

# Chapter 70

## Reimbursement of CDT-based Care

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Though knowledge about lymphedema and treatment options has drastically increased, reimbursement issues continue to hinder patients' access to successful treatment.

Lymphedema, specifically related to breast cancer treatment, has garnered the attention of national associations and agencies, increasing the momentum of efforts to improve insurance coverage. This has led to legislative efforts that may eventually improve compensation.

For primary lymphedema (congenital or hereditary) and other secondary forms, such as postsurgical cases or phlebolymphelemas, it remains difficult for patients to obtain a correct diagnosis.<sup>1</sup> Lower extremity cases are often more costly to treat and are frequently complicated by conditions such as chronic wounds, obesity, and peripheral neuropathy.<sup>2</sup>

Patients continue to report seeking diagnosis and appropriate treatment for years. Many describe being referred to numerous specialists before obtaining answers. Some are even hospitalized for complications from untreated symptoms of lymphedema. Numerous patient support groups, advocacy networks, websites, and organizations have sprung up across the United States.<sup>3</sup> These organized efforts by patients and health care professionals are now focused primarily on reimbursement for therapy and supplies necessary to manage the disease.

Initially, most of the efforts to obtain reimbursement were driven by manufacturers of the products used in the treatment of lymphedema. These efforts continue today, but are now more accessory to measures being taken by groups and individuals committed to securing improved reimbursement for all components of care for lymphedema patients.

In the 1980s, only a handful of lymphedema clinics existed in North America. In the 1990s, patient awareness, interested therapists, and physicians stimulated an

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increase in treatment centers in the United States. In 1992, Medicare (Kansas) approved reimbursement for CDT treatment for lymphedema. By 1997, the state of Florida had approved the protocol. The Women's Health and Cancer Rights Act of 1998 was passed, which stipulated provision of treatment and supplies for those receiving benefits in connection with a mastectomy and/or subsequent breast reconstruction.<sup>4</sup> In 1999, the new CPT code describing manual therapies, including manual lymph drainage (97140) was approved by the American Medical Association.<sup>5</sup> Other CPT codes reportedly used across the country include those for therapeutic exercise (97110), therapeutic activity (97530), and activities of daily living (97535). An application for a CPT code that describes the provision of skilled services for the compression bandaging component of lymphedema therapy is currently in development.

In February 2010, a bill was introduced in the House of Representatives as H.R. 4662, the *Lymphedema Diagnosis and Treatment Cost Saving Act of 2010*.<sup>6</sup> The Centers for Medicare and Medicaid Services (CMS) requested a Technology Assessment to be performed through the Department of Health and Human Services (HHS) and Agency for Healthcare Research and Quality (AHRQ). This document, entitled *Diagnosis and Treatment of Secondary Lymphedema*, was published on 28 May 2010.

The Technology Assessment concluded that although a great deal of research into the diagnosis and treatment of secondary lymphedema has already been undertaken, there is no evidence to suggest the optimal diagnostic test or treatment. Additionally, there is no evidence to suggest whether certain tests or treatments might benefit some types of patients more than others. The field of research into secondary lymphedema is ripe for advancement and the contents of the report may serve as a springboard to guide future scientific endeavors in this domain.<sup>7</sup>

Setting reimbursement schedules requires consensus about the diagnosis and treatment protocols supported by data, neither of which exists. The need for better reimbursement is not disputed. It is regrettable that the determined actions of many efforts to date will not soon enough improve compensation for treatment or supplies. Until consensus occurs, there is no guide to successful billing or coding for reimbursement available.

Lymphedema treatment is primarily provided by physical therapists and occupational therapists.<sup>8</sup> The codes utilized for reimbursement are those in the Rehabilitation Medicine section of the Current Procedural Terminology (CPT) manual. Despite years of effort by individuals and associations, many qualified nurses, massage therapists, and other allied healthcare professionals are not able to treat and bill insurance for reimbursement. While national policy may allow for licensed massage therapists or nurses to provide treatment, it is regulated by each state.

Currently, for massage therapists, the educational requirements vary from state to state. Some states do not recognize the profession within the regulations of their Board of Healing Arts. There are no standards of education formally recognized and few physicians in the United States have had training in the specialty of lymphology to properly provide oversight or know what results to expect from treatment performed.<sup>9</sup>

A similar scenario occurred in the late 1960s. Nurses took the lead in developing wound care protocols and established a curriculum and credential that recognized them as wound care specialists that reflected the training, experience level, and designation for subsequent reimbursement.<sup>10</sup> There now are more than eight separate organizations for health care professionals interested in the field of wound care in the United States. Wound care supplies are covered by Medicare and most insurance companies. Coding for reimbursement of these services correlating with wound care is differentiated among the professionals delivering the care.

In 2006, there was a watershed change in the ownership of medical practices; for the first time, more were owned by hospitals and other health care providers than by the physicians themselves. That figure, medical professionals predict, could rise to 80% within a few years.<sup>11</sup> Most remaining in private practice are specialists. Phlebologists, oncologists, dermatologists, and physiatrists are among the specialists who have included lymphedema services in their practice. This is a tremendous opportunity for specialists interested in expanding their services and improving patients' quality of life.

There is an established need for continuing medical education courses for physicians to learn more about lymphedema and other functions and disorders of the lymphatic system.<sup>12</sup> Several curriculums are being developed at the time of writing. This will provide better evaluation of treatment protocols and assist in the collection of necessary data toward more reliable and measurable outcomes.

From the staging and treatment of the disease, to supplies, the opportunity is here to establish guidelines for care, professional education requirements, and subsequent insurance reimbursement. It is recommended that until these are in place, physicians and allied health care professionals establish a direct relationship with their insurance carriers or find a knowledgeable consultant who can direct them through the establishment, provision, and billing for the services of a lymphedema program.

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