ONCE**:.

- Patient Demographics (Including Insurance Card)
- Signed Physician Order (Rx) or Physician-Signed Plan of Care
- Detailed Garment Order
  - Brand
  - Class
  - Style
  - Size
  - Color
  - Qty (3 Day/Body Part, 2 Night/Body Part)
  - Shipping Instructions (Therapist Clinic/Patient Home)

You can't give us too much information. Consider this the minimum, but include anything else you have. **If in doubt, send it out!**

WITHOUT APPROPRIATE DOCUMENTATION, WE WILL NOT PROCEED WITH AN ORDER.

Questions? Please call or email Joshua Perkins at:
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