Pneumatic Compression Devices and Compression Garments

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Coverage Policy

Coverage for the treatment of lymphedema, including lymphedema pumps and compression garments, may be governed by federal and/or state mandates. Lymphedema compression garments are generally covered under the core medical benefits of the plan.

Coverage for pneumatic compression devices/lymphedema pumps used in the home is subject to the terms, conditions and limitations of the applicable benefit plan's Durable Medical Equipment (DME) benefit and schedule of copayments. Please refer to the applicable benefit plan document to determine benefit availability and the terms, conditions and limitations of coverage. Under many benefit plans, coverage for DME is limited to the lowest-cost alternative.

Unless excluded from the benefit plan, the following conditions of coverage apply.

Compression Garment

The purchase of a lymphedema compression garment for the extremities (e.g., sleeve, gauntlet, and stocking) is considered medically necessary for the treatment of lymphedema.
Pneumatic Compression Device in the Home Setting

A pneumatic compression device in home setting is considered medically necessary for EITHER of the following:

- for the treatment of intractable lymphedema when there is failure of a four-week trial of conservative medical management including ALL of the following:
  - home exercise program
  - limb elevation
  - compression bandage or compression garment use

- for the treatment of chronic venous insufficiency (CVI) with venous stasis ulcer(s) of lower extremities, (HCPCS code E0650–E0652, E0660, E0666–E0667, E0669–E0671, E0673, E0676) when BOTH of the following criteria are met:
  - The individual has received medically-supervised treatment of the ulcer(s) for at least 24 weeks using standard wound care treatment, including compression, wound dressings, exercise, and elevation of the limb.
  - Failure of the ulcer(s) to decrease in size or demonstrate improvement despite conventional therapy.

When a pneumatic compression pump has been found to be medically necessary according to the above criteria, the following devices are considered medically necessary limited to the lowest-cost alternative:

- non-segmental/segmental (HCPCS code E0650, E0651)
- segmental with calibrated gradient pressure (HCPCS code E0652) when there is evidence of failure of relief with the non-segmental device or a requirement of specified pressure to a localized area

Continuation of Use

Continuation of use of a pneumatic compression device is considered medically necessary when BOTH of the following criteria are met:

- there is adherence with the use of equipment as ordered by the healthcare professional
- clinical documentation from the health care professional confirms clinical improvement (e.g., improvement in venous stasis ulcers, decrease in edema or lymphedema)

EXPERIMENTAL, INVESTIGATIONAL OR UNPROVEN

Each of the following is considered experimental, investigational or unproven:

- a chest (HCPCS code E0657) and/or trunk (HCPCS code E0656, E0670) pneumatic appliance for use with a pneumatic compression pump
- a compression garment for trunk or chest
- a pneumatic compression device, with or without a cooling component, utilized in the home setting for ANY other indication including but not limited to:
  - the prevention of deep vein thrombosis.
  - a pump for arterial insufficiency (HCPCS code E0675)

Overview

This Coverage Policy addresses lymphedema compression garments for the extremities that are used in the treatment of lymphedema and pneumatic compression devices used in the home environment.
General Background

There are several types of pneumatic compression devices. The use of a pneumatic compression device in the home environment may be an alternative to other compression therapies (e.g., stockings, bandages, Unna boots) for patients who are unable or refuse to comply with other methods of treatment or are refractory to standard wound care treatment. Pumps may be classified as single-chambered, multi-chambered with fixed sequential inflation, or multi-chambered with sequential inflation and manually calibrated gradient chamber pressure. Older models include intermittent single-chamber non-segmented pumps that provide even pressure throughout the limb; however, they allow backflow of lymphatic fluid. This can cause an increase of fluid in the distal limb. Newer devices have multiple segmented chambers and have the ability to provide sequential compression. Multiple-chamber units typically inflate from distal to proximal, producing a wave of pressure that ascends through the extremity, with the same pressure being delivered in each garment section. Proponents contend that this wave brings edema fluid with it, allowing the retained fluid to be brought to functional lymphatics.

Segmental pumps that have a calibrated gradient pressure feature are typically used only in patients who require limited pressure to be applied to a specific area (e.g., significant scars; the presence of contracture or pain caused by the clinical condition).

