Medicare Medical Policy

Pneumatic Compression Devices

MEDICARE MEDICAL POLICY NUMBER: 138

Effective Date: 12/1/2024

Last Review Date: 11/2024

Next Annual Review: 6/2025

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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
Pneumatic Compression Devices (PCD)	*General Coverage Guidance – Specifically when used for lymphedema (**not** related to breast cancer) and chronic venous insufficiency (CVI) with venous stasis ulcers:* • National Coverage Determination (NCD): Pneumatic Compression Devices (280.6) **NOTES:** • HCPCS code E0676: In addition to the above NCD criteria, in order for pneumatic compression items to be considered for coverage, there are specific statutory payment policy requirements that also must be met. A PCD that provides intermittent limb compression for the purpose of prevention of venous thromboembolism (E0676) is considered to be a preventive service under Medicare, and items that are used for a preventative service or function are excluded from coverage under the Medicare DME benefit. Therefore, HCPCS E0676 will is considered not covered, and will deny as **not medically necessary**. *(PDAC Article)* • Post-mastectomy lymphedema: The Company will consider pneumatic compression devices to treat **post-mastectomy** lymphedema to be **medically necessary**. The above coverage criteria references will not be applied to these requests; however, utilization must still be considered reasonable and necessary, including the frequency of equipment replacement. See *Regulatory Status* below. **PRIOR TO 11/14/2024:** *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) **As of 11/14/2024:** The DME Medicare Contractor (DME MAC) LCD for pneumatic compression devices is retired as of 11/14/2024.

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

None

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

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
	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

None

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