Pneumatic Compression Devices (NCD 280.6)

Guideline Number: MPG251.09
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Terms and Conditions

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Policy Summary

See Purpose

Overview

Pneumatic compression devices (PCD) consist of an inflatable garment for the arm or leg and an electrical pneumatic pump that fills the garment with compressed air. The garment is intermittently inflated and deflated with cycle times and pressures that vary between devices.

Guidelines

Pneumatic devices are covered for the treatment of lymphedema or for the treatment of chronic venous insufficiency with venous stasis ulcers.

Lymphedema

Lymphedema is the swelling of subcutaneous tissues due to the accumulation of excessive lymph fluid. The accumulation of lymph fluid results from impairment to the normal clearing function of the lymphatic system and/or from an excessive production of lymph. Lymphedema is divided into two broad classes according to etiology. Primary lymphedema is a relatively uncommon, chronic condition which may be due to such causes as Milroy's Disease or congenital anomalies. Secondary lymphedema, which is much more common, results from the destruction of or damage to formerly functioning lymphatic channels, such as surgical removal of lymph nodes or post radiation fibrosis, among other causes.

Pneumatic compression devices are covered in the home setting for the treatment of lymphedema if the patient has undergone a four-week trial of conservative therapy and the treating physician determines that there has been no significant improvement

or if significant symptoms remain after the trial. The trial of conservative therapy must include use of an appropriate compression bandage system or compression garment, exercise, and elevation of the limb. The garment may be prefabricated or custom-fabricated but must provide adequate graduated compression.

Chronic Venous Insufficiency with Venous Stasis Ulcers

Chronic venous insufficiency (CVI) of the lower extremities is a condition caused by abnormalities of the venous wall and valves, leading to obstruction or reflux of blood flow in the veins. Signs of CVI include hyperpigmentation, stasis dermatitis, chronic edema, and venous ulcers. Pneumatic compression devices are covered in the home setting for the treatment of CVI of the lower extremities only if the patient has one or more venous stasis ulcer(s) which have failed to heal after a 6 month trial of conservative therapy directed by the treating physician. The trial of conservative therapy must include a compression bandage system or compression garment, appropriate dressings for the wound, exercise, and elevation of the limb.

General Coverage Criteria

Pneumatic compression devices are covered only when prescribed by a physician and when they are used with appropriate physician oversight, i.e., physician evaluation of the patient's condition to determine medical necessity of the device, assuring suitable instruction in the operation of the machine, a treatment plan defining the pressure to be used and the frequency and duration of use, and ongoing monitoring of use and response to treatment.

The determination by the physician of the medical necessity of a pneumatic compression device must include:

- The patient's diagnosis and prognosis;
- Symptoms and objective findings, including measurements which establish the severity of the condition;
- The reason the device is required, including the treatments which have been tried and failed; and
- The clinical response to an initial treatment with the device.

The clinical response includes the change in pre-treatment measurements, ability to tolerate the treatment session and parameters, and ability of the patient (or caregiver) to apply the device for continued use in the home.

A segmented, calibrated gradient pneumatic compression device (HCPCS code E0652) is only covered when the individual has unique characteristics that prevent them from receiving satisfactory pneumatic compression treatment using a non-segmented device along with a segmented appliance or a segmented compression device without manual control of pressure in each chamber. The only “unique characteristics” identified in the clinical literature that requires the use of an E0652 device is lymphedema extending onto the chest, trunk and/or abdomen which has remained unresponsive to all other therapies. A PCD coded as E0652 is not covered for the treatment of lymphedema of the extremities alone even if the criteria for lymphedema are met. A PCD coded as E0652 is not covered for the treatment of CVI even if the criteria for CVI with venous stasis ulcers are met. Claims will be denied as not reasonable and necessary. Refer to the sections in the Pneumatic Compression Devices LCD (L33829) on Lymphedema Extending Onto the Chest, Trunk and/or Abdomen and PCD Code Selection for additional information about the limited coverage for PCD coded as E0652.