Pneumatic compression pumps include, but are not limited to, the following:

- Nonsegmented pneumatic compressor (E0650): This device has a single outflow port on the compressor. Although there is a single tube, air from this single tube may be transmitted to a sleeve with multiple compartments and would be functionally equivalent to a segmented pneumatic compressor with a segmented sleeve; or the device can be used with a nonsegmented sleeve. An example of this type of pump is the Huntleigh Flowtron® Hydroven 3 Pump (ArjoHuntleigh, Addison IL.)
- Segmented pneumatic compressor (E0651, E0652): This device has multiple outflow ports on the compressor that lead to distinct segments on the appliance, which inflates in a sequential manner.
  - (E0651) A segmented device without calibrated pressure is one in which either (a) the same pressure is present in each segment, or (b) there is a predetermined pressure gradient in successive segments but no ability to individually set or adjust pressures in each of the several segments. The pressure is usually set by a single control on the distal segment. Examples of models include: Wright 51 Non-Gradient (Wright Therapy Products, Oakdale, PA), BHI Sequential Compression Pump (Biomedical Horizons, Inc., Scottsdale, Arizona), Model SC-2004 Sequential Circulator (Bio Compression, Moonachie, New Jersey).
  - (E0652) A segmented device with calibrated gradient pressure is characterized by a manual control on at least three outflow ports that can deliver individually determined pressure to each segmental unit. Examples include but are not limited: Chattanooga 4333 Multi 6 Compression Therapy System (Chattanooga Group, Chattanooga, TN), Talley Multipulse™ 500 sequential compression system (Talley Medical USA, Lansing, MI), Wright 52 Gradient (Wright Therapy Products, Oakdale, PA), Model SC-3004 Sequential Circulator (Bio Compression, Moonachie, New Jersey). Flexitouch system (Tactile Systems Technology, Inc., Shakopee, MN), Lympha Press Optimal™ (Mego Afek, Manalapan, NJ)

One type of pneumatic compression device combines intermittent pneumatic compression with cold therapy. This pneumatic compression device has been proposed for elimination of knee, shoulder and ankle swelling as a result of traumas or surgery. These devices are also proposed for use on soft tissue injuries such as pulled hamstrings, tendinitis, sprains and inflamed joints. For information on the coverage of pneumatic compression with cold therapy, please refer to the Cigna Coverage Policy, Cryounits/Cooling Devices.

U.S. Food and Drug Administration (FDA)

There are numerous manufacturers and models of pneumatic compression devices. Pneumatic compression devices are cleared for marketing under the FDA 510(k) process as Class II devices intended for use in prevention of blood pooling in a limb by periodically inflating a sleeve around the limb. No clinical data was needed for FDA approval since they existed prior to the passage of the Medical Device Amendments of 1976.
Pneumatic compression pumps for use with lymphedema are approved under the U.S. Food and Drug Administration (FDA) 510(k) process. They are classified as Class II devices, cardiovascular therapeutic devices, and compressible limb sleeves. Manufacturers include, but are not limited to: Advantage (Microtek Medical Inc., Jacksonville, FL); Bio Compression Inc. (Moonachie, NJ); Thera-Con (Bethesda, MD); Kendall (Tyco Healthcare Group, LP, Mansfield, MA); Talley (Talley Group Ltd., Romsey, UK); Jobst (BSN-JOBST, Inc., Charlotte, NC); Wright Linear Pump, Inc. (Oakdale, PA); and, Flexitouch system (Tactile Systems Technology, Inc., Shakopee, MN).

Lymphedema

Primary lymphedema is a result of congenital defects of the lymphatic system and is rare. Secondary lymphedema is acquired and due to an obstruction or interruption in the lymphatic system. In the United States, the most common causes of lymphedema are cancer and treatment related to cancer. Patients undergoing surgery for breast cancer that includes node dissection or axillary radiation therapy are at high risk of developing lymphedema. The goals of lymphedema treatment are to decrease the excess volume as much as possible and maintain the limb at its smallest size.

When provided as the sole treatment modality, lymphedema pumps are generally reserved for patients with intractable lymphedema for whom an adequate trial of more conservative medical treatment has failed. Established conservative medical treatments include the use of bandaging and compression garments, limb elevation, and home exercise programs. Segmental pumps that have a calibrated gradient pressure feature are typically used only in patients who require limited pressure to be applied to a specific area (e.g., significant scars or the presence of contracture or pain caused by the clinical condition).

