

August 29, 2023

Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1767-P, P.O. Box 8016  
Baltimore, MD 21244-8016

Submitted electronically at <http://www.regulations.gov>

**Re: Calendar Year (CY) 2024 Home Health (HH) Prospective Payment System Rate Update (CMS-1780-P)**

Dear Administrator Brooks-LaSure:

On behalf of our nearly 4,000 member physical therapists of the Private Practice Section of the American Physical Therapy Association, thank you for the opportunity to submit comments in response to the new Medicare benefit for lymphedema compression garments, as proposed in [CMS' Calendar Year 2024 Home Health proposed rule](#) (CMS-1780-P) (the Rule).

APTA Private Practice is an organization of physical therapists in private practice who use their expertise to restore function, improve mobility, relieve pain, and prevent or limit permanent physical disabilities in patients with injury or disease. The rehabilitative, maintenance, and habilitative care they provide restores, maintains, and promotes overall fitness and health across the age span to a range of patient types. Representing physical therapists who are also independent small business owners, APTA Private Practice encourages and supports policies that enable our members to focus on providing high-quality, cost-effective, and clinically appropriate outpatient physical therapy. Our members are proud of the quality of care they provide, but as small business owners are quick to realize the impact of deleterious administrative hurdles they encounter after providing clinically appropriate care for Medicare beneficiaries. They chafe at duplicative administrative tasks and unfair payment schedules. If they had more time and more resources to care for patients, physical therapists know that the care they provide would improve overall health and prevent the need for other avoidable health care services.

Lymphedema is common within the Medicare population. Lymphedema is a chronic, progressive group of conditions characterized by swelling and discomfort in various parts of the body due to malfunctions in the lymphatic system. Between 1.5 and 3 million Medicare beneficiaries currently

**APTA Private Practice**

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suffer from lymphedema. Patients undergoing treatment for cancer are particularly susceptible to lymphedema. When left untreated or undertreated, lymphedema can lead to complications, infections, comorbidities, loss of function, and disability—often necessitating costly emergency department or hospital visits. Commercial insurance and state Medicaid programs currently cover compression therapy.

This comment focuses on areas of interest to physical therapists in private practice and their patients.

APTA Private Practice seeks initially to focus on the differences between clinical services and items that CMS has conflated in the Rule: measuring, fitting, and training services. We believe that these differences justify varied payment for these clinically-oriented services and the items that DME companies supply.

### **Measuring and Fitting Services Performed by Therapists are More Cost-Effective**

Regardless of where they obtain their DME items, lymphedema patients receiving compression therapy require significant attention during early decongestive treatment, necessitating the skilled services of a lymphedema specialist. Physical therapists know that patients who receive measuring and fitting services from third-party, non-therapist professionals have the added burden of coordinating their measuring and fitting needs with that third-party measurer and fitter, as opposed to running the full spectrum of decongestive therapy, and measuring and fitting through their therapist evaluation. This lower quality care can result in additional visits, as well as a disconnect between the items needed and services provided throughout the course of therapy. Ultimately, patients who receive measuring, fitting, and training services through their lymphedema therapist are likely to receive more efficient, higher quality care and spend less time receiving care.

As an example, a patient initiates treatment under complete care of a therapist and by their fourth visit achieves a reduction. During the fourth visit, the therapist determines that the patient's progress requires a new set of custom-made gradient compression garments. At the therapist's office, the patient will receive necessary measuring in the same session, and the garment will be ordered within a day.

In comparison, a patient using a third-party DME measurer/fitter would need to complete the visit with their therapist, who would indicate to the patient the need for the new garment. The patient would then have to schedule an appointment with a DME measurer, who may have limited availability; typically, same-day availability is not possible no matter the DME measurer's availability. The result for the patient is a delay of several days to a week to begin the next stage of reduction. It is important to note that garments can take several weeks from measurement to receipt of their custom garment.

In addition, consider a patient in a more rural environment or who does not have easy access to patient-friendly transportation in a suburban or urban environment. Access to DME measurer/fitters is not as widespread as access to physical therapists in many communities, and

adding a transportation burden by limiting access to physical therapists for this vulnerable population is undesirable for optimal patient care.