Deep Venous Thrombosis Prevention

A pneumatic compression device coded as E0676 is used only for prevention of venous thrombosis. An E0676 is a PCD that delivers pressure and inflation/deflation cycles for the prevention of DVT. A PCD that provides intermittent limb compression for the purpose of prevention of venous thromboembolism (E0676) is a preventive service. Items that are used for a preventative service or function are excluded from coverage under the Medicare DME benefit. Therefore, claims for E0676 will be statutorily denied as no Medicare benefit. HCPCS code A4600 (replacement sleeve for intermittent limb compression device) is used only when the appliance used with an E0676 device is being replaced.

Peripheral Artery Disease (PAD)

A PCD coded as E0675 is used only for peripheral artery disease. Other PCD codes are not used for this condition. A PCD coded as E0675 to treat PAD is not eligible for reimbursement. There is insufficient evidence to demonstrate that reimbursement is justified. Claims for E0675 will be denied as not reasonable and necessary.

Documentation Requirements – General

There are numerous CMS manual requirements, reasonable and necessary requirements, benefit category, and other statutory and regulatory requirements that must be met in order for payment to be justified. In the event of a claim review, a DMEPOS supplier must provide sufficient information to demonstrate that the applicable criteria have been met thus justifying payment. Refer to the LCD, NCD or other CMS Manuals for more information on what documents may be required.

See Article A55426 Standard Documentation Requirements for All Claims Submitted to DME MACs.

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 guideline 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.

HCPCS Code	Description
A4600	Sleeve for intermittent limb compression device, replacement only, each (Non-Covered; See the Medicare Advantage Coverage Summary titled Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics), Nutritional Therapy and Medical Supplies Grid)
E0650	Pneumatic compressor, non-segmental home model
E0651	Pneumatic compressor, segmental home model without calibrated gradient pressure
E0652	Pneumatic compressor, segmental home model with calibrated gradient pressure
E0655	Non-segmental pneumatic appliance for use with pneumatic compressor, half arm
E0656	Segmental pneumatic appliance for use with pneumatic compressor, trunk
E0657	Segmental pneumatic appliance for use with pneumatic compressor, chest
E0660	Non-segmental pneumatic appliance for use with pneumatic compressor, full leg
E0665	Non-segmental pneumatic appliance for use with pneumatic compressor, full arm
E0666	Non-segmental pneumatic appliance for use with pneumatic compressor, half leg
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, 2 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) (Non-Covered; See the Medicare Advantage Coverage Summary titled Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics), Nutritional Therapy and Medical Supplies Grid)
E0676	Intermittent limb compression device (includes all accessories), not otherwise specified (Non-Covered; See the Medicare Advantage Coverage Summary titled Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics), Nutritional Therapy and Medical Supplies Grid)

Diagnosis Code	Description
I83.011	Varicose veins of right lower extremity with ulcer of thigh
I83.012	Varicose veins of right lower extremity with ulcer of calf
I83.013	Varicose veins of right lower extremity with ulcer of ankle

