

Pneumatic Compression Devices

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[Instructions for Use](#)

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Related Commercial Policy
<ul style="list-style-type: none"> Durable Medical Equipment, Orthotics, Ostomy Supplies, Medical Supplies and Repairs/Replacements
Community Plan Policy
<ul style="list-style-type: none"> Pneumatic Compression Devices

Coverage Rationale

Pneumatic compression devices are proven and medically necessary in certain circumstances. For medical necessity clinical coverage criteria, see MCG™ Care Guidelines, 24th edition, 2020, Intermittent Pneumatic Compression with Extremity Pump ACG: ACG: A-0340 (AC).

Click [here](#) to view the MCG™ Care Guidelines.

Refer to the [Applicable Codes](#) section of this policy for more information regarding the review of HCPCS code E0652 (pneumatic compressor, segmental home model with calibrated gradient pressure).

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Note: Refer to the Coverage Determination Guideline titled [Durable Medical Equipment, Orthotics, Ostomy Supplies, Medical Supplies and Repairs/Replacements](#) for information regarding HCPCS code E0652 (pneumatic compressor, segmental home model with calibrated gradient pressure).

HCPCS Code	Description
A4600	Sleeve for intermittent limb compression device, replacement only, each
E0650	Pneumatic compressor, nonsegmental home model
E0651	Pneumatic compressor, segmental home model without calibrated gradient pressure
E0655	Nonsegmental pneumatic appliance for use with pneumatic compressor, half arm
E0660	Nonsegmental pneumatic appliance for use with pneumatic compressor, full leg
E0665	Nonsegmental pneumatic appliance for use with pneumatic compressor, full arm
E0666	Nonsegmental pneumatic appliance for use with pneumatic compressor, half leg

HCPCS Code	Description
E0667	Segmental pneumatic appliance for use with pneumatic compressor, full leg
E0668	Segmental pneumatic appliance for use with pneumatic compressor, full arm
E0669	Segmental pneumatic appliance for use with pneumatic compressor, half leg
E0670	Segmental pneumatic appliance for use with pneumatic compressor, integrated, two full legs and trunk
E0671	Segmental gradient pressure pneumatic appliance, full leg
E0672	Segmental gradient pressure pneumatic appliance, full arm
E0673	Segmental gradient pressure pneumatic appliance, half leg
E0675	Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency (unilateral or bilateral system)
E0676	Intermittent limb compression device (includes all accessories), not otherwise specified

U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

Devices and systems to perform pneumatic compression are regulated by the FDA as Class II devices. See the following website for more information (use product code JOW):

<http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmnm.cfm>. (Accessed January 13, 2020)

Centers for Medicare and Medicaid Services (CMS)

Medicare does cover pneumatic compression devices when criteria are met. Refer to the National Coverage Determination (NCD) for [Pneumatic Compression Devices \(280.6\)](#). Also see the Local Coverage Determinations (LCDs) for [Pneumatic Compression Devices](#). (Accessed January 13, 2020)

Policy History/Revision Information

Date	Summary of Changes
08/01/2020	Template Update <ul style="list-style-type: none"> Reformatted policy; transferred content to new template
04/01/2020	Coverage Rationale <ul style="list-style-type: none"> Replaced reference to "MCG™ Care Guidelines, 23rd edition, 2019" with "MCG™ Care Guidelines, 24th edition, 2020" Supporting Information <ul style="list-style-type: none"> Archived previous policy version 2019T0563I

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

This Medical Policy may also be applied to Medicare Advantage plans in certain instances. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence ([Medicare IOM Pub. No. 100-16, Ch. 4, §90.5](#)).

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.