Department of HUMAN SERVICES

Pneumatic Compression Devices

Iowa Medicaid Program:	Prior Authorization	**Effective Date:**	7/1/2010
Revision Number:	6	**Last Rev Date:**	7/17/2020
Reviewed By:	Medicaid CAC	**Next Rev Date:**	7/16/2021
Approved By:	Medicaid Medical Director	**Approved Date:**	6/4/2018

Narrative Description

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.

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 femoro-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.

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
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.

Coding

E0650	Pneumatic compressor, nonsegmental home model.
E0651	Pneumatic compressor, segmental home model without calibrated gradient pressure.
E0652	Pneumatic compressor, segmental home model with calibrated gradient pressure.
E0655	Nonsegmental 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	Nonsegmental pneumatic appliance for use with pneumatic compressor, full leg.
E0665	Nonsegmental pneumatic appliance for use with pneumatic compressor, full arm.
E0666	Nonsegmental 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, two 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.

References

Ashinoff RL, Chang EI Lower extremity lymphedema conservative with treatment pneumatic compression. UpToDate Oct 31, 2019.

EncoderPro Optum 360.

Local Coverage Determination (LCD): Pneumatic Compression Devices (L33829). Updated February 14, 2020.

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
Signature			

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			

Criteria Change History (continued)

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			