Diagnosis Code	Description
I83.014	Varicose veins of right lower extremity with ulcer of heel and midfoot
I83.015	Varicose veins of right lower extremity with ulcer other part of foot
I83.018	Varicose veins of right lower extremity with ulcer other part of lower leg
I83.019	Varicose veins of right lower extremity with ulcer of unspecified site
I83.021	Varicose veins of left lower extremity with ulcer of thigh
I83.022	Varicose veins of left lower extremity with ulcer of calf
I83.023	Varicose veins of left lower extremity with ulcer of ankle
I83.024	Varicose veins of left lower extremity with ulcer of heel and midfoot
I83.025	Varicose veins of left lower extremity with ulcer other part of foot
I83.028	Varicose veins of left lower extremity with ulcer other part of lower leg
I83.029	Varicose veins of left lower extremity with ulcer of unspecified site
I83.211	Varicose veins of right lower extremity with both ulcer of thigh and inflammation
I83.212	Varicose veins of right lower extremity with both ulcer of calf and inflammation
I83.213	Varicose veins of right lower extremity with both ulcer of ankle and inflammation
I83.214	Varicose veins of right lower extremity with both ulcer of heel and midfoot and inflammation
I83.215	Varicose veins of right lower extremity with both ulcer other part of foot and inflammation
I83.218	Varicose veins of right lower extremity with both ulcer of other part of lower extremity and inflammation
I83.219	Varicose veins of right lower extremity with both ulcer of unspecified site and inflammation
I83.221	Varicose veins of left lower extremity with both ulcer of thigh and inflammation
I83.222	Varicose veins of left lower extremity with both ulcer of calf and inflammation
I83.223	Varicose veins of left lower extremity with both ulcer of ankle and inflammation
I83.224	Varicose veins of left lower extremity with both ulcer of heel and midfoot and inflammation
I83.225	Varicose veins of left lower extremity with both ulcer other part of foot and inflammation
I83.228	Varicose veins of left lower extremity with both ulcer of other part of lower extremity and inflammation
I83.229	Varicose veins of left lower extremity with both ulcer of unspecified site and inflammation
I87.311	Chronic venous hypertension (idiopathic) with ulcer of right lower extremity
I87.312	Chronic venous hypertension (idiopathic) with ulcer of left lower extremity
I87.313	Chronic venous hypertension (idiopathic) with ulcer of bilateral lower extremity
I87.331	Chronic venous hypertension (idiopathic) with ulcer and inflammation of right lower extremity
I87.332	Chronic venous hypertension (idiopathic) with ulcer and inflammation of left lower extremity
I87.333	Chronic venous hypertension (idiopathic) with ulcer and inflammation of bilateral lower extremity
I89.0	Lymphedema, not elsewhere classified
I97.2	Postmastectomy lymphedema syndrome
Q82.0	Hereditary lymphedema

References

CMS National Coverage Determinations (NCDs)

NCD 280.6 Pneumatic Compression Devices
Reference NCD: NCD 280.1 Durable Medical Equipment Reference List

CMS Local Coverage Determinations (LCDs) and Articles

LCD	Article	Contractor	DME MAC
L33829 Pneumatic Compression Devices	A52488 Pneumatic Compression Devices	CGS	AL, AR, CO, FL, GA, IL, IN, KY, LA, MI, MN, MS, NC, NM, OH, OK, PR, SC, TN, TX, VA, VI, WI, WV
	A55426 Standard Documentation Requirements for All Claims Submitted to DME MACs	Noridian	AK, AS, AZ, CA, CT, DC, DE, GU, HI, IA, ID, KS, MA, MD, ME, MO, MP, MT, ND, NE, NH, NJ, NV, NY, OR, PA, RI, SD, UT, VT, WA, WY

CMS Benefit Policy Manual

Chapter 15; § 110 Durable Medical Equipment-General
Chapter 16; §20 Services Not Reasonable and Necessary

CMS Claims Processing Manual

Chapter 20; § 10.1.1 Durable Medical Equipment (DME)

CMS Transmittal(s)

Transmittal 623, Change Request 9364, Dated November 3, 2015 (Written Orders Prior to Delivery (WOPD))

MLN Matters

Article SE20007, Standard Elements for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Order, and Master List of DMEPOS Items Potentially Subject to a Face-to-Face Encounter and Written Orders Prior to Delivery and, or Prior Authorization Requirements

UnitedHealthcare Commercial Policy

Pneumatic Compression Devices

Others

Certificate of Medical Necessity CMS 846 Pneumatic Compression Devices
CMS DMEPOS Fee Schedules
CMS HCPCS Application Summaries and Coding Recommendations: Second Biannual, 2021 HCPCS Coding Cycle
Code of Federal Regulations Title 42 § 410.38 Durable medical equipment: Scope and conditions
Federal Register Vol. 84, No. 217, November 8, 2019 Rules and Regulations (DMEPOS Face-to-Face Encounter Requirements)
Medicare Program Integrity Manual, Chapter 5 Items and Services Having Special DME Review Considerations; § 5.2.5 Face-to-Face Encounter Requirements

Guideline History/Revision Information

Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

Date	Summary of Changes
03/09/2022	Policy Summary *General Coverage Criteria* • Added language to indicate: ○ The only "unique characteristics" identified in the clinical literature that require the use of HCPCS code E0652 device is lymphedema extending onto the chest, trunk and/or abdomen which has remained unresponsive to all other therapies

