Frequently Asked Questions

Last Update - 2/9/2024

This document will be updated as additional information becomes available, with new information being added at the end. Unless otherwise noted, answers are regarding Medicare coverage/Medicare beneficiaries.

CMS Website for providers and suppliers - https://www.cms.gov/medicare/payment/fee-schedules/dmepos-fee-schedule/lymphedema-compression-treatment-items

Responses follow the list of questions on the noted page number, or you can click on each question to jump to the answer.

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1. **Can I read a copy of the bill/law?**

   The Lymphedema Treatment Act (LTA) was passed into law as part of the Consolidated Appropriations Act of 2023. This was the 2022 year-end omnibus legislative package. The text of our bill that was included in that package was identical to the version that was passed by the House as a stand alone bill on November 17, 2022, and can be read here.

2. **Can I read the Final Rule?**

   On November 13, 2023 CMS published the final coverage details of the new benefit category created for Lymphedema Compression Treatment Items. The details are part of the larger rule and can be read here.

3. **What does the LTA do, and why is it only about compression supplies?**

   The LTA created a Medicare benefit category for lymphedema compression supplies. The reason Medicare has been unable to cover compression supplies is because they could not be classified under any of the existing benefit categories. Only Congress has the authority to create new Medicare benefit categories, and that is why legislation was needed. All other aspects of lymphedema treatment (whether covered or not) fall under other existing benefit categories, and therefore could not be included in the LTA. Changes to other aspects of treatment do not require an act of Congress. Although the LTA only directly mandates Medicare coverage, it will indirectly benefit all patients, because almost all other insurance plans follow Medicare coverage guidelines. During the 12 years it took to pass the LTA private insurance plans increasingly aligned their coverage with that of Medicare's, with many citing this as the reason for changes to their coverage. While that was to our detriment prior to passage of the LTA, it is now to our benefit.

4. **Does a Medicare beneficiary need to be diagnosed with lymphedema in order to qualify for coverage?**

   Yes, in order to qualify for coverage of compression supplies a Medicare beneficiary will have to have a diagnosis of lymphedema. CMS lists the following diagnosis codes in the final rule.
   - Lymphedema, not elsewhere classified (I89.0)
   - Hereditary Lymphedema (Q82.0)
   - Postmastectomy Lymphedema Syndrome (I97.2)
   - Other postprocedural complications and disorders of the circulatory system, not elsewhere classified (I97.89)

5. **Will the LTA cover patients with primary lymphedema and non-cancer related lymphedema?**

   Yes! The bill/law language makes no distinction regarding the cause of lymphedema.

6. **When will coverage begin?**

   Medicare coverage began 1/1/2024.

7. **What about patients not on Medicare?**

   Although the LTA only directly mandates Medicare coverage, it will indirectly benefit all patients, because almost all other insurance plans follow Medicare coverage guidelines. During the 12 years it took to pass the LTA private insurance plans increasingly aligned their coverage with that of Medicare's, with many citing this as the reason for changes to their coverage. While that was to our detriment prior to passage of the LTA, it is now to our benefit. We encourage you to contact your insurance company and request they follow the new Medicare coverage. Click here for more information and a template letter.

8. **Will this cover patients with Lipedema?**

   Per the answer to question #3, anyone with a lymphedema diagnosis, regardless of cause, will be eligible for coverage.

9. **Will this cover patients with Venous Insufficiency?**

   Per the answer to question #3, anyone with a lymphedema diagnosis, regardless of cause, will be eligible for coverage.

10. **Will this cover both standard-fit and custom-fit compression garments?**

    Yes! The bill/law explicitly states "standard and custom fitted gradient compression garments."

11. **Will compression garments for all parts of the body be covered, or only arms and legs?**

    Yes! Coverage for compression garments is per affected body area.

12. **Will the bill allow for patient choice in regard to brand?**

    Yes. The final rule does not make any specifications to brands or manufacturers. Be certain to discuss your preferences with the supplier when placing your order.

13. **Will other compression items such as bandaging supplies, low stretch (velcro) garments, nighttime garments, etc. also be covered?**

    Yes. The new benefit category will cover the following:
    - Custom and standard fit daytime and nighttime garments.
    - Custom and standard fit gradient compression wraps with adjustable straps.
    - Bandaging supplies for any phase of treatment.
    - Accessories including but not limited to donning and doffing aids, padding, fillers, linings, and zippers.

