Pneumatic Compression Devices
DME-013

Iowa Medicaid Program	Prior Authorization	**Effective Date**	7/1/2010
Revision Number	9	**Last Rev Date**	10/18/2024
Reviewed By	Medicaid Medical Director	**Next Rev Date**	10/17/2025
Approved By	Medicaid Clinical Advisory Committee	**Approved Date**	7/24/2020

Descriptive Narrative

Pneumatic compression devices are a treatment option for patients with lymphedema who have failed conservative measures. These devices consist of an inflatable garment for the arm, leg, trunk, or chest and an electrical pneumatic pump that fills the garment with compressed air. The garment is intermittently inflated and deflated with cycle times and pressures that vary between devices. A variety of pumps are available, including single chamber (non-segmented) or multi-chamber (segmented) and have varying design and complexity.

In general, a non-segmented or segmented compression device without manual control is sufficient to meet the needs of most patients. The only time a segmented, calibrated gradient pressure device may be indicated is the presence of contractures or extensive scarring that would prevent satisfactory treatment from a non-segmented or segmented device without manual control.

For the management of lymphedema, there is sufficient evidence to determine that treatment results in an improvement of the net health outcome.

Criteria

Prior authorization is required.

Non-Programmable Devices

(E0650, E0655, E0660, E0665, E0666, E0651, E0656, E0657, E0667, E0668, E0669) Single or multi-chamber non-programmable pneumatic compression devices are considered medically necessary when the patient has undergone a 4-week trial of conservative therapy which includes **ALL** of the following:

1. Daily use of an appropriate compression bandage or compression garment; **AND**
2. Daily exercise; **AND**
3. Daily elevation of the affected limb; **AND**
4. The provider has documented there has been no significant improvement and significant symptoms remain after a 4-week trial of conservative therapy.

Programmable Devices

(E0652, E0671, E0672, E0673)
Single or multi-chamber programmable (for example, calibrated gradient pressure) pneumatic compression devices are considered medically necessary when **ONE** of the following is met:

1. A single or multi-chamber non-programmable pneumatic compression device has been tried for a minimum of 3 months, there is documentation of compliance with treatment with the non-programmable pneumatic compression device, and there is documentation that lymphedema has progressed; **OR**
2. There is clear documentation of a condition that prevents the satisfactory treatment of lymphedema with a non-programmable device, such as the presence of a contracture deformity or significant scarring.

Not Medically Necessary

1. Two-stage devices which involve an initial programmed compression of the chest and/or trunk, the “preparatory stage,” followed by a second programmed compression of the affected limb(s), the “drainage” stage are considered not medically necessary.
2. Use of these devices in the home setting for prevention of DVT of the extremities for all indications.
3. The use of compression devices to treat lymphedema for any body part other than the upper or lower extremities.

Contraindications

1. Peripheral arterial disease
2. Presence of superficial or deep vein thrombosis
3. Heart failure
4. Acute cellulitis (untreated), infection or presence of necrotic tissue

Investigational

Use of pneumatic compression devices for treatment of the following conditions would be considered investigational. Literature does not support a net improvement in health outcomes.

1. Peripheral artery disease/arterial insufficiency.
2. Restless leg syndrome.
3. Management of edema following femoral-popliteal bypass surgery.
4. Rehabilitation for distal radial fracture.
5. Fracture and soft tissue healing.
6. Treatment of sensory impairment in the upper limbs following a stroke.
7. Treatment of upper extremity vascular ulcers.
8. Edema related to obesity.
9. Diabetic neuropathic ulcers of the lower extremities.
10. Trunk or chest pneumatic compression therapy in the treatment of lymphedema.
11. Prevention of deep vein thrombosis for low risk individuals following ambulatory surgery.

Coding

The following list(s) of codes are provided for reference purposes only and may not be all inclusive. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment, nor does the exclusion of a code imply that its association to the HCPCS/CPT code is inappropriate.

HCPCS	Description
E0652	Pneumatic compressor, segmental home model with calibrated gradient pressure.

References

Armstrong DG. Meyr AL. Compression therapy for the treatment of chronic venous insufficiency. UpToDate. Topic last updated: Jul 18, 2023.

EncoderPro Optum 360.

Intermittent Pneumatic Compression with Extremity Pump. Milliman Care Guidelines. MCG Health Ambulatory Care 27th Ed. ACG: A-0340 (AC) copyright 2023.

Pneumatic Compression Devices. Local Coverage Determination. CMS. LCD ID L33829. Revision Effective Date: 10/22/2023

Development of utilization management criteria may also involve research into other state Medicaid programs, other payer policies, consultation with experts and review by the Medicaid Clinical Advisory Committee (CAC). These sources

may not be referenced individually unless they are specifically published and are otherwise applicable to the criteria at issue.

Criteria Change History

Change Date	Changed By	Description of Change	Version
10/18/2024	CAC	Annual Review. Updated Descriptive Narrative section. Added #2&3 under Not Medically Necessary. Added Contraindications & Investigational sections. Coding table & References updated.	9
Signature William (Bill) Jagiello, DO			
Change Date	**Changed By**	**Description of Change**	**Version**
7/21/2023	CAC	Annual review.	8
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Change Date	**Changed By**	**Description of Change**	**Version**
7/15/2022	CAC	Annual review.	7
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Change Date	**Changed By**	**Description of Change**	**Version**
6/15/2020	Medical Director	Added narrative, revised criteria.	6
Signature William (Bill) Jagiello, DO			
Change Date	**Changed By**	**Description of Change**	**Version**
4/20/2018	CAC	Added f and g under criterion #1. Added “with member on a mineralcorticoid” to criterion #7.	5
Signature C. David Smith, MD			
Change Date	**Changed By**	**Description of Change**	**Version**
4/15/2016	CAC	Under criteria, added “medical conditions which have failed traditional standard therapies”.	4
Signature			
Change Date	**Changed By**	**Description of Change**	**Version**
4/17/2015	CAC	Added last paragraph in References.	3
Signature			
Change Date	**Changed By**	**Description of Change**	**Version**
4/18/2014	Medical Director	Formatting changes. Added HCPCS code S8429.	2
Signature			
Change Date	**Changed By**	**Description of Change**	**Version**
4/27/2012	CAC	Changed “off the shelf” to non-customized.	1
Signature			