Frequently Asked Questions

Last Update - 2/16/2023

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.

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 Appropriation 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. **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.

3. **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.

4. **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.

5. **When will coverage begin?**

   Medicare coverage will begin 1/1/2024 - it was not possible to have a sooner effective date, because a minimum of one year to implement the coverage was required by the Medicare program.

6. **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.

7. **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.

8. **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.

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

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

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

    It is our expectation that compression garments will be covered for all parts of the body.

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

    That is our expectation.

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

    That is our expectation, however, this is an area in which our continued advocacy will be very important. It was impossible for every type of compression supply to be named in the bill/law, and could have had unintended negative consequences if an item now or in the future did not match the wording, and was therefore excluded. In order to ensure that a benefit category was created that was flexible enough to cover all current compression supplies and any future types of compression supplies, the bill/law defines lymphedema compression treatment items as "standard and custom fitted gradient compression garments and other items determined by the Secretary." The clause "other items determined by the Secretary" is what ensures this flexibility, both now and in the future.

13. **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.

14. **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.

15. **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.

16. **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.

17. **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.

18. **Will I need a prescription?**

    You will need a prescription (in addition to a lymphedema diagnosis) in order to be eligible for coverage.

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

    It is unlikely that Medicare would impose this requirement.

20. **Will there be criteria that must be met in order to receive custom-fit versus standard-fit garments?**

    Possibly. This is one of the many important details that will be determined as Medicare implements the coverage.

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

    It will likely be two garments at one time (or two sets of garments, if your treatment requires more than one piece) replaced every 6 months. This is the precedent established by policies that already cover compression garments, however, this is one of the many important details that will be determined as Medicare implements the coverage. Further, some items (night garments, low-stretch velcro garments, etc.) have longer life spans, and therefore different allowable quantities or replacement frequencies may be established for these products.

22. 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%. 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.

23. Will there be an insurance cap on lymphedema compression supplies?

That is unlikely, but not yet known.

24. Will insurance companies make you jump through hoops to get this coverage?

Most insurance providers have prerequisites for coverage of certain items. The prerequisites for Medicare beneficiaries, as established by the LTA, are a lymphedema diagnosis and prescription. It is not yet known if any additional prerequisites will be imposed as Medicare implements the coverage.

25. Will there be any retroactive coverage? In other words, could I buy a compression garment in 2023 and submit it for reimbursement in 2024?

No, there will be no retroactive coverage.

26. 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.

27. 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?

This is yet to be determined, and is an area in which our continued advocacy will be very important. A lower reimbursement rates means lower out of pocket costs for patients (see the answer to question #22), however, if the rates are too low some suppliers may choose to not sell compression garments, and this in turn could result in access issues in areas where there are insufficient suppliers. This is a problem that currently exists in some areas due to private insurance companies setting reimbursement rates that are too low.

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

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.

29. 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.

30. 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?

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.

31. If an item that can be refurbished (for example, a Reid Sleeve) will Medicare cover refurbishment?

If refurbishment is more cost-effective than replacement it is likely that Medicare would deem that coverable, but this is a detail yet to be established.

32. 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 #30, 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.

33. 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.

34. 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.

35. **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?**

    There are many other steps that can be taken to remedy this if the need arises, and we will share information on how to pursue those actions if necessary.

36. **What is involved with the CMS process and timeline, and what can I do to help in this process of implementing the LTA?**

    We are still in the process of determining how advocates from all aspects - patients, clinicians, industry members, and other stakeholders and groups - can engage in this process. Please subscribe to our newsletter if you haven't yet. Through those communications we will keep everyone informed on next steps, timing, how you can help, etc.

37. **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. As with question #36, 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.

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

    That is not known yet, but more codes would be helpful, so if CMS is not able to consider adding additional codes as part of the LTA implementation process then we our group may pursue that separately.

39. **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?**

    This is not known yet and is something that will need to be determined this year.

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

    Yes, you can file a claim directly with Medicare for the following reasons: your provider or supplier isn't able to file the claim, your provider or supplier refuses to file the claim, and/or your provider or supplier isn't enrolled in Medicare. Information on how to file a claim and the required documents can be found on the Medicare website.

41. **What is the Public Comment Period, why is it important, and can I participate?**

    Whenever there is new coverage or significant changes to existing coverage the Centers for Medicare and Medicaid Services (CMS) is required to offer a Public Comment Period. There will be a Public Comment Period for the Lymphedema Treatment Act, likely mid-year during the summer months, and this will be an important opportunity for all stakeholders and advocates to take action! Just prior to the comment period, CMS will release preliminary rules related to the coverage (like how many garments each patient can get at one time, how often they can be replaced, etc.), then the public will have 60 days to comment on those proposed rules, after which CMS may decide to make changes. If there is

anything we don't like about the initial proposals, or wish were better, the public comment period is our opportunity to try and convince them to modify those things before the rules are finalized. Everyone will be encouraged to participate when this opportunity becomes available. You can learn more about the Rulemaking Process and Public Comment Periods here.