Literature Review–Lymphedema: There is no consensus in the scientific literature on optimal pump selection and use. The scientific evidence supporting the use of pneumatic pumps as a solitary treatment modality for lymphedema is extremely limited and of poor quality. There is some evidence to indicate that using pumps as an adjunct to complex lymphedema treatment (CLT) has beneficial effects on the outcome of the therapy. Comparative studies evaluating the most effective pumping times, pressure levels or kind of pump are lacking (Harris, 2001). Optimal pressure ranges, inflation/deflation cycles, and length and frequency of individual pumping sessions have not been established (Brennan, 1998; Kerchner, et al., 2008). There is some evidence to suggest that sequential multi-chambered pumps are more effective than single-chambered pumps. One randomized trial attempted to evaluate pneumatic compression pumps for the treatment of lymphedema. Dini et al. (1998) randomized 80 post-mastectomy women to either intermittent pneumatic compression or no treatment. Women in the treatment group underwent a two-week cycle of five pump sessions per week, followed by a five-week break in treatment and then another two-week cycle of treatment. There was no statistically significant difference in response rates between the two groups. The authors concluded that pneumatic compression pumps have a limited role in the management of patients with lymphedema.

Karaca-Mandic et al. (2015) reported on a retrospective analysis of a de-identified private insurance database, and multivariate regression analysis comparing outcomes for the 12 months before and after advanced pneumatic compression device (APCD) purchase while adjusting for baseline patient characteristics. The study population was evaluated as cancer-related (n=374) and non–cancer-related lymphedema cohorts (n=344). The main outcomes were rates of cellulitis, use of lymphedema-related manual therapy, outpatient hospital visits, and inpatient hospitalizations. Measurements of lymphedema-related direct costs were made for home health care, hospital outpatient care, office visits, emergency department use, and inpatient care. In both cohorts, use of an APCD was associated with similar reductions in adjusted rates of cellulitis episodes (cancer cohort - from 21.1% to 4.5% and 28.8% to 7.3% in the noncancer cohort; P<.001 both), lymphedema-related manual therapy (cancer cohort 35.6% to 24.9% and 32.3% to 21.2% in noncancer cohort; P<.001 for both), and outpatient visits (from 58.6% to 41.4% in the cancer cohort and 52.6% to 31.4% in noncancer cohort; P<.001 for both). Among the cancer cohort, total lymphedema related costs per patient, excluding medical equipment costs, were reduced by 37%. The corresponding decline in costs for the noncancer cohort was 36%. Limitations of this study include the retrospective nature of the study and lack of a comparison group.

Muluk et al. (2013) reported on a prospective cohort study of 196 patients to examine the effectiveness of an advanced pneumatic compression device (APCD) (Flexitouch pump) on limb volume (LV) reduction in the treatment of lymphedema. Patients had at least stage II lymphedema. Primary outcome was limb volume with
secondary outcomes to compare pre-and post-treatment patient reported outcomes and clinical reported outcomes after treatment. Follow-up clinical assessment was done approximately 60±27 days (range 17-242; median 55.5) after the baseline measurements and initial APCD treatment. Ninety per cent of the APCD treated patients had a 35% reduction in the limb volume. Mean LV reduction was 1,150 mL or 8% (p<.0001). Limitations of the study included the lack of comparator and randomization, other lymphedema treatment components were not standardized, and LV measurements were done at variable time points after initiation of therapy.

Fife et al. (2012) conducted a randomized, controlled trial that compared an advanced pneumatic compression device (APCD) to a standard PCD (SPCD) in 36 patients with arm lymphedema after breast cancer treatment. The patients were randomized to an APCD (Flexitouch system, HCPCS E0652) or SPCD (Bio Compression 2004, HCPCS E0651) used for home treatment one hour a day for 12 weeks. Outcomes included arm volumes that were determined from arm girth measurements and suitable model calculations, and tissue water volume that was determined based on measurements of the arm tissue dielectric constant (TDC). The APCD-treated group had an average of 29% reduction in edema compared to a 16% increase in the SPCD group. Mean changes in TDC values were 5.8% reduction for the APCD group and a 1.9% increase for the SPCD group. This study did not compare different types of advanced pneumatic compression devices, but rather compared a standard PCD to an advanced PCD. In addition, while the patients had not received treatment with PCD within the past three months, it is not noted if they had received PCD therapy in the past. Limitations of the study include the small sample size, absence of recording of symptoms, quality and life and functional outcomes.