### **Therapist Selection of Garments are Driven by Clinical Need, Not Payment**

DME suppliers have incentive to sell products, while therapists act with patient clinical interest foremost due to professional ethical and licensure obligations.<sup>1</sup> DME suppliers will have a strong financial incentive to sell compression products that result in the highest payment under the payment structure that CMS proposes. When viewed through the lens of the patient, it is important to also note that the Medicare benefit does not cover 100% of the cost of care, but instead 80%, and prices driven by profit motive will also result in larger out-of-pocket spending for vulnerable beneficiaries.

Further, therapists that work with the patient during the reduction/decongestive phase enjoy a deeper understanding of the patient's tissue texture, and the needs of the patient that cannot be replicated with the DME's limited measuring and fitting knowledge. Additionally, DMEs may not assess donning and doffing needs, understand volumetric reduction goals, or integrate other clinically relevant information that goes into the garment selection for gradient compression garments, whether ready-made or custom-fit.

### **CMS Should Pay for Items and Therapy Services Separately**

APTA Private Practice opposes CMS' proposal to bundle reimbursement for fitting and measuring services with payment for lymphedema compression garments. For CMS to achieve Congress' intent to create a compression garment benefit, these integral services must be reimbursed separately when performed by a therapy provider. Measuring and fitting services provided by therapists are functionally and clinically distinct.

APTA Private Practice also opposes CMS' alternative comment solicitation that would call for services to be paid for separately but require lymphedema specialists to enroll as DME suppliers to receive separate payment for their services. The structure proposed is unduly burdensome because it assumes that large DME supplier companies are in a worse position than clinicians, who would both be accepting risk as a clinician that does not actually manufacture or supply garments, and remain subject to the full slate of onerous and continuous DME supplier enrollment requirements.

As proposed, CMS would pay suppliers for the items, and suppliers would be responsible for providing appropriate reimbursement to independent measurers and fitters. Effectively, CMS' proposal would provide manufacturer suppliers the authority to set rates for clinician services, who have limited mechanisms to compel adequate payment for their services. Congress did not intend for CMS to rely on DME suppliers to provide appropriate payment for services. Under one potential outcome of the CMS proposal, physical therapists would be required to negotiate each individual claim, with each supplier, and across an inordinate number of items and products. Further, the CMS proposal creates additional uncertainty and challenge for therapists who will

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<sup>1</sup> See <https://www.apta.org/siteassets/pdfs/policies/codeofethicshods06-20-28-25.pdf>. See also <https://www.fsbpt.org/Secondary-Pages/The-Public/File-a-Complaint/Sample-Violations-Complaints>.

have to ensure they receive timely payment for their services rendered. CMS provides no guidance to help ensure these payments are made in a timely manner. There are also no provider appeal rights for under- or un-paid claims. The level of uncertainty for therapists created by the Rule is neither equitable, nor administratively feasible.

Alternatively, suppliers could set standard rates unconnected to the actual costs of therapist work. If suppliers assess rates for therapist services based on their own analysis of costs associated with measuring and fitting services, they would certainly not be comparable. These services are only nominally similar—therapists provide more comprehensive and clinically informed assessments than their supplier counterparts. It is also likely that these rates would not account for the difference in necessary skill and condition that impacts the amount of time necessary for these services—for instance, in low complexity patients, skilled therapy services can take 15 minutes, but for high complexity patients, measuring services might need more than one hour. It is unrealistic to assume that therapists will be appropriately paid under the bundled payment proposal if suppliers are left to work out the specific payment details for these services.

If, in the alternative, CMS does not accept these arguments and chooses to finalize its proposal to bundle payment with the items, we respectfully urge the agency to set standard payment parameters to ensure manufacturer-suppliers provide therapists with adequate reimbursement for their services. For instance, payment for measuring could entail setting a standard percentage paid to therapists out of the items and supplies paid to the manufacturer (e.g. 25% of the total HCPCS codes value paid, with percentage increases for a set of standard complexity factors—bilateralism, presence of wounds, cardiovascular or venous complications, and phase of lymphedema present).

In any case, it is critical that CMS establish and identify the formal mechanisms that would ensure payment for these services.

