


MEDICAL POLICY	Compression: Outpatient Pneumatic Devices (Medicare Only)	
Effective Date: 05/01/2020  5/1/2020	Section: DME	Policy No: 416
	Medical Policy Committee Approved Date: 04/2020	
Medical Officer	Date	

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

SCOPE:

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

APPLIES TO:

Medicare only

MEDICARE POLICY CRITERIA

Notes:

- In compliance with the Affordable Care Act and Women’s Health and Cancer Rights Act of 1998, outpatient pneumatic compression devices following mastectomy are considered medically necessary.
- 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
<i>Pneumatic compression devices</i>	<ul style="list-style-type: none"> • National Coverage Determination: Pneumatic Compression Devices: 280.6¹ • Local Coverage Determination (LCD): L33829, Pneumatic Compression Devices² • Local Coverage Article (LCA): A52488, Pneumatic Compression Devices - Policy Article³ • LCA: A55426, Local Coverage Article: Standard Documentation Requirements for All Claims Submitted to DME MACs⁴

BILLING GUIDELINES

If these pneumatic devices are billed for use during ambulatory surgery (POS 24) they will deny as not-covered to the facility fee.

The LCDs and LCAs contain specific guidance for billing and coding. See the CODING GUIDELINES and MISCELLANEOUS sections of LCA [A52488](#) for guidance. Per LCD [L33829](#), specific elements must be contained in the submitted records. See section titled, DOCUMENTATION REQUIREMENTS within the LCD for precise guidance. Reference the general requirements for all DME, [A55426](#), which also includes documentation requirements.

HCPCS CODES

Medicare Only	
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
No Prior Authorization Required	
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

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.

REFERENCES

1. Centers for Medicare & Medicaid Services National Coverage Determination (NCD) for Pneumatic Compression Devices (280.6). Effective Date of this Version: 1/14/2002. <https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=225>. Accessed 03/20/2020.
2. Centers for Medicare & Medicaid Services Local Coverage Determination (LCD): Pneumatic Compression Devices (L33829). Revision Effective Date: For services performed on or after 01/01/2020. <https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33829>. Accessed 03/20/2020.
3. Centers for Medicare & Medicaid Services Local Coverage Article: Pneumatic Compression Devices - Policy Article (A52488). Revision Effective Date: 01/01/2020. <https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=52488>. Accessed 03/20/2020.
4. Centers for Medicare & Medicaid Services Local Coverage Article (LCA): A55426, Local Coverage Article: Standard Documentation Requirements for All Claims Submitted to DME MACs. Revision Effective Date: For services performed on or after 01/01/2020. <https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=55426>. Accessed 03/20/2020.