Priority Health	BILLING POLICY No. 067
COMPRESSION GARMENTS	
Date of origin: Jan. 3, 2025	**Review dates: 2/2025**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise stated
- Medicaid follows MDHHS unless otherwise stated

DEFINITION

Compression garments are special clothing containing elastic support materials used to apply varying and substantial pressure to an area of the body. Compression garments assist with the reduction of swelling and to help with tissue remodeling. This policy outlines guidelines for reimbursement of compression garments.

MEDICAL POLICY

- Orthotics/Support Devices (#91339)
- Durable Medical Equipment (#91110)
- Surgical Treatments of Lipedema and Lymphedema (#91631)

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Get additional details on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

Billing for lymphedema compression treatment items for more than one body part or area per member is allowed, and for both a daytime and nighttime garment for the same body part or area per member.

CPT codes 29581 and 29584 include payment for the bandaging systems. Separate billing of the lymphedema compression treatment bandaging systems Level II HCPCS A codes in conjunction with these CPT codes aren't payable.

Frequency

- Daytime: 3 garments per affected body part every 6 months
- Nighttime: 2 garments per affected body part every 2 years
- As needed:
    - To replace lost, stolen, or irreparably damaged items
    - If a patient's condition changes, like a change in limb size

Place of service

Review specific information regarding DME place of service billing requirements in our Durable Medical Equipment (DME) place of services (POS) billing policy.

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Get more information in our Provider Manual.

Documentation requirements

We align with the Centers for Medicare & Medicaid Services (CMS) standard documentation requirements for supplies and DME. Reference CMS Article A55426 – Standard Documentation Requirements for All Claims Submitted to DME MACs.

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the provider should consult any specific documentation requirements that are necessary of any applicable defined guidelines.

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. Get more information on modifier use in our Provider Manual.

HCPCS modifiers:

- Anatomic modifiers must be used when appropriate
- RA modifier: should be used when billing for a replacement
- KX modifier: Modifier should be appended to indicate that policy criteria has been met for all wheelchair DME items (includes base, seating, power devices and additional accessories). Claims reported without KX modifier will deny as non-payable per medical policy. (Commercial, Medicaid products)
- KX, GA, GY, GZ modifiers (Medicare only): Per CMS local coverage determinations, one of these modifiers are required for claim processing all wheelchair DME items (includes base, power bases, seating, and additional accessories). See more information about these modifiers in our Provider Manual.

RESOURCES

- MLN Matters: Lymphedema Compression Treatment Items: Implementation (CMS)
- Lymphedema Compression Treatment Items (CMS)

RELATED POLICIES

- DME Place of Service

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to

document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Feb. 14, 2025	Added "Disclaimer" section