#### *CMS Should Use Its Authority to Establish Temporary G-Codes First for Measuring and Second for Fitting/Training Services*

The most appropriate path for the best patient outcomes will create separate payments. We urge CMS to use its authority to establish two temporary “G” codes – one for measuring, and the other for fitting/training on the use of the compression garment. CMS [can use this authority to establish temporary codes for services](#) that would otherwise be coded in CPT-4 but for which there are no CPT-4 codes, which allows CMS the flexibility to establish codes that are needed before the next January 1 annual update. Further, there is [no formal process to establish these codes, which can be created through notice and comment rulemaking](#). We believe that the most patient-friendly strategy would be for CMS to establish temporary codes while clinician groups seek permanent addition of two temporary codes through the CPT process. APTA and AOTA have worked with clinical experts to develop a sample Description of Procedure, Clinical Vignette, and payment crosswalk that outlines the long term goal of developing these codes for separately recognized payment. We believe this is a reasonable and simplified set of codes that would better recognize the work that therapists provide to ensure that compression therapy can effectively be provided to patients using correctly measured and fitted garments.

### *DME Supplier Status is Not Necessary to Separately Pay for Associated Therapy Services*

CMS indicates that it is aware that separate payment may be appropriate, but indicates that separate payment is not realistic given that it would require therapists to enroll as DME suppliers to receive payment for these measuring and fitting services. We agree with CMS that DME supplier enrollment and compliance with its corresponding requirements would be unduly burdensome for individual or small practice therapists to use to receive separate payment for their measuring and fitting services. Hospital-based therapists have also acknowledged that buy-in from leadership would be unlikely. However, there is nothing that would compel CMS to require DME enrollment, and the agency's concerns around replacement garments fail to consider the reality of how therapists, manufacturers, and DME suppliers interact with one another. **Without affirmative legal or regulatory requirements compelling them to do so, current practice indicates that a CMS final decision to require DME supplier enrollment for therapists will hinder patient care.**

Currently, when a therapist or DME supplier makes a measuring mistake, extant manufacturer warranties consistently acknowledge that garments will be replaced *at the cost of the manufacturer*. Commonly, therapists that order garments through a DME supplier typically are granted at least 30 days to issue a replacement. Therapists request the replacement through the DME supplier, which issues a return authorization. At this point, the therapist sends new measurements to the supplier, who forwards the measurements to the manufacturer. The manufacturer replaces the garment at no cost to the therapist or supplier under their policies.

The process is even simpler when the therapist orders directly through the manufacturer for self-pay patients. Common practice is for therapists to provide updates to the manufacturer directly. Historically, manufacturers would request that the garment be returned, but currently, manufacturers require only a return authorization and allow patients to keep the improperly fitting item.

In any scenario of which we are aware, replacing a garment *comes at no cost to the DME supplier itself*. In some cases, separate from issues stemming from improper measurement, a patient may change their mind about a certain practical aspect of the garment, such as the use of pull-up loops to assist with donning and doffing. In almost all cases, major manufacturers apply a "no-questions asked" policy, they receive the returned garment, and make modifications as necessary. For custom nighttime garments, manufacturers typically allow for one modification per year. These are generous policies, whose generosity extends from the shared understanding between clinicians and manufacturers that patients' physical conditions change rapidly.

These contracting structures are supported through both public and anecdotal evidence. Lymphedema therapists typically attend 3-4 fitter trainings annually, primarily those hosted by major manufacturers such as JOBST, Juzo, and Medi. During training, manufacturers remind therapists that that correct fit and use of the garments they manufacture is their top priority, and that replacements are anticipated as part of that process.

There are also systems in place to reduce and prevent measuring errors. Therapists and manufacturers have working relationships, and when a measurement appears incorrect, manufacturers call the ordering therapist or DME to clarify what they perceive as the measuring error. They will pause production and make adjustments based on the resulting discussion with the therapist. When working through a DME supplier, the manufacturer will let the supplier know, and in turn will contact the therapists. In either case, there are mechanisms in place to prevent and correct errors.

Trusted sources have specifically sought comparative information on how inaccurate measurements from DME suppliers are dealt with, and ultimately determined that the same policies apply from the manufacturers, whether measured by the DME supplier or the therapist. We have found no instances in which the DME supplier incurs any additional costs for replacements. One group reported that one therapist detailed a recent encounter with a pediatric patient whose guardian requested six new garments and did not wish to receive new measurements. Instead, they requested the new garments be based on the patient's most recent measurements. The patient eventually received the garments, which did not fit. The therapist had sent the order to the DME supplier and noted the patient's preference for the most recent measurements on file, which the DME supplier then mistakenly used to provide an older set of measurements to the manufacturer. When the garments did not fit, the DME supplier issued a return authorization and noted that incorrect measurements had been forwarded. The manufacturer provided six new garments with no questions asked to the patient, and at no cost to the DME supplier since the replacements were covered under their replacement policy.