14. **What about coverage for other items currently not covered, such as surgery, custom shoes, etc?**

    Per the answer to question #2, all other aspects of lymphedema treatment (whether covered or not) fall under other existing benefit categories, and therefore could not be included in the LTA. Therefore, the LTA does not change the status of coverage for any other supply, device, or medical service or procedure.

15. **Will this affect coverage for lymphedema therapy/MLD (manual lymphatic drainage), and will it affect which providers can bill for lymphedema therapy?**

    No, however, Medicare beneficiaries should be aware that the Medicare therapy cap was lifted through passage of the Bipartisan Budget Act of 2018. More information on that is available here.

16. **Will this affect coverage for lymphedema/pneumatic compression pumps?**

    No, pumps are covered under the DME (durable medical equipment) category and the LTA does not affect coverage for pumps.

17. Will this affect the coverage I am receiving due to the Women's Health and Cancer Rights Act (WHCRA) of 1998?

No, if you are on a private insurance policy subject to the WHCRA then your plan must still conform to the requirements of the WHCRA.

18. Will this affect coverage for compression supplies used in wound care?

Compression coverage for wound care in the absence of lymphedema is unaffected by the LTA and remains in place as part of the surgical dressing category.

19. Will I need a prescription?

You will need a prescription (in addition to a lymphedema diagnosis) in order to be eligible for coverage. An authorized practitioner prescribes the item.

20. Will I have to see a CLT (Certified Lymphedema Therapist) before I can order my compression garments?

This is not a requirement for Medicare coverage.

21. What criteria must be met in order to receive custom-fit versus standard-fit garments?

Medicare covers custom fitted (custom or non-standard) gradient compression garments. Custom fitted gradient compression garments are uniquely sized and shaped to fit the exact dimensions of the affected extremity of an individual to provide accurate gradient compression to treat lymphedema. Examples of scenarios where a custom fitted gradient compression garment might be used (not all-inclusive) are:

- If the circumference of the proximal portion of the limb is significantly greater than the distal limb;
- If the skin/tissue has folds or contours requiring a specific type of knitting pattern;
- Beneficiary is unable to tolerate the fabric composition of a standard garment.

There must be documentation in the beneficiary's medical record necessitating the use of a custom fitted gradient compression garment versus an off-the-shelf standard gradient compression garment.

22. How many compression garments will I be able to get at one time and how often will I be able to replace them?

Medicare will cover the following:

- Daytime garments – 3 sets (one garment for each affected body part) every six months, standard or custom fit, or a combination of both
- Nighttime garments – 2 sets (one garment for each affected body part) every two years, standard or custom fit, or a combination of both
- Bandaging supplies – no set limit in the rule.
- Accessories – no set limit, will be determined on a case-by-case basis depending on the needs of the patient.

23. What will my out of pocket costs be?

Compression supplies will be covered under Medicare Part B, and like all medical supplies covered under Part B the patient responsibility will be 20%. If you have a secondary or supplemental Medicare Plan, it should help cover the patient responsible. Medicare Advantage plans coverage may vary. Private insurance plans differ, but likewise, whatever your out of pocket responsibility is for other covered medical supplies you should expect that it will be the same for your compression garment and supplies.

24. Where will I be able to get my compression garments, will online purchases be allowed, and can I choose the brand I want?

Medicare beneficiaries will be able to get their compression garments from any Medicare participating supplier, whether a brick and mortar business or an online supplier, and be able to choose from any brand they sell. For a list of suppliers currently accepting Medicare for compression garments and supplies click here.

25. What will the reimbursement rates be? In other words, what will the suppliers who sell compression garments be paid by Medicare for providing these items?

The reimbursement rates are included in the 2024 DMEPOS Fee Schedule. Click here to locate the most current version.

26. What will the terms of coverage be for patients receiving home health services?

CMS is awaiting further details from their medical directors regarding this question, but we've been given no indication that the coverage for compression supplies would be any different than that of any other medical supplies covered under Part B.

27. Will facilities be compensated if the garment is supplied while the patient is in a skilled nursing facility, long term acute care, or inpatient rehabilitation?

