Local Coverage Article:
Lymphedema Decongestive Treatment (A55710)

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Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
Noridian Healthcare Solutions, LLC	A and B MAC	01111 - MAC A	J - E	California - Entire State
Noridian Healthcare Solutions, LLC	A and B MAC	01112 - MAC B	J - E	California - Northern
Noridian Healthcare Solutions, LLC	A and B MAC	01182 - MAC B	J - E	California - Southern
Noridian Healthcare Solutions, LLC	A and B MAC	01211 - MAC A	J - E	American Samoa Guam Hawaii Northern Mariana Islands
Noridian Healthcare Solutions, LLC	A and B MAC	01212 - MAC B	J - E	American Samoa Guam Hawaii Northern Mariana Islands
Noridian Healthcare Solutions, LLC	A and B MAC	01311 - MAC A	J - E	Nevada
Noridian Healthcare Solutions, LLC	A and B MAC	01312 - MAC B	J - E	Nevada
Noridian Healthcare Solutions, LLC	A and B MAC	01911 - MAC A	J - E	American Samoa California - Entire State Guam Hawaii Nevada Northern Mariana Islands

Article Information

General Information

Article ID

Original Effective Date

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08/31/2017

Article Title
Lymphedema Decongestive Treatment

Revision Effective Date
01/01/2018

Article Type
Article

Revision Ending Date
N/A

AMA CPT / ADA CDT / AHA NUBC Copyright Statement

Retirement Date
N/A

Article Guidance

Article Text:

We are providing clarification of coverage and documentation requirements for lymphedema decongestive treatment

based on Noridian medical review findings. The two basic types of decongestive treatment are:

- Manual Lymphatic Drainage (MLD) which stimulates the movement of fluids in the tissues using gentle massage and;
- Comprehensive Decongestive Therapy (CDT) which is a combination of MLD, bandaging, skin care and exercises.

Coverage Requirements

Medicare will reimburse for necessary components of decongestive treatment when the medical record supports

- A diagnosis of lymphedema (not tissue edema due to other etiologies e.g., chronic venous insufficiency, congestive heart failure, acute infection).
- Recent changes in the patient's condition
- Prior unsuccessful therapies (e.g., elevation, bandaging, diuresis) reported to justify the need for skilled services.
- Services were provided by a qualified clinician (i.e., physician, non-physician practitioner (NPP), qualified therapist, or appropriately supervised therapist assistant).
- Services must be under accepted standards of medical practice and considered to be specific and effective treatment for the patient's condition.

Limitations

The goal of therapy is not to achieve maximum volume reduction but to ultimately transfer the responsibility for the care from the provider to the patient and/or caregiver, generally within a 1-3 week time period. There is only temporary benefit from the treatment unless the patient and/or caregiver are able to complete treatments at home on an ongoing basis. The end of treatment is not when the edema resolves or stabilizes but when the patient and/or caregiver are able to continue the treatments at home.

Skilled Level of Care

The key issue is whether the skills of a therapist are needed, or whether the services can be carried out by the patient and/or caregiver after sufficient training. The medical record must clearly indicate the patient's condition before, during, and after the therapy episode to support that the patient significantly benefitted from ongoing therapy services and that the progress was sustainable and of practical value when measured against the patient's condition at the start of treatment. Documentation should indicate clear objective evidence of improvement generally within the first week or 10 days of therapy (e.g., changes in weight, extremity circumference).

Maintenance Level of Care

When it is reasonable to assume that ongoing services could reasonably be carried out by the patient and/or appropriately trained caregiver(s), then the services are considered to be at a maintenance level of care and no longer require the skills of a qualified clinician. It is the patient's responsibility to acquire caregiver assistance for carrying out the of the home maintenance program when necessary. Generally, it is anticipated that an efficient home maintenance program will be effective for a lifetime. However, in the rare instance, when additional treatment for the same condition is necessary, then the documentation must support reasonableness and medical necessity for the additional services. For additional information, see the Noridian article titled "Medical Necessity of Therapy Services".