It is clear that replacement for incorrect measurement is treated the same for therapists and DME suppliers. The cost for fixing a garment as a result of incorrect measurements is clearly built into the cost of the garment production. It is the manufacturer that establishes and honors its policies and warranties – the DME requirement, as proposed, does not protect an investment from the therapist, patient, or DME supplier since the manufacturer dictates the standard. It is standard policy to ensure correct fit at no additional cost. Therapists should be seeing the patient for fitting specifically for these reasons. It is also an extremely rare circumstance when a garment must be remade multiple times. Nevertheless, policies often cover more than one remake, as discussed below.

Warranties of major manufacturers support the real-world, operational understanding of garment replacement. Notably, replacement policies from the major manufacturers typically cover at least one free remake of their custom-fit garments; for instance, JOBST and Elvarex provide between 1-2 free "no questions asked" remakes for custom garments available up to 45 days from delivery receipt. Others, such as Medi USA have a limited 30-day period under which they "will replace the garment at no cost to the patient or in the case of custom garments, product may be altered or modified as needed." Juzo provides a "Fitting Guarantee" that "ensures each custom-made garment will be produced correctly as per the measurements provided to Juzo. If the garment does not fit properly, return the garment to Juzo within 14 days of the original ship date."

No current warranty or replacement standards of leading garment manufacturers that distinguish between whether the supply is measured/fitted by the DME supplier, or by therapist measurers or fitters could be identified. Some policies do not even limit the number of remakes under the policy.

Ultimately, the current replacement practices and policy standards tend to recognize several critical facts that make it unclear why CMS believes it is necessary to require measuring therapists to assume the risk for replacements by enrolling as a DME supplier:

- (1) improperly measured/fitted items, regardless of the measuring origin, are covered by manufacturers under the cost of the original garment;
- (2) improperly measured garments can be altered, meaning the item does not always have to be fully replaced; and
- (3) manufacturers acknowledge that even with accurate measurement there is no guarantee of proper fit since there can be reduction or increase in volume during production—the weeks between measuring and receipt of the garment.

These operationally and clinically relevant points strongly indicate CMS concerns about replacement garments are unfounded, and that requiring DME supplier status to receive payment for associated services is inappropriate and draconian. If CMS can rely on manufacturers to pay measurers and fitters for their services, it is unclear why suppliers cannot work on a resolution with DME suppliers in the extremely rare instances where replacements exceed garment warranties. It is clear that manufacturers and suppliers price their items with the expectation that remakes will be necessary.

Nevertheless, CMS proposes that therapists assume a significant level of burden and risk to perform these critical services. Therapists are neither the source of pricing, nor in any reasonable position to bear the risk associated with replacement. Additionally, the costs of replacement are built into the costs of the item themselves as evidenced by current practice, warranties, and training. Finally, if the same garment required many remeasures, the supplier can simply deny the return authorization.

Beyond these other relevant practical considerations, there is no administratively simple way to distinguish the source of the error, which is part of the reason why these policies do not distinguish between the source. The time and energy to do so and coordinate between the three potential sources of error would far outweigh the cost of replacing the garment itself.

Ultimately there is no existing regulatory or legal requirement compelling CMS to bundle these integral services with the item itself, or which was cited in the Rule. In an analogous situation for custom-made orthotics, therapists have a significant role in measuring and fitting, but are not DME suppliers. Typically, therapists might perform a movement analysis, provide a mold made of plaster, and send the results of the assessment and mold out for fabrication of the orthotic. The therapist is only able to bill for services, such as CPT Code 97760, unless they are a DME

supplier, in which case they would bill a HCPCS L Code, which provides for service payments, as proposed here.