Date	Summary of Changes
	▪ A pneumatic compression device (PCD) coded as HCPCS code E0652 is not covered for the treatment of lymphedema of the extremities alone even if the criteria for lymphedema are met ▪ A PCD coded as HCPCS code E0652 is not covered for the treatment of chronic venous insufficiency (CVI) even if the criteria for CVI with venous stasis ulcers are met; claims will be denied as not reasonable and necessary ○ Refer to the sections in the Pneumatic Compression Devices Local Coverage Determination (LCD) (L33829) for *Lymphedema Extending Onto the Chest, Trunk and/or Abdomen* and *PCD Code Selection* for additional information about the limited coverage for PCD coded as HCPCS code E0652 ● Replaced language indicating "a segmented, calibrated gradient pneumatic compression device (HCPCS code E0652) is only covered when the individual has unique characteristics that prevent them from receiving satisfactory pneumatic compression treatment using a non-segmented device along with appliance or a segmented compression device without manual control of pressure in each chamber" with "a segmented, calibrated gradient pneumatic compression device (HCPCS code E0652) is only covered when the individual has unique characteristics that prevent them from receiving satisfactory pneumatic compression treatment using a non-segmented device along with appliance or *a segmented* compression device without manual control of pressure in each chamber" ● Relocated language addressing Medicare coverage rules for PCDs that provide intermittent limb compression (see section titled *Deep Venous Thrombosis Prevention*) *Deep Venous Thrombosis Prevention* ● Added language to indicate: ○ A pneumatic compression device coded as HCPCS code E0676 is used only for prevention of venous thrombosis ▪ HCPCS code E0676 is a PCD that delivers pressure and inflation/deflation cycles for the prevention of deep vein thrombosis (DVT) ▪ A PCD that provides intermittent limb compression for the purpose of prevention of venous thromboembolism (HCPCS code E0676) is a preventive service ▪ Items that are used for a preventative service or function are excluded from coverage under the Medicare DME benefit ▪ Claims for HCPCS code E0676 will be statutorily denied as no Medicare benefit ○ HCPCS code A4600 (replacement sleeve for intermittent limb compression device) is used only when the appliance used with an E0676 device is being replaced *Peripheral Artery Disease (PAD) (new to policy)* ● Added language to indicate: ○ A PCD coded as HCPCS E0675 is used only for peripheral artery disease; other PCD codes are not used for this condition ○ A PCD coded as HCPCS E0675 to treat PAD is not eligible for reimbursement ▪ There is insufficient evidence to demonstrate that reimbursement is justified ▪ Claims for HCPCS E0675 will be denied as not reasonable and necessary *Durable Medical Equipment (DME) Face-to-Face Encounter Requirements* ● Removed content/language pertaining to face-to-face encounter requirements *Documentation Requirements (new to policy)* ● Added language to indicate: ○ There are numerous Centers for Medicare & Medicaid (CMS) manual requirements, reasonable and necessary requirements, benefit category, and other statutory and regulatory requirements that must be met in order for payment to be justified ○ In the event of a claim review, a DMEPOS supplier must provide sufficient information to demonstrate that the applicable criteria have been met thus justifying payment ○ Refer to the Local Coverage Determination (LCD), National Coverage Determination (NCD) or other CMS Manuals for more information on what documents may be required

Date	Summary of Changes
	○ See the Local Coverage Article (LCA) titled *Standard Documentation Requirements for All Claims Submitted to DME MACs (A55426)* **Applicable Codes** • Removed CPT code 91999 • Updated notation pertaining to HCPCS code E0675 to indicate this code is "non-covered" **Supporting Information** • Updated *References* section to reflect the most current information • Archived previous policy version MPG251.08

Purpose

The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers' submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:

- Medicare coding or billing requirements, and/or
- Medical necessity coverage guidelines; including documentation requirements.

UnitedHealthcare follows Medicare guidelines such as NCDs, LCDs, LCAs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the References section below to view the Medicare source materials used to develop this resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

Terms and Conditions

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

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 member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of publication and is provided on an "AS IS" basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage Policy Guidelines use Current Procedural Terminology (CPT®), Centers for Medicare and

Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

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*For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the Administrative Guide.