Like the previous question, this is an area in which we need to gather more information, but we've been given no indication that the coverage for compression supplies would be any different than that of any other medical supplies covered under Part B. CMS has stated that for patients in a SNF, suppliers must provide proof of delivery documentation from the nursing facility demonstrating receipt and/or usage of item(s) by the beneficiary and that quantities delivered and used must justify the quantity billed.

28. What if I need to replace my garments sooner than what is allowed, or want to get more at one time than what is allowed?

Medicare will cover compression sooner to replace lost, stolen, or irreparably damaged items or if a patient's condition changes, like a change in limb size. As it is with coverage for any item or service under any insurance policy, there is always an appeals process whereby patients can seek exceptions.

29. What if Medicare is unwilling to cover everything that I need, or all types of compression products currently on the market?

Just as with question #28, the appeals process is always an option for dealing with situations like this on a case-by-case basis. However, if broad gaps in coverage remain after the initial implementation of the LTA our group will continue to work with CMS to try and remedy that. Should that occur, continued involvement for all advocates will be important, and as always, we will let advocates know how they can assist. Lymphedema treatment is complex and varied, and there is not a one-size-fits-all approach. Despite everyone's best efforts (including that of Medicare officials) it is possible continued work will be needed, especially during the first year coverage is in effect, to make adjustments and improvements. The important thing to remember is, there are procedures in place for making annual adjustments. The need for this could also come into play if a new compression product is developed, to ensure that it is added to coverage.

30. What if Medicare incorrectly denies the claim, is the provider then able to bill the patient?

Vendors, providers, and patients will be subject to the same protocols and rules as any other medical supply covered under Part B. Since coverage will exist, it is unlikely that an Advance Beneficiary Notice of Noncoverage (ABN) would be applicable. Without an ABN, the provider would not be able to bill a patient.

31. What if new compression products are developed that are different from the choices available today - will they be covered?

If they are not considered experimental and have been proven effective, then yes! The clause "other items determined by the Secretary" in the LTA is what ensures this flexibility.

32. What can be done if a non-Medicare insurance plan still fails to cover compression garments and supplies after the Medicare coverage has gone into effect?

Visit the Take Action page of our website for information and templates for contacting non-Medicare insurance plans.

33. What can I do to help after the LTA is implemented? Many lymphedema patients will not know about the LTA and how its provisions affect them. Would a longer-term public education campaign be possible to spread the word among providers, patients, insurers, etc.?

There will definitely be work such as this to do even after the coverage goes into effect. The best way to stay informed on all of the Lymphedema Advocacy Group's efforts and how you can help is to subscribe to our newsletter.

34. Will any new diagnosis or billing codes be added as part of implementing the LTA?

No new diagnosis codes were created for the new coverage. As stated in question #4 CMS lists the following diagnosis codes in the final rule:

- Lymphedema, not elsewhere classified (I89.0)
- Hereditary Lymphedema (Q82.0)
- Postmastectomy Lymphedema Syndrome (I97.2)

- Other postprocedural complications and disorders of the circulatory system, not elsewhere classified (I97.89)

Several new HCPCS codes were created for compression treatment products. For the full list of HCPCS click here.

35. **Will any credentialed Medicare provider be able to bill for lymphedema compression supplies, especially bandaging supplies applied during therapy, or will only Medicare participating DMEPOS vendors be able to bill for compression supplies?**

    You must be an enrolled DMEPOS supplier to get Medicare payment for furnishing these treatment items. To become a DMEPOS supplier click here.

    If you're enrolling in Medicare for the first time to supply lymphedema compression treatment items, submit a letter stating this with your application. We're working on updating the CMS 855S to include these items. Medicare provider and supplier enrollment inquiries may contact CMS - Frank Whelan (410) 786–1302

36. **Will there be a way to submit the bill directly to Medicare for reimbursement if my provider is not enrolled in Medicare?**

    No, a supplier must submit the claim to Medicare for the patient.

37. **Where can I read the Public Comments on the Proposed Rule, which influenced the Final Rule?**

    The 2024 Home Health Prospective Payment System Rate Update and Public Comments can be viewed here. You can read the Public Comments submitted by the Lymphedema Advocacy Group by clicking here.