Finally, we seek clarification on [42 CFR 424.57\(d\)\(15\)](#), and whether private practice physical and occupational therapists are exempt from proposed surety bond requirements if the business is solely owned and operated by the PT or OT; the items are furnished only to the PT or OT's own patients as part of their professional service, and the business is only billing for orthotics, prosthetics, and supplies. Ultimately, the exception is so limited as to be rendered pointless. The idea that the PT/OT would have sole ownership and also only bill for O&P is impractical and would likely not solve the problem for any lymphedema practitioners. Changes to this provision would be appropriate if CMS premised payment on enrolling as a DME supplier.

### **Service Codes for Treatment of Lymphedema**

*CMS Should Permit Code Pairings of 29XXX Series Codes With Manual Therapy (97140)*

Currently, these codes are not permitted to be billed together by various MACs. Despite CMS modifying the language in its NCCI manual to permit this combination, which now reads:

When reporting manual therapy techniques (e.g., CPT code 97140) in the anatomic region where a multi-layer compression system (e.g., CPT codes 29581-29584) is applied, it may be necessary to indicate that the manual therapy techniques are distinct from the multi-layer compression system application, modifier 59 or – X{EPSU} may be appended to either column code.

However, various [LCDs](#) still [prohibit this combination of codes](#) when 97140 is billed with 29581-29584—meaning when they are used specifically during treatment of lymphedema, even though they're permitted for other diagnoses. This should be seen as a necessary change that ensures that the services associated with lymphedema treatment are covered; as we communicated to CMS during the pre-rulemaking period, coverage of these garments will be less effective if associated services are inadequately covered or unpaid.

Since NCDs and LCDs continue to restrict the billing of 29581 and 29584 by physical therapists when treating patients with lymphedema, providers are instead directed to bill 97535 for instructing patients and/or caregivers in the application of a multilayer compression system. To instruct a patient and/or caregiver in the application of a multilayer compression system a physical therapist must perform the application of a multilayer compression system. Given the expectation that providers bill the CPT code that most closely represents the care being provided, APTA Private Practice requests that CMS provide coverage for CPT codes 29581 and 29584 when billed by physical therapists for sessions required to instruct a patient and or caregiver in the application of a multilayer compression system that is integral to their lymphedema management.

As noted elsewhere in our comments, therapists often receive compression garments and assess fit and conduct associated training to ensure patient adherence during the maintenance



phase. Additionally, APTA Private Practice requests that CMS clarify the conditions for which the application of a multi-layer compression system and manual therapy can be billed by a physical therapist during the same episode of care as indicated in the NCCI Manual.<sup>2</sup> As we strive to support the provision of clinically appropriate care and encourage correct coding, we appreciate CMS consideration of this issue.

### **Conclusion**

Thank you for the opportunity to comment on the Rule. APTA Private Practice welcomes the opportunity to work with CMS to identify solutions that will safeguard the financial health of the Medicare program and use taxpayer dollars wisely while ensuring that beneficiaries have adequate access to high-quality physical therapy services in safe, cost-effective community-based settings.

Sincerely,

A handwritten signature in black ink, appearing to read "Mike Horsfield". The signature is written in a cursive, flowing style.

Mike Horsfield, PT, MBA

President, Private Practice: a Section of the American Physical Therapy Association

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<sup>2</sup> We respectfully urge CMS to withdraw all remaining local coverage articles that deny payment for lymphedema compression bandaging application. This would make it explicit that coverage for these services is required. See <https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=55710&ver=7&keywordtype=starts&keyword=Lymphedema&bc=0>, which states "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."

## **Appendix A: Recommendation for Temporary “G” Codes for Measuring and Fitting/Training Services / Corresponding “L” Codes**

We believe it is within CMS’ authority to establish separate payment for measuring, fitting, and training services without premising such payment on therapists enrolling as DME suppliers. To this end, we provide a recommendation below of an implementable payment structure, closely modeled after the framework CMS provides in the alternative comment solicitation. Generally, our recommendation would necessitate that CMS: (1) Establish two temporary “G” codes for measuring and fitting services; (2) Establish four modifiers that indicate which entity (the DME supplier or a therapist) provided the associated measuring and fitting services; and (3) **does not** require DME supplier status for clinicians performing and billing these services.

