Medicare Advantage Coverage for Lymphedema Compression Garments and Supplies

---

Does the Lymphedema Treatment Act apply to Medicare Advantage (MA) Plans?

Yes! MA plans are required to provide coverage for all items and services covered by Original Medicare; however, the terms of the coverage can differ. This means that as of January 1, 2024, MA plans must cover all types of standard-fit and custom-fit daytime and nighttime compression garments, as well as bandaging supplies, but details such as how many garments you can get at once, whether or not a prior authorization is required, what suppliers are in-network, and your out-of-pocket costs will differ based on the particular MA plan.

What if my MA plan is unaware of the new coverage requirements and/or codes?

All details related to the new coverage requirements can be found on Medicare's Lymphedema Compression Treatment Items page or by entering "lymphedema" into the search box at CMS.gov. Additionally, the DME Medicare Administrative Contractor (MAC) published billing, coding, and coverage guidelines on their Lymphedema Compression Treatment page.

What if my MA plan is denying my claim or failing to process my claim in a timely manner?

Every MA plan must enter into a contract with the Centers for Medicare and Medicaid Services (CMS). The contract must meet the requirements stated in 42 CFR 522.520(a). Further, the MA organization must comply with the prompt payment provisions of § 422.520. Generally, claims from contracted providers and suppliers must be paid within 30 days, and claims from non-contracted providers and suppliers must be paid within 60 days. If a plan is violating these coverage or payment requirements the provider/supplier should file a complaint and notify CMS. Please also report any denials or failure to process claims through our Denial Reporting Form. Patients are encouraged to reach out to their provider/supplier, as they might have additional insight into the denial or delay in payment. There may be a valid reason for the delay, such as a request for medical records, which will often delay the timeframe for payment as the MA plan must receive and review the records before a payment determination can be made.

What if my MA plan does not have any in-network supplier who sells the compression garments or compression bandaging supplies that I have been prescribed?

The Code of Federal Regulations (42 CFR 422.112(a)(1(iii)) explicitly requires MA plans to maintain and monitor a network of appropriate providers/suppliers that is supported by written agreements and is sufficient to provide adequate access to covered services to meet the needs of the population served. They must also arrange for and cover any medically necessary covered benefit outside of the plan's provider network, but at in-network cost sharing, when an in-network provider or benefit is unavailable or inadequate to meet an enrollee's medical needs. For additional details please see the MA Payment Guide for Out of Network Payments and Payment Dispute Resolutions pages.