

## L - Medicare Advantage Coverage Requirements (NOV 2025)

**Bottom line up front: Medicare Advantage (MA) Plans ARE required to cover the same things that traditional Medicare covers.** So, for example, a MA plan should not be able to exclude RevoFit® (covered under L5783 and L7406) as a “non-covered” device. Traditional Medicare recognizes the technology as covered as outlined in the Lower Limb Prostheses LCD and Policy Article (A52496) for Lower Extremity Prostheses, which names RevoFit the predicate product for HCPCS code L5783. As well Upper Extremity coding was approved for activation on April 1, 2025 ([HERE](#)):

The key question, practically speaking, is what can a customer facing such a denial do?

1. Customers should notify MA insurers that denials like those described above are inconsistent with the explicit directive of CMS. They should reference the following regulation: *Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly*.
2. Customers should cite the following from the above-referenced rule when appealing denials of covered Medicare prosthetic benefits:
  - “CMS regulations at § 422.101(a) and (b) **require that MA plans provide coverage of all basic benefits** (that is, services covered under Medicare Parts A and B, except hospice care and the cost of kidney acquisitions for transplant) and that **MA plans must comply with Traditional Medicare national coverage determinations (NCDs) and local coverage determinations (LCDs)** applicable in the MA plan’s service area.” [emphasis added] (p. 66 of *Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly*)
  - “[In April 2022, the Office of the Inspector General (OIG) released a report.] ... The OIG found that **some prior authorization requests were denied by MA plans, even though the requested services met Traditional Medicare coverage guidelines.**” [emphasis added] (pp. 66-67)
  - “**As originally stated in the June 2000 final rule (65 FR 40207), MA organizations must cover all Part A and B benefits**, excluding hospice services and the cost of kidney acquisitions for transplant, **on the same conditions that items and services are furnished in Traditional Medicare.** This means that MA organizations may not limit coverage through the adoption of policies and procedures—whether those policies and procedures are called utilization management and prior authorization or the standards and criteria that the MA organization uses to assess and evaluate medical necessity— when those policies and procedures result in denials of coverage or payment where the Traditional Medicare program would cover and pay for the item or service furnished to the beneficiary. [emphasis added] (p. 67)
  - Medicare has a “longstanding policy that MA organizations **may only apply coverage criteria that are no more restrictive than Traditional Medicare coverage criteria found in NCDs, LCDs, and Medicare laws.**” (p. 70).