This recommendation would provide an immediate short-term framework that adequately recognizes and directly pays therapists for the services they provide, without enabling DME suppliers to act as administrators of payments for these services. Again, it is neither appropriate nor administratively simple under CMS’ proposed structure, which would allow DME suppliers to set rates, and be relied upon to administrate payments for these services without oversight or infrastructure to address non-payments, appeals, and other unforeseen circumstances described in greater detail in the body of this letter. If CMS elects to adopt this framework, the eventual goal would be to pursue two permanent CPT service codes through the AMA/CPT process that mirror the temporary “G” codes.

It is critical that, as CMS works toward its final rule, that associated services are paid separately to providers, and do not require DME supplier status. Again, we direct CMS to the extensive comments above explaining why DME supplier status is neither necessary nor appropriate to require for clinicians. We believe our recommendations below are feasible, and would ensure that only DME suppliers would be paid through DME MACs, while therapists would be able to bill their claims separately through their traditional MACs using these temporary service codes.

### ***Establish Two Temporary “G” Codes***

We request CMS establish two temporary “G” codes for therapists to use when they provide measuring and fitting/training services. Below are descriptions of these procedures, as well as recommended sources for establishing associated payment amounts.

#### *Recommended Codes and Descriptions*

- *GXXXI*— Lymphedema Compression Garment Measurement
  - **Description of Procedure:** Patient is seen for assessment of lower extremity(ies) and explanation of the measurement process. Measurements are taken in sitting or lying position with additional measurements in standing for thigh length and panty options. All length measurement points are marked on the patient with a skin marker prior to taking measurement for circumferences. Length measurements are taken as needed to follow the contour of the leg. Consideration is taken regarding the patient or caregiver’s ability level, functional level, or lifestyle to ensure a

clinically effective fit. All measurements are recorded and provided to the manufacturer or fabricator.

- GXXX2— Lymphedema Compression Garment Fitting and Education
  - **Description of Procedure:** The patient presents after receiving the ordered/prescribed garment. The Qualified Healthcare Professional (QHP) assists the patient in donning the garment and checks the fit of the garment. The QHP determines if any adjustments are needed. The QHP provides training and education to the patient and caregiver if applicable on skin inspection, proper donning/doffing of the garment, wearing schedule, and any relevant patient specific considerations.

*Recommended Payment Amounts Associated with Temporary “G” Codes*

There are two sources that we believe could help CMS establish payment for these temporary “G” codes – pricing that can be crosswalked from similar existing codes, and survey data from the US Medical Compression Alliance.

The temporary G code would allow reimbursement for QHP work until a permanent CPT code could be created through the American Medical Association CPT process. CMS could cross walk the rate from codes within the CPT code set that have similar practice expense, clinical labor and skill level:

CPT Code	Descriptor	Pre/Intra/Post time	Work RVUs	PE Clinical Labor	PE Supplies Equipment	Non-Facility Payment
29505	Application of long leg splint (thigh to ankle or toes)	9/22/10	0.69	RN/LPN /MTA	Drape, gloves, underpad, cast cart	\$90.14
29520	Strapping; hip	7/9/2	0.39	PT Aide	Gloves, tape (surgical paper 1 in), foam underwrap, rigid strapping tape, skin prep barrier wipes	\$35.24
29584	Application of multi-layer compression system; upper arm, forearm, hand, and fingers	4/12/2	0.35	PT Aide, PTA	Pack, bandage system, lotion, exam table	\$83.02

There is precedent for this manner of coding methodology within the code set for DME related to orthotics and prosthetic devices and the fitting and training services that occur when the device is issued. With orthotics and prosthetics, a HCPCs code captures the device supply and its initial fitting/training when initial fitting and training is performed by the DMEPOS supplier who has supplied the device, however when a qualified healthcare professional (QHP) such as an occupational or physical therapy practitioner conducts the initial fitting and training for the

orthotic, CPT code 97760 *Orthotic management and training, initial orthotics encounter* is billed by the QHP to reimburse the “work” associated with the service.

**However, while similar, these codes do not directly reflect the costs associated with providing these services.** However, USMCA performed a survey with over 700 respondents to estimate the costs associated with measuring, fitting, and training. Sixty percent of respondents were therapists, and we believe that the results would better reflect appropriate payment for these services as well.

#### *Recommended HCPCS Modifiers*

To identify which claims are appropriate for therapists to bill for their services, we would anticipate that appending modifiers that reduce payment for the item would be most administratively simple. Our recommendation would function just as CMS recommends in its own alternate proposal, where the payment for services is backed out of the overall payment for the item.

