

# PNEUMATIC COMPRESSION DEVICES

**Policy Number:** DME 037.8 T2

**Effective Date:** October 1, 2018

Table of Contents	Page
<a href="#">INSTRUCTIONS FOR USE</a> .....	1
<a href="#">CONDITIONS OF COVERAGE</a> .....	1
<a href="#">BENEFIT CONSIDERATIONS</a> .....	1
<a href="#">COVERAGE RATIONALE</a> .....	2
<a href="#">APPLICABLE CODES</a> .....	2
<a href="#">U.S. FOOD AND DRUG ADMINISTRATION</a> .....	2
<a href="#">POLICY HISTORY/REVISION INFORMATION</a> .....	3

## Related Policy

- [Durable Medical Equipment, Orthotics, Ostomy Supplies, Medical Supplies, and Repairs/Replacements](#)

## INSTRUCTIONS FOR USE

This Clinical Policy provides assistance in interpreting Oxford benefit plans. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members. Oxford reserves the right, in its sole discretion, to modify its policies as necessary. This Clinical Policy is provided for informational purposes. It does not constitute medical advice. The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies.

When deciding coverage, the member specific benefit plan document must be referenced. The terms of the member specific benefit plan document [e.g., Certificate of Coverage (COC), Schedule of Benefits (SOB), and/or Summary Plan Description (SPD)] may differ greatly from the standard benefit plan upon which this Clinical Policy is based. In the event of a conflict, the member specific benefit plan document supersedes this Clinical Policy. All reviewers must first identify member eligibility, any federal or state regulatory requirements, and the member specific benefit plan coverage prior to use of this Clinical Policy. Other Policies may apply.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines 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.

## CONDITIONS OF COVERAGE

Applicable Lines of Business/ Products	This policy applies to Oxford Commercial plan membership.
Benefit Type	DME
Referral Required (Does not apply to non-gatekeeper products)	No
Authorization Required (Precertification always required for inpatient admission)	Yes
Precertification with Medical Director Review Required	Yes <sup>1</sup>
Applicable Site(s) of Service (If site of service is not listed, Medical Director review is required)	All
Special Considerations	<sup>1</sup> Review by a Medical Director and/ or their designee is required.

## BENEFIT CONSIDERATIONS

Before using this policy, please check the member specific benefit plan document and any federal or state mandates, if applicable.

## **Essential Health Benefits for Individual and Small Group**

For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits ("EHBs"). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage for benefits which are deemed EHBs, the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute EHBs is made on a state by state basis. As such, when using this policy, it is important to refer to the member specific benefit plan document to determine benefit coverage.

### **COVERAGE RATIONALE**

#### **Pneumatic compression devices are proven and medically necessary in certain circumstances.**

For medical necessity clinical coverage criteria, see MCG™ Care Guidelines, 22<sup>nd</sup> edition, 2018, Intermittent Pneumatic Compression with Extremity Pump ACG: A-0340 (AC).

[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 may apply.

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
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)
E0676	Intermittent limb compression device (includes all accessories), not otherwise specified

**Note:** Refer to the policy 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).

### **U.S. FOOD AND DRUG ADMINISTRATION (FDA)**

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

<http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmnm.cfm>. (Accessed January 3, 2018)

POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
10/01/2018	<ul style="list-style-type: none"><li>• Updated coverage rationale; modified language to clarify:<ul style="list-style-type: none"><li>○ The listed devices are proven <b>and</b> medically necessary in certain circumstances</li><li>○ See the referenced MCG™ Care Guidelines for <i>medical necessity</i> clinical coverage criteria</li></ul></li><li>• Archived previous policy version DME 037.7 T2</li></ul>