Medicare Medical Policy

Pneumatic Compression Devices

MEDICARE MEDICAL POLICY NUMBER: 138

Effective Date: 7/1/2026

Last Review Date: 6/2026

Next Annual Review: 6/2026

MEDICARE COVERAGE CRITERIA 2
POLICY CROSS REFERENCES 4
POLICY GUIDELINES 4
REGULATORY STATUS 5
BILLING GUIDELINES AND CODING 6
REFERENCES 8
POLICY REVISION HISTORY 8

INSTRUCTIONS FOR USE: Company Medicare Medical Policies serve as guidance for the administration of plan benefits and do not constitute medical advice nor a guarantee of coverage. Company Medicare Medical Policies are reviewed annually to guide the coverage or non-coverage decision-making process for services or procedures in accordance with member benefit contracts (otherwise known as Evidence of Coverage or EOCs) and Centers of Medicare and Medicaid Services (CMS) policies, manuals, and other CMS rules and regulations. In the absence of a CMS coverage determination or specific regulation for a requested service, item or procedure, Company policy criteria or applicable utilization management vendor criteria may be applied. These are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. 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.

The Company reserves the right to determine the application of Medicare Medical Policies and make revisions to these policies at any time. Any conflict or variance between the EOC and Company Medical Policy will be resolved in favor of the EOC.

SCOPE: Providence Health Plan, Providence Health Assurance, and Providence Plan Partners as applicable (referred to individually as “Company” and collectively as “Companies”).

PRODUCT AND BENEFIT APPLICATION

☒ Medicare Only

MEDICARE COVERAGE CRITERIA

IMPORTANT NOTE: More than one Centers for Medicare and Medicaid Services (CMS) reference may apply to the same health care service, such as when more than one coverage policy is available (e.g., both an NCD and LCD exist). All references listed should be considered for coverage decision-making. The Company uses the most current version of a Medicare reference available at the time of publication; however, these websites are not maintained by the Company, so Medicare references and their corresponding hyperlinks may change at any time. If there is a conflict between the Company Medicare Medical Policy and CMS guidance, the CMS guidance will govern.

Service	Medicare Guidelines

IMPORTANT NOTES THAT APPLY TO ALL PNEUMATIC COMPRESSION DEVICES:
• To ensure correct coverage policy criteria are applied, accurate and appropriate coding is required. Medicare rules state that all providers/suppliers report services or items correctly, which means items (equipment) must be reported with the HCPCS code that describes the item provided. *(**Source:** CMS National Correct Coding Initiative Policy Manual for Medicare Services, Chapter I(A))*
• Place of service (POS) or setting:
  ○ Coverage of pneumatic compression devices (PCDs) detailed below are specific to use in a **home** setting.
  ○ *In-Facility Use:* Use of a PCD *in* a facility (i.e., ambulatory surgical center or ASC) is **not** eligible for coverage or reimbursement because this is included in facility reimbursement for the procedure(s). Therefore, PCD **cannot** be separately billed by either the facility or a DME supplier for this purpose.[1]
  ○ *Home Use:* If a PCD is dispensed by a facility for *home* use, the place of service (POS) on the claim must reflect this (POS 12).	

*Pneumatic Compression Devices (PCDs) for **Lymphedema or Chronic Venous Insufficiency (CVI) With Ulcers** (HCPCS E0650, E0651, E0651; Accessory codes E0655-E0660, E0665-E0673)*	**GENERAL CRITERIA** • National Coverage Determination (NCD): Pneumatic Compression Devices (280.6) **NOTES:** • Specific coverage of PCDs under the NCD 280.6 is limited to treatment of lymphedema or chronic venous insufficiency (CVI) with venous stasis ulcers. • Consistent with the NCD, the Company considers PCDs to treat post-mastectomy lymphedema to be **medically necessary.** The Plan has opted to **not** apply full NCD coverage criteria to these claims; however, utilization must remain within reasonable and necessary limits, including the frequency of equipment replacement. See *Regulatory Status* below.