Through discussions with clinicians and manufacturers, APTA identified four potential situations that need to be delineated. As such we propose that CMS establish a set of four modifiers that can be appended to the HCPCS claim to distinguish when, and how much separate payment is permissible, ensuring payment is appropriately distributed between the DME supplier and clinician.

- **Modifier A** – Lymphedema Compression Garment, Garment Only
  - This modifier would be billed with the associated garment HCPCS code when the DMEPOS supplier supplies the garment but an external qualified healthcare provider such as an occupational or physical therapist performs **both** the measuring service and provides the fitting and training once the garment arrives.
- **Modifier B** – Lymphedema Compression Garment, Includes **Measuring** by DME Supplier
  - This modifier would be billed with the associated garment HCPCS code when the DMEPOS supplier conducts the measuring task and supplies the garment but an external qualified healthcare provider such as an occupational or physical therapist performs the fitting and training once the garment arrives.
- **Modifier C** – Lymphedema Compression Garment, Includes **Fitting** by DME Supplier
  - This modifier would be billed with the associated garment HCPCS code when the DMEPOS supplier supplies the garment following receipt of measurements from an external qualified healthcare provider such as an occupational or physical therapist. The DMEPOS supplier then conducts the garment fitting and patient instruction after the garment is received.
- **Modifier D** – Lymphedema Compression Garment, Includes **Measuring and Fitting** by DME Supplier

- This modifier would be billed with the associated garment HCPCS code when the DME supplier conducts all aspects of the custom garment process including measuring, supplying, and then assesses fit and provides patient instruction in use when the custom garment is received.

### Examples of Recommended Payment Structure

To provide clarity around these recommendations, we have provided below two simplified examples where that use the following numbers. These numbers **do not** reflect actual pricing, but, again, are simplified to illustrate how our recommended payment structure would function in practice.

- Custom-Fit Garment X (represented by HCPCS Code 12345) (\$100)
- Measuring/Training Services Only (represented by *GXXX1*) (\$20)
- Fitting Services Only (represented by *GXXX1*) (\$20)

#### Example 1: Measuring and Fitting/Training Performed by Therapist

Therapist sees Medicare beneficiary “MB” and takes measurements for Custom-Fit Garment X. Therapist sends measurements to DME supplier to fill order with manufacturer. Garment X is shipped to the therapist, who provides follow-up visit with Medicare beneficiary “MB” and then provides fitting and training services.

- **The claims and payment would be administered as follows:**
  - **DME Supplier:** Bills HCPCS Code 12345 appended with Modifier “A”
    - This indicates that the DME supplier provided only the garment, and that the therapist provided the associated measuring and fitting services. As such, the garment payment of \$100 dollars is reduced to **\$60** to exclude payment for both the measuring and fitting/training services, which the therapist will bill separately. The DME MAC would pay \$60 directly to the DME supplier, while the remaining \$20 would be available to be billed separately by the therapist.
  - **Therapist:** Bills Temporary “G” Codes *GXXX1* and *GXXX2*.
    - Therapist would be paid \$40 — \$20 for associated measuring services, and \$20 for associated fitting/training services with Custom Garment “X.”

#### Example 2: DME Performs Measuring Services, Therapist Performs Fitting/Training Services

Therapist sees Medicare beneficiary “MB” during decongestive phase, and sends “MB” to DME supplier to be measured for Custom-Fit Garment X. DME supplier measures and submits order to manufacturer. Garment X is shipped to the therapist, who provides follow-up visit with Medicare beneficiary “MB” and provides fitting and training services with them.

- **The claims and payment would be administered as follows:**
  - **DME Supplier:** Bills HCPCS Code 12345 appended with Modifier “B”
    - This indicates that the DME provided the garment, as well as performed the associated measuring services, while the therapist provided the associated

fitting/training services. As such, the garment payment of \$100 dollars is reduced to \$60 to exclude the measuring and fitting services, which the therapist will bill separately. The DME MAC would pay \$60 directly to the DME supplier, while the remaining \$40 would be available to be billed separately by the therapist.

- **Therapist:** Bills Temporary “G” Codes *GXXX2*.
  - Therapist would be paid \$20 for associated fitting services with Custom Garment “X.”