Patient Information

Insurance Coverage for Lymphedema Compression Garments and Supplies

What Is the Lymphedema Treatment Act and What Does It Mean for You?

The Lymphedema Treatment Act (LTA) is a law that expanded Medicare coverage to include compression garments and supplies for people with lymphedema. If you have Medicare, this means you now qualify for coverage of these essential items, helping reduce out-of-pocket costs. The information here applies to traditional Medicare, but many other insurance plans tend to follow Medicare's lead—so it's worth checking with your provider to see what's covered.

The official Medicare page for the new coverage can be found at go.cms.gov/48PxTKf.

Compression Supplies Covered

- Custom and standard-fit daytime and nighttime garments.
- Custom and standard-fit gradient compression wraps with adjustable straps.
- Bandaging supplies for the initial and ongoing phases of treatment.
- Accessories including but not limited to lining, padding, zippers, donning and doffing aids.

Requirements for Coverage

- A lymphedema diagnosis, applicable codes are:

  Q82.0 Hereditary lymphedema

  I89.0 Lymphedema, not elsewhere classified

  I97.2 Postmastectomy lymphedema syndrome

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

- A prescription for the item or items.
- Clinical notes must include the stage of lymphedema, and if a custom garment is ordered, notes must indicate why a standard-fit garment is not indicated for the patient.

Quantities Covered

- **Daytime Garments**
  3 sets (one garment for each affected body part) every six months.
- **Nighttime Garments**
  2 sets (one garment for each affected body part) every two years.
- **Bandaging Supplies**
  No set limit.
- **Accessories**
  No set limit, determined on a case-by-case basis depending on needs of the patient.

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What will my out-of-pocket costs be?

Traditional Medicare covers compression supplies under Part B, so the annual Part B deductible and 20% coinsurance apply. If you have a secondary or supplemental plan, it should cover the 20%. Out-of-pocket costs for Medicare Advantage and all other types of insurance will vary depending on the specific terms of the plan. They will likely be subject to the same copays and deductibles as other supplies covered under the DMEPOS (Durable Medical Equipment, Prosthetic, and Orthotic Supplies) section of the policy.

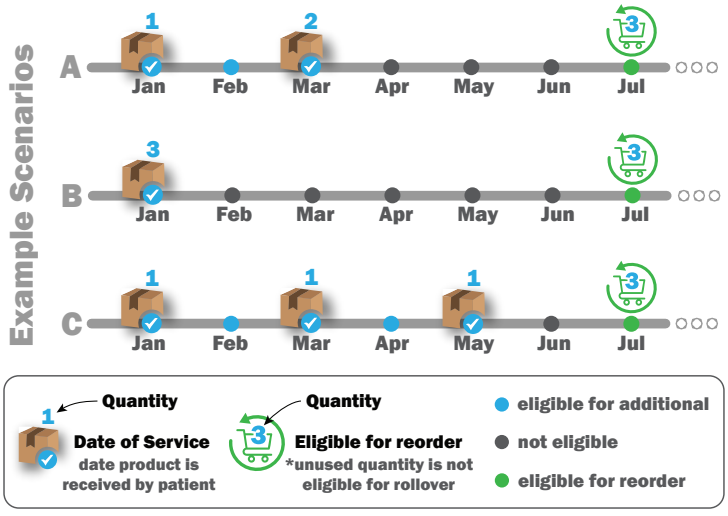
Where can I purchase my compression supplies?

Use our **Supplier Directory** to help locate suppliers who may meet your needs. **lymphedemaproject.org/find-a-supplier/**

In order to maximize the insurance benefits available to you and minimize your out of pocket costs, make sure to use an in-network supplier. Note that there are two categories of Medicare suppliers. Those who accept claims "on-assignment" can only charge the Medicare approved amounts. Those who accept claims as "non-participating" may bill more than the Medicare approved amount, and pass that additional amount onto the patient.

When can I reorder my lymphedema compression supplies?

As illustrated by the graphic below, you can reorder one, two, or all three sets once you have reached six months from the delivery date of your first set.



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This information does not constitute legal or billing advice. DME suppliers are responsible for following appropriate and accurate billing practices.

What can I do if the compression supplies I need are denied?

If your insurance plan isn't covering the supplies you need please vist our **Take Action** page for further instructions.

We recommend appealing every insurance denial. Many patients win their appeals. Further, the documentation of denials can help guide future policy changes. If you choose to appeal a denial, follow the procedures outlined in your insurance plan. We also recommend that you enlist the help of other departments and agencies as appropriate. If you have employer-based insurance, especially a self-funded plan, contact your HR representative. If you have private or state-based plans, contact your state's insurance department to file a complaint and request assistance with your appeal. If you have Medicare or a Medicare Advantage plan, contact your House and/or Senate congressional offices, which have case workers to assist constituents.