Coding Considerations

- Medically necessary hands-on MLD is a covered Medicare service and is coded using CPT® 97140 for manual therapy.
- There is no Medicare coverage for lymphedema compression bandage application as this is considered to be an unskilled service. This non-coverage extends to the application of high compression, multi-layered, sustained bandage systems (e.g., Profore®, Dynaflex®, Supress®, coded with CPT® 29581 or 29584.
- Minutes spent applying compression bandaging without patient/caregiver education should not be billed as skilled therapy services.
- However, Medicare will cover a brief period (e.g. three or fewer sessions if no new specific issues are identified), of patient/caregiver instruction in compression bandaging home management. Medical necessity for this education must be clearly documented and meet the code descriptor requirements for CPT® 97535.
- Note that high compression bandage application used for treatment of wounds may be appropriately coded with CPT® 29581 or 29584. However, these codes should not be billed for unskilled lymphedema compression bandage application. For additional information, see the Noridian article titled "High Compression Bandage System Clarification."

Sources:

- **Federal Register (FR), Volume 76, Number 228, Part III, Section C-5**
- **Internet Only Manual (IOM) Medicare National Coverage Determinations Manual, Publication 100-03, Chapter 1, Part 4, Sections 270.5, 280.1, 280.6**
- **IOM Medicare Benefit Policy Manual, Publication 100-02, Chapter 15, Sections 220-230**
- **IOM Medicare Claims Processing Manual, Publication 100-04, Chapter 5, Section 20(B)**
- **Current Procedural Terminology Coding Manual**
- **Social Security Act (SSA), Title 18, Section 1862(a)(1)(A)**

Coding Information

CPT/HCPCS Codes

Group 1 Paragraph:

N/A

Group 1 Codes:

CODE	DESCRIPTION
29581	APPLICATION OF MULTI-LAYER COMPRESSION SYSTEM; LEG (BELOW KNEE), INCLUDING ANKLE AND FOOT
29584	APPLICATION OF MULTI-LAYER COMPRESSION SYSTEM; UPPER ARM, FOREARM, HAND, AND FINGERS
97140	MANUAL THERAPY TECHNIQUES (EG, MOBILIZATION/ MANIPULATION, MANUAL LYMPHATIC DRAINAGE, MANUAL TRACTION), 1 OR MORE REGIONS, EACH 15 MINUTES
97535	SELF-CARE/HOME MANAGEMENT TRAINING (EG, ACTIVITIES OF DAILY LIVING

CODE	DESCRIPTION
	(ADL) AND COMPENSATORY TRAINING, MEAL PREPARATION, SAFETY PROCEDURES, AND INSTRUCTIONS IN USE OF ASSISTIVE TECHNOLOGY DEVICES/ADAPTIVE EQUIPMENT) DIRECT ONE-ON-ONE CONTACT, EACH 15 MINUTES

ICD-10 Codes that Support Medical Necessity

N/A

ICD-10 Codes that DO NOT Support Medical Necessity

N/A

Additional ICD-10 Information

N/A

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type.Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

N/A

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the policy, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

N/A

Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
01/01/2018	R2	This article has been revised to reformat the article text and added IOM

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
		Medicare Claims Processing Manual, Publication 100-04, Chapter 5, Section 20(B) under the sources section.
01/01/2018	R1	Article is revised to delete 29582 and 29583 per the 2018 Annual HCPCS Code update.

Associated Documents

Related Local Coverage Document(s)

Article(s)
A53304 - Billing and Coding: Medical Necessity of Therapy Services
A53287 - High Compression Bandage System Clarification

Related National Coverage Document(s)

N/A

Statutory Requirements URL(s)

N/A

Rules and Regulations URL(s)

N/A

CMS Manual Explanations URL(s)

N/A

Other URL(s)

N/A

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- CDT
- MDT

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- 29581
- 29584
- compression