Ridner et al. (2011) reported on a randomized, controlled trial to compare the therapeutic benefit of truncal/chest/arm advanced pneumatic compression therapy (experimental group) (n=21) verses arm only pneumatic compression (control group) (n=21) in self-care for arm lymphedema without truncal involvement using the Flexitouch System. The outcomes included self-reported symptoms, function, arm impedance ratios, circumference, volume, and trunk circumference. While the findings indicated a statistically significant reduction in both the number of symptoms and overall symptom burden within each group, there were no statistically significant differences in these outcomes between the two groups. No statistically significant overall change or differential pattern of change between the groups in function was found. A statistically significant reduction in bioelectrical impedance and arm circumference within both of the groups was realized; however, there was no statistically significant difference in reduction between groups. The findings indicate that both treatments appear to be effective, but that there may be no added benefit to advanced pneumatic treatment of the truncal lymphatics prior to arm massage when the trunk is not also affected.

A technology assessment requested by Centers for Medicare and Medicaid Services (CMS) was conducted by McMaster University Evidence-based Practice Center for the Agency for Healthcare Research and Quality (AHRQ) (Oremus, et al., 2010) diagnosis and treatment of secondary lymphedema. The review included randomized controlled trials or observation studies with comparison groups (e.g., cohort, case control). The assessment included the following:

- Regarding the question of whether one type of pneumatic compression device and sleeve (e.g., non-segmented compression device, sequential segmented compression, or segmented compression with calibrated gradient pressure) is more effective in reducing lymphedema than another for any type of lymphedema along the continuum, or patient characteristics—the review found that there was a lack of evidence from which to determine whether one type of intermittent pneumatic compression device and sleeve were more effective in reducing lymphedema based on specific sets of patient characteristics.

- There was no evidence concerning the optimal criteria to initiate or stop treatment for secondary lymphedema.

- There was significant heterogeneity in terms of treatments, inclusion and exclusion criteria, and treatment protocols to suggest the optimality of one type of treatment over another.

- There is no evidence to suggest an optimal frequency or duration of treatment, the most efficacious treatment combinations, the length of time for which persons should be tested or treatment for lymphedema and whether certain tests or treatments may benefit some types of patients more than others.

Shao et al. (2014) reported on a systematic review and meta-analysis of randomized controlled trials (RCT) to determine whether the use of an intermittent pneumatic pump (IPC) could manage lymphedema effectively. The review included seven clinical randomized controlled trials with 287 patients, with three RCTs (162 patients)
included in meta-analysis. The review included patients with prior history of treatment of breast carcinoma and lymphedema defined as an absolute increase in arm volume of at least 10% or 2 cm between the affected and unaffected arms. The primary outcome was the percent of volume reduction, with secondary outcomes subjective symptoms and joint mobility. The types of intervention were routine management of breast carcinoma and lymphedema BCRL with or without IPC. The results indicate that DLT and IPC reduced lymphedema and improved subjective symptoms, and neither of the methods was superior to the other. The studies were limited by small number of patients, the lack of reported details of randomization in many of the studies, and none of the trials stated if allocated concealment was performed.

Devoogdt et al. (2010) published a systematic review of combined physical therapy (CPT), intermittent pneumatic compression and arm elevation for the treatment of lymphedema secondary to an axillary dissection for breast cancer. After CPT, the maintenance phase consists of skin care, exercises, wearing a compression sleeve and manual lymphatic drainage if needed. The review included 10 randomized controlled trials (RCT), one pseudo-randomized controlled trial and four non-randomized experimental trials that investigated the effectiveness of combined physical therapy and its different parts, of intermittent pneumatic compression and arm elevation. Five studies (three RCT and two pseudo-RCTs) examined intermittent pneumatic compression. It was noted that the effectiveness of skin care, exercises, wearing a compression sleeve and arm elevation has not been investigated by a controlled trial. The studies indicate that intermittent pneumatic compression is effective, but once the treatment is interrupted, the lymphedema volume increases. The authors concluded that the long-term effect of compression is not yet proven.

A systematic review of the common conservative therapies for arm lymphedema secondary to breast cancer treatment was conducted by Mosely et al. (2007). The review included the following treatments: complex physical therapy, manual lymphatic drainage, pneumatic pumps, oral pharmaceuticals, low level laser therapy, compression bandaging and garments. The review found that the more intensive and health professional based therapies, such as complex physical therapy, manual lymphatic drainage, pneumatic pump and laser therapy generally yielded the greater volume reductions. Self-initiated therapies such as compression garment wear, exercise and limb elevation were found to yield a lesser volume reduction. The review included randomized, controlled, parallel and cross-over, case-control and cohort studies. A meta-analysis could not be performed due to the treatment and data heterogeneity. Five studies were included that examined pneumatic pump therapy. Two of these studies demonstrated that volume reduction could be achieved from pump therapy alone, although one study utilized higher pressure that was usually recommended. Three studies demonstrated that better results in volume reduction were achieved when the pneumatic pump was used in combination with other treatments, including: manual lymphatic drainage, compression garments and self massage. In addition, it was noted that three studies demonstrated that continuing pump therapy or wearing a compression garment were beneficial in maintaining the reduction in volume. The review concluded that, “Despite the range of positive outcomes identified in this review, the evidence to support them is, in some instances, poor. Therefore, there is still a need for large scale, high level clinical trials in this area”.

Ridner et al. (2008) conducted a study to compare treatment protocol adherence, satisfaction and perceived changes in emotional and functional status between patients with lymphedema using the home-based Flexitouch system. One hundred fifty-five patients were included in the study—93 with cancer related symptoms and 62 with noncancer-related lymphedema. A survey was completed before treatment and a post-therapy survey was completed during the maintenance phase of the protocol. Participants without cancer were more adherent to the prescribed protocol. Both groups were found to be satisfied with the system, perceived it to be effective and reported improvement in physical and emotional status. The limitations of the study included: post-therapy questionnaires were obtained from 64% of the participants, the findings in this study were self-reported, and there was no control group.

Wilburn, et al. (2006) reports on a prospective, randomized crossover study involving 10 patients that compared the efficacy of the Flexitouch to massage for treatment of lymphedema of the arm (Each phase included self-administered treatment with Flexitouch or massage for one hour daily for 14 days. Each phase was preceded by a one-week treatment washout, which included use of a garment only. It was noted that post-treatment arm volume was reduced with the Flexitouch, but not with massage. The device appeared to be well-tolerated by patients. This study was limited by the small sample size and short duration of treatment. In addition, there was no comparison to standard pneumatic lymphedema pumps or complex lymphedema therapy.
Chronic Venous Insufficiency (CVI)

Treatment of CVI is best initiated before the occurrence of venous ulceration. Knee-length heavyweight elastic stockings are recommended. Mild diuretic therapy (e.g., hydrochlorothiazide) may be of some help in persistent edema. The recommended treatment when ulceration occurs is an extended period of bed rest with elevation of the involved extremity well above heart level at all times, combined with wet-to-dry saline dressings to the ulceration, applied three times daily. The patient is encouraged to exercise the calf muscles repeatedly while in bed, ideally against a footboard, to minimize the occurrence of acute DVT (Freischlag, et al., 2012; Cantelmo and Brewster, 2009).

Pressure dressings are an alternative for patients with venous ulcers who are unable to spend extended periods with their legs elevated. The Unna paste venous boot is the standard approach to pressure dressings. Properly applied, this zinc-impregnated gauze pressure bandage can supply good compression and allows the patient to remain ambulatory. The boot is typically changed every 7–10 days and continued for 3–6 months. It is reported that up to 60% of ulcers will heal if continued for one year, with healing occurring in nearly 80% of cases. Once the ulcer is healed, chronic use of a heavyweight elastic stocking is resumed. Surgical referral may be recommended for recurrent or nonhealing ulcerations (Freischlag, et al., 2012; Cantelmo and Brewster, 2009).

Literature Review—Chronic Venous Insufficiency (CVI): Although there is limited evidence in the peer-reviewed published medical literature to support the use of pneumatic compression devices for the treatment of patients chronic venous insufficiency with significant ulceration of the lower extremities who have failed standard therapy (i.e., a compression bandage system or garment, dressings for the wounds, exercise, and elevation of the limb), the treatment has become the standard of care for this subset of patients.

Margolis et al. (1999) studied factors that predict which venous ulcers will not heal with limb compression bandages alone. They found that most ulcers that were < 6 months old and were < 5 cm² healed within 24 weeks with compression bandages alone. They chose a 24-week period, because it is a reasonable length of time to receive limb compression therapy, and it is the time frame frequently used for randomized clinical trials evaluating therapy for venous leg ulcers.

The effectiveness of intermittent pneumatic compression (IPC) as a treatment for venous leg ulcers was reviewed by Mani et al. (2001) and updated by Nelson et al. (2011; 2014). The review included nine, randomized controlled trials (including 489 people in total) with only one trial at low risk of bias overall having reported adequate randomization, allocation concealment and blinded outcome assessment. The results noted, “In one trial (80 people) more ulcers healed with IPC than with dressings (62% vs 28%; p=0.002). Five trials compared IPC plus compression with compression alone. Two of these (97 people) found increased ulcer healing with IPC plus compression than with compression alone. The remaining three trials (122 people) found no evidence of a benefit for IPC plus compression compared with compression alone. Two trials (86 people) found no difference between IPC (without additional compression) and compression bandages alone. One trial (104 people) compared different ways of delivering IPC and found that rapid IPC healed more ulcers than slow IPC (86% vs 61%).” The authors concluded that IPC may increase healing compared with no compression, however, it is unclear whether it can be used instead of compression bandages. It was found that there is some limited evidence that IPC may improve healing when added to compression bandages and rapid IPC was better than slow IPC in one trial. Further trials are required to determine the reliability of current evidence, which patients may benefit from IPC in addition to compression bandages, and the optimum treatment regimen.

The Agency for Healthcare Research and Quality (AHRQ) conducted a systematic review of the literature to evaluate evidence on the use of pneumatic compression devices in the home environment for treatment of CVI and venous ulcers. Eight trials met the inclusion criteria, including several randomized controlled trials. With the use of pneumatic compression devices, several studies showed significant improvement of longstanding chronic ulcers that had not healed with other methods. No studies compared the effectiveness of single-chamber devices with that of gradient multi-chamber devices. The authors noted that relative contraindications to pneumatic compression are significant arterial insufficiency, edema from congestive heart failure, active phlebitis, deep vein thrombosis, and the presence of localized wound infection or cellulitis (Berliner, et al., 2003).

Prevention of Deep Vein Thrombosis (DVT)
DVT is generally treated with the anticoagulants warfarin or heparin or a combination of the two drugs. Heparin acts quickly and is often stopped once warfarin starts working, usually two to three days after it is initiated. Other treatments include vena cava filters, which catch existing blood clots before they travel to the lung, and graduated compression stockings. Stockings fit over the foot up to the knee and are tight at the ankle and looser at the knee, creating a gentle pressure up the leg to prevent blood pooling and clotting. With pneumatic compression devices, the application and release of pressure promotes venous blood flow and may prevent DVT in patients who are at risk of developing this condition. Compression devices may be designed to fit over the patient’s leg, calf, or foot (foot pumps).

The use of pneumatic compression devices in the hospital setting for the prevention of VTE in high risk patients may be used as an alternative in medical patients with a high risk of bleeding or in whom anticoagulant drugs are contraindicated (e.g., GI bleeding, intracranial hemorrhage) and may be considered standard of care. It is theorized that intermittent pneumatic compression (IPC) prevents DVT by enhancing blood flow in the deep veins of the legs, thereby preventing venous stasis (Pai, et al., 2017). Pneumatic compression therapy in the home setting for the prevention of VTE including DVT and PE is not considered standard of care in the practicing medical community. The scientific evidence supporting the use of pneumatic compression therapy as a treatment modality in the home setting for the prevention of VTE including DVT is extremely limited. The literature mainly addresses the use of intermittent compression devices for prevention of DVT in the hospital setting until time of discharge.

Textbooks indicate that the best method of prophylaxis for thromboembolism is debatable. Currently in the inpatient setting, mechanical and pharmacologic modalities are used. It is generally agreed that patients should be mobilized as early and as rapidly as their general condition permits and that active exercises of both lower extremities help reduce venous stasis and thrombus formation. External pneumatic compression devices compare favorably with chemical prophylaxis in some randomized studies. Patient dissatisfaction with these devices occurs, and compliance may be a problem, although mobile units may have better acceptance (Harkness, et al., 2017).

Literature Review—Prevention of Deep Vein Thrombosis (DVT): The published literature for the use of pneumatic pumps for prevention of DVT in the home setting is limited. The published literature mainly addresses the use of pneumatic pumps in the hospital setting post-operatively for prevention of DVT.

Snyder et al. (2017) reported on a randomized controlled trial that examined whether there is a difference in deep vein thrombosis (DVT) occurrence after a limited tourniquet total knee arthroplasty (TKA) using aspirin-based prophylaxis with or without extended use of mechanical compression device (MCD) therapy in low-risk TKA patients. One hundred patients, whose DVT risk was managed with aspirin 325 mg twice daily for 3 weeks, were randomized to either using an MCD during hospitalization only (inpatient VPULSE group-52) or extended use at home up to 6 weeks (postdischarge VPULSE group-48) postoperatively. Lower extremity duplex venous ultrasonography (LEDVU) was completed on the second postoperative day, 14 days postoperatively, and at 3 months postoperatively to confirm the absence of DVT after treatment. The Cothera VPULSE Compression and Cold Therapy System (Cothera, LLC, Plano, TX) was the device used in the study, which provides both compression and cold therapy. There was early rapid mobilization and all received prophylactic aspirin at 325 mg twice daily for 3 weeks immediately postoperatively. The DVT rate for the postdischarge MCD therapy group was 0% and 23.1% for the inpatient MCD group (P < .001). All DVTs resolved by 3 months postoperatively. Patient satisfaction was 9.56 (±0.82) for postdischarge MCD patients vs 8.50 (±1.46) for inpatient MCD patients (P<.001). A data chip in the device was collected for recording the total number of hours of MCD usage; however, the chip did not allow the researchers to examine how this usage was spread over the three weeks and patient compliance in the postdischarge VPULSE group may have dropped off significantly following the first several days postdischarge. The authors concluded that although the study demonstrated a lower incidence of DVT in the post hospital group, this did not establish the best VTE prevention protocol. Additional studies of the use of aspirin in conjunction with MCD therapy may reinforce the findings of this study and lead to the creation and subsequent implementation of optimized regimens that offer low incidence of VTE in postoperative TKA patients.

Zhao et al. (2014) reported on a Cochrane review to assess the comparative effectiveness and safety of different intermittent pneumatic pump (IPC) devices with respect to the prevention of venous thromboembolism in patients
after total hip replacement (THR). One quasi-randomized controlled study with 121 study participants comparing two types of IPC devices met the inclusion criteria. The study found no cases of symptomatic deep vein thrombosis or pulmonary embolism in either the calf-thigh compression group or the plantar compression group during the first three weeks after the THR. The strength of the evidence in this review was determined to be weak since only one trial was included and was classified as having a high risk of bias. The authors concluded that there is a lack of evidence from randomized controlled trials to make an informed choice of IPC device for preventing venous thromboembolism following total hip replacement.

Colwell, et al (2014) reported on a noninferiority study of the mobile compression device compared to the standard pharmacological prophylaxis, including warfarin, enoxaparin, rivaroxaban, and dabigatran, with symptomatic end points and similar patient demographics. The study included following primary knee arthroplasty (1,551 patients) or hip arthroplasty (1,509) patients from ten sites. The compression device was used perioperatively and continued for a minimum of ten days. Patients with symptoms of deep venous thrombosis or pulmonary embolism underwent duplex ultrasonography and/or spiral computed tomography. All patients were evaluated at three months postoperatively to document any evidence of deep venous thrombosis or pulmonary embolism. The authors hypothesized that the mobile compression device would have approximately the same efficacy as pharmacological prophylaxis without the risk of major bleeding. The study adopted a 1.0% margin in the noninferiority study, with the hypothesis that a 1.0% difference in venous thromboembolism rates between the mobile compression device registry cohort and the pharmacological comparators would not constitute a clinically meaningful difference. Twenty-eight (0.92%) of the patients had venous thromboembolism (twenty distal deep venous thrombi, three proximal deep venous thrombi, and five pulmonary emboli). One death occurred, with no autopsy performed. The authors found that symptomatic venous thromboembolic rates observed in patients who had an arthroplasty of a lower-extremity joint using the mobile compression device were noninferior, at a margin of 1.0%, to the rates reported for pharmacological prophylaxis, including warfarin, enoxaparin, rivaroxaban, and dabigatran, except in the knee arthroplasty group, in which the mobile compression device fell short of the rate reported for rivaroxaban by 0.06%. Limitations of the study included the lack of randomization, the registry had a limited data set, and neither bleeding rates nor compliance were documented, compliance was not documented in the study. In addition, the study was not designed to establish conclusions regarding the use or nonuse of aspirin in addition to the mobile compression device- of the twenty-eight patients who had a venous thromboembolic event, 46% were on the aspirin protocol.

Peripheral Artery Disease

Peripheral artery disease (PAD) is a circulatory problem that develops when the arteries that supply blood to the extremities (usually the legs) become narrowed or blocked, resulting in an insufficient blood supply, or arterial insufficiency. PAD may be silent or present with a variety of symptoms and signs indicative of extremity ischemia (Berger, et al., 2017). Clinical manifestations of arterial insufficiency due to a lack of blood flow to the musculature may result in pain in the affected muscle groups. Other signs and symptom include presence of an extremity ulcer, claudication and rest pain. Treatment for PAD focuses on reduction of symptoms and prevention of further progression of the disease. Most individuals with claudication benefit from a comprehensive medical approach that includes risk factor modification, exercise rehabilitation, and use of standard pharmacotherapy for claudication. Critical limb ischemia is considered to be present in patients with lower extremity ischemic rest pain, ulceration, or gangrene. If left untreated, severe PAD could lead to major limb amputation. Minimally invasive treatment or surgery may be needed for patients who do not respond to medical intervention. Arterial ulcers, however, should not be compressed for fear of further arterial compromise (American Heart Association [AHA], 2012; Brewster, 2009; Hirsch, et al., 2006).

A proposed alternative for individuals with PAD who are ineligible or who fail medical or surgical therapies is the application of high pressures by compression cuffs placed on the thigh, the calf, and/or the foot. These devices intermittently inflate and deflate with cycle times and pressures that vary between devices. These devices offer higher pressures than offered in the typical pneumatic compression device. An example is the ArtAssist® Device (ACI Medical LLC, San Marcos, CA) a mechanical pneumatic pump consisting of an impulse generator and two plastic inflatable cuffs, applies high pressure in a synchronized manner to the foot and calf. This treatment is usually performed for three hours per day while the patient is sitting upright (ACI Medical, Inc.).

Literature review—Peripheral Artery Disease:
Moran et al. (2015) reported on a systematic review of intermittent pneumatic compression for critical limb ischemia. Two controlled before-and-after (CBA) studies and six case series were identified. No randomized controlled trials (RCTs) or non-randomized controlled trials (NRCTs) were identified. One retrospective CBA study involving compression of the calf reported improved limb salvage and wound healing and one prospective CBA study involving sequential compression of the foot and calf reported statistically significant improvements in claudication distances and SF-36 quality of life scores. There was no difference in all-cause mortality found. Complications included pain associated with compression, as well as skin abrasion and contact rash as a result of the cuff rubbing against the skin. It was noted that all studies had a high risk of bias.

The authors concluded that the limited available results suggest that IPC may be associated with improved limb salvage, wound healing and pain management; however, in the absence of additional well-designed analytical studies examining the effect of IPC in critical limb ischemia, the treatment remains unproven.

Abu Dabrh et al (2015) reported on a systematic review that examined evidence about various nonrevascularization-based therapies used to treat patients with severe or critical limb ischemia (CLI) who are not candidates for surgical revascularization. The review included 19 studies (2779 patients) of controlled randomized and nonrandomized studies that compared the effect of medical therapies (prostaglandin E1 and angiogenic growth factors) and devices (pumps and spinal cord stimulators). None of the nonrevascularization-based treatments were associated with a significant effect on mortality. Intermittent pneumatic compression (IPC) use was associated with statistically significant improvements in ulcer healing and amputation, but these results were derived from single small nonrandomized study. The authors note that replication of such results is needed, and the effect needs to be verified in larger randomized controlled trials.

Hayes published a Medical Technology Directory Report regarding intermittent pneumatic compression (IPC) for PAD (Hayes, 2013; 2017). Fourteen studies were included for the review that addressed IPC as a treatment for PAD of the lower extremities. Twelve studies were designed to assess the safety and efficacy of IPC for PAD including three randomized controlled trials (RCTs), three randomized comparative trials, two prospective controlled trials, and four prospective case series. The primary outcome measures reported in the reviewed studies include: initial claudication distance (ICD) (walking distance at which pain first occurs), absolute claudication distance (