MEDICAL POLICY	Compression: Outpatient Pneumatic Devices (Medicare Only)
Effective Date: 7/1/2022  7/1/2022 Medical Officer Date	Medical Policy Number: 138 Medical Policy Committee Approved Date: 04/2020; 06/2021; 6/2022

See Policy CPT/HCPCS CODE section below for any prior authorization requirements

SCOPE:

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as "Company" and collectively as "Companies").

APPLIES TO:

Medicare only

MEDICARE POLICY CRITERIA

The following Centers for Medicare & Medicaid Service (CMS) guidelines should be utilized for medical necessity coverage determinations. Click the link provided in the table below to access applicable medical necessity criteria. All listed guidelines apply.

Service	Medicare Guidelines
Pneumatic compression devices	*General Coverage Guidance – Specifically when used for lymphedema and chronic venous insufficiency (CVI) with venous stasis ulcers:* • National Coverage Determination (NCD): Pneumatic Compression Devices (280.6) *Additional Coverage Guidance – Includes above coverage information, as well as detailed coverage information for HCPCS code E0652 and additional covered and non-covered situations:* • Local Coverage Determination (LCD): Pneumatic Compression Devices (L33829) **NOTE:** The Company will consider outpatient pneumatic compression devices to treat lymphedema directly caused by a mastectomy to be **medically necessary**. See *Regulatory Status* below.

BILLING GUIDELINES

General

See associated local coverage articles (LCAs) for related billing and coding guidance, as well as additional coverage and non-coverage scenarios and frequency utilization allowances and limitations:

- LCA: Pneumatic Compression Devices - Policy Article (A52488)

HCPCS CODES

Medicare Only	
No Prior Authorization Required Note: Inclusion of a code in this section does not guarantee reimbursement or coverage. The following codes do not require routine review for medical necessity, but they may be subject to audit or benefit denial.	
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
Not Covered	
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

INSTRUCTIONS FOR USE

Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed

annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days notice of policy changes that are restrictive in nature. The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement.

REGULATORY STATUS

Mental Health Parity Statement

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

Women's Health and Cancer Rights Act (WHCRA) of 1998 Statement

The Women's Health and Cancer Rights Act (WHCRA) of 1998 provides protections to individuals who have opted to undergo breast reconstruction in connection with a mastectomy. Under the WHCRA, coverage is provided for all stages of breast reconstruction for both the affected breast (the breast undergoing the mastectomy procedure) and the contralateral breast (for symmetry) and breast prostheses, as well as treatment of complications caused by the mastectomy, such as lymphedema. While the criteria in this policy are primarily based on Medicare guidance, in accordance with the WHCRA, Company coverage may exceed Medicare coverage for items or services required to treat conditions that are the direct result of a mastectomy.