	• Appliances/Accessories: When a PCD is determined to be not medically necessary, all related appliances and accessories are also non-covered.
*PCDs for **Prevention of Deep Vein Thrombosis (DVT) or Venous Thromboembolism** (HCPCS E0676)*	According to a Medicare PDAC Article, as well as a Joint DME MAC Article: • 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, HCPCS E0676 is considered **not medically necessary**. • The only HCPCS code for PCDs used for the prevention of DVT is HCPCS E0676. This code should **not** be reported for any other PCD use/indication. • The appliance(s) and any other accessories, options, and supplies used with PCD E0676 are included in the payment for HCPCS code E0676 at the time of initial issue and must **not** be billed separately to Medicare. If they are reported separately, they may be reported with codes A9900 and/or A4600; however, they are still subject to non-coverage rules found in this policy.[2] • When a PCD is considered not medically necessary, all related appliances and accessories are also non-covered.

Medicare Coverage Criteria: "MA organizations may create publicly accessible internal coverage criteria… when coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs." *(§ 422.101(b)(6) – see Policy Guidelines below*)

- **Medicare Coverage Manuals:** Medicare does not have criteria for pneumatic compression devices or PCDs in a coverage manual.
- **Noridian J-D DMEPOS Local Coverage Determination (LCD)/Local Coverage Article (LCA):** As of the most recent policy review, neither DME Medicare Administrative Contractor (MAC) has an LCD or LCA which specifically addresses PCDs for PAD. There was previously an LCD for these devices, and it gave explicit non-coverage instruction for HCPCS code E0675 (L33829). However, it was retired on 11/14/2024. According to the Noridian *Pneumatic Compression Devices (PCD)* webpage, no specific Medicare policy guidance is available for E0675, and the medical record must support the item ordered is reasonable and necessary, reviewed on a claim-by-claim basis using available Medicare coverage policy.
- **National Coverage Determination (NCD):** Medicare **does** have an NCD for PCDs, which is noted above. Peripheral artery disease (PAD) or arterial insufficiency is not a covered indication under NCD 280.6, so PCDs supplied for this indication would not be expected to meet Medicare coverage policy criteria. However, the Plan considers this NCD to be "not fully established" under CFR § 422.101(6)(i)(A). While it provides general coverage criteria, it does not provide explicit information sufficient for coverage decisions.
- Therefore, in the absence of **fully established** Medicare coverage criteria in a manual, NCD, LCD, or other regulatory guidance, evidence-based Company criteria are applied for medical necessity decision-making. Medicare coverage policy does provide general coverage criteria for PCDs, but additional criteria to interpret or supplement the Medicare criteria are being used in order to determine medical necessity on a consistent basis. These additional criteria provide clinical benefits that are highly likely to outweigh any clinical harms, including from

delayed or decreased access to items or services (e.g., avoidance of common adverse events and complications of compression therapy, such as skin irritation or contact rash, soft tissue damage, compartment syndrome, pain, pressure ulcers or necrosis and skin abrasion[3]). Services that do not meet the medical necessity criteria may result in unnecessary exposure to potential complications. Specifically, the evidence supporting the use of intermittent PCDs for peripheral arterial disease (PAD) or arterial insufficiency is limited and insufficient to establish safety and efficacy or to determine the impact on net health outcomes. Available studies are small, heterogeneous and frequently subject to significant methodological limitations, including risk of bias and lack of generalizability. Evidence is largely derived from surrogate physiological or intermediate outcomes (e.g., blood flow or walking distance) with limited and inconsistent data on clinically meaningful endpoints such as wound healing, limb salvage, or functional improvement.

- ***NOTE:*** *The summary of evidence, as well as the list of citations/references used in the development of the Company's internal coverage criteria, are publicly available and can be found using the Company medical policy link below [CFR § 422.101(6)(ii)(A) and (B)].*

*PCDs for **Peripheral Artery Disease or PAD** (HCPCS E0675; Accessory codes E0667, E0668, E0669)*	Company medical policy for Pneumatic Compression Devices I. These devices are considered **not medically necessary** for Medicare based on the Company medical policy. *See Policy Guidelines below.* **NOTE:** The only HCPCS code for PCDs used for the treatment of PAD is HCPCS E0675. The code description for this HCPCS is specific to *arterial* insufficiency, which is different from *venous* thromboembolism or DVT. Therefore, E0675 should **not** be used for PCDs supplied for DVT prevention, and Company criteria should not be used for PCDs provided for this purpose.

IMPORTANT NOTICE: While some services or items may appear medically indicated for an individual, they may also be a direct exclusion of Medicare or the member's benefit plan. Such excluded services or items by Medicare and member EOCs include, but are not limited to, services or procedures considered to be cosmetic, not medical in nature, or those considered not medically reasonable or necessary under *Title XVIII of the Social Security Act, §1862(a)(1)(A).* If there is uncertainty regarding coverage of a service or item, please review the member EOC or submit a pre-service organization determination request. Note that the Medicare Advance Beneficiary Notice of Noncoverage (ABN) form **cannot** be used for Medicare Advantage members. *(Medicare Advance Written Notices of Non-coverage. MLN006266 May 2021)*

POLICY CROSS REFERENCES

None

The full Company portfolio of Medicare Medical Policies is available online and can be accessed here.

POLICY GUIDELINES

MEDICARE AND MEDICAL NECESSITY

Only medically reasonable and necessary services or items which treat illness or injury are eligible for Medicare coverage, as outlined in *Title XVIII of the Social Security Act, §1862(a)(1)(A)*. MA organizations (MAOs) make medical necessity determinations based on coverage and benefit criteria, current standards of care, the member's unique personal medical history (e.g., diagnoses, conditions, functional status, co-morbidities, etc.), physician recommendations, and clinical notes, as well as involvement of a plan medical director, where appropriate. *(§ 422.101(c)(1))*

In addition:

> "MA organizations may create publicly accessible internal coverage criteria that are based on current evidence in widely used treatment guidelines or clinical literature when coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs. Current, widely-used treatment guidelines are those developed by organizations representing clinical medical specialties, and refers to guidelines for the treatment of specific diseases or conditions. Acceptable clinical literature includes large, randomized controlled trials or prospective cohort studies with clear results, published in a peer-reviewed journal, and specifically designed to answer the relevant clinical question, or large systematic reviews or meta-analyses summarizing the literature of the specific clinical question." *(§ 422.101(b)(6) and Medicare Managed Care Manual, Ch. 4, §90.5)*

The Plan's Medicare policy for *PHA Medicare Medical Policy Development and Application* (MP50) provides details regarding Medicare's definition of medical necessity and the hierarchy of Medicare references and resources during the development of medical policies, as well as the Plan's use of evidence-based processes for policy development.

Since there are not fully established coverage criteria for PCDs specifically for the use of PAD or arterial insufficiency available in applicable Medicare statutes, regulations, NCDs or LCDs, then Company medical policy criteria will be applied. See the Medicare Coverage Criteria table above for more information regarding the use of internal coverage criteria when Medicare coverage criteria are not fully established.

REGULATORY STATUS

U.S. FOOD & DRUG ADMINISTRATION (FDA)

While clearance by the Food and Drug Administration (FDA) is a prerequisite for Medicare coverage, the 510(k) premarket clearance process does not in itself establish medical necessity. Medicare payment policy is determined by the interaction of numerous requirements, including but not limited to, the availability of a Medicare benefit category and other statutory requirements, coding and pricing guidelines, as well as national and local coverage determinations and clinical evidence.

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. In addition, utilization must be medically reasonable and necessary and clinically appropriate.

BILLING GUIDELINES AND CODING

GENERAL

Medicare Place of Service Rules and DME

Place of service (POS) codes indicate where the procedure (or in this case, DME) will be used. According to Medicare rules, DME is covered only when used in the home setting (see NCD 280.1 and Medicare Benefit Policy Manual, Ch. 15, Section 110.1), so DME is required to be billed with certain place of service (POS) codes to reflect the DME will be used in the home (see Noridian J-D website for Place of Service).[1] Claims submitted with a POS of 24 indicate the equipment was used while the member was still in the ASC.

DME suppliers cannot bill separately for DME that is used by a member while in an ambulatory surgical center (ASC) because the ASC's all-inclusive facility fee typically covers this equipment while the member is still a patient. Medicare considers in-facility, post-operative use of DME to be part of the services included in the ASC's payment for the surgical procedure. Thus, while DME intended to be sent home with the patient for use in the patient's home may be eligible for separate reimbursement, in-facility use of equipment is not.

Therefore, all claims for PDCs billed with POS 24 will be denied.

If the DME was sent home with the member for use in the home setting, the correct POS must be used on the claim.

Services or Items Related to Non-Covered Items

PCD accessories are only eligible for coverage when the related base PCD equipment meets Medicare coverage criteria. According to Medicare rules, if the base PCD is not covered, then related accessories would not be eligible for coverage or reimbursement.

Appliances

The only appliances appropriate for use with an E0675 PCD are E0667, E0668, E0669. HCPCS code E0673 is **not** an acceptable appliance code to be reported with HCPCS E0675.[2]

In addition, HCPCS code E0676 is considered “all-inclusive,” meaning that all product variations in pressures, cycle characteristics, timing, control systems, appliance configurations, etc., are considered as described by the code. The appliance(s) and any other accessories, options, and supplies used with PCD E0676 are included in the payment for HCPCS code E0676 at the time of initial issue and must **not** be billed separately. If a supplier chooses to bill separately for these items at the time of initial issue, then

may use HCPCS code A9900, but it also is not allowed separate reimbursement. Note that the PDAC article explicitly states "E0673 must not be used when billing for appliances used with E0676 devices."[2]

Diagnosis Codes for Lymphedema

A diagnosis of lymphedema must include one of the following lymphedema ICD-10 codes:

- Lymphedema, not elsewhere classified (I89.0)
- Hereditary Lymphedema (Q82.0)
- Postmastectomy Lymphedema Syndrome (I97.2)
- Other postprocedural complications and disorders of the circulatory system, not elsewhere classified (I97.89)

CODES*		
CPT	None	
HCPCS	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
	E0658	Segmental pneumatic appliance for use with pneumatic compressor, integrated, 2 full arms and chest
	E0659	Segmental pneumatic appliance for use with pneumatic compressor, integrated, head, neck and 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)
	E0676	Intermittent limb compression device (includes all accessories), not otherwise specified

***Coding Notes:**

- The code list above is provided as a courtesy and may not be all-inclusive. Inclusion or omission of a code from this policy neither implies nor guarantees reimbursement or coverage. Some codes may not require routine review for medical necessity, but they are subject to provider contracts, as well as member benefits, eligibility and potential utilization audit. According to Medicare, "presence of a payment amount in the MPFS and the Medicare physician fee schedule database (MPFSDB) does not imply that CMS has determined that the service may be covered by Medicare." The issuance of a CPT or HCPCS code or the provision of a payment or fee amount by Medicare does **not** make a procedure medically reasonable or necessary or a covered benefit by Medicare. *(Medicare Claims Processing Manual, Chapter 23 - Fee Schedule*

Administration and Coding Requirements, §30 - Services Paid Under the Medicare Physician's Fee Schedule, A. Physician's Services)

- All unlisted codes are reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is submitted for non-covered services addressed in this policy then it will be **denied as not covered**. If an unlisted code is submitted for potentially covered services addressed in this policy, to avoid post-service denial, **prior authorization is recommended**.
- **See the non-covered and prior authorization lists on the Company Medical Policy, Reimbursement Policy, Pharmacy Policy and Provider Information website for additional information.**
- HCPCS/CPT code(s) may be subject to National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) bundling edits and daily maximum edits known as "medically unlikely edits" (MUEs) published by the Centers for Medicare and Medicaid Services (CMS). This policy does not take precedence over NCCI edits or MUEs. Please refer to the CMS website for coding guidelines and applicable code combinations.

REFERENCES

1. Noridian Healthcare Solutions, Inc. (Noridian) Jurisdiction D (JD). Place of Service. Updated: 2/22/2024. https://med.noridianmedicare.com/web/jddme/claims-appeals/claim-submission/pos. Accessed 5/20/2026.
2. PDAC. Pneumatic Compression Devices – Correct Coding and Billing – Revised. Updated: 12/12/2025. https://dmepdac.com/palmetto/pdacv2.nsf/DIDC/3YRJX7WQJA~Articles%20and%20Publications~Advisory%20Articles. Accessed 5/20/2026.
3. Lachmann EA, Rook JL, Tunkel R, Nagler W. Complications associated with intermittent pneumatic compression. Arch Phys Med Rehabil. 1992 May;73(5):482-5. PMID: 1580778.

POLICY REVISION HISTORY

DATE	REVISION SUMMARY
7/2022	Annual review (converted to new format 2/2023)
7/2023	Annual review; no changes
7/2024	Annual review; no changes
12/2024	Interim update; DME MAC LCD and LCA were retired 11/14/2024
7/2025	Annual review; no changes
10/2025	Q4 2025 code updates
7/2026	Interim update; add language to clarify Medicare coverage of PCDs, information regarding correct place of service for PCD use, and information regarding components and accessories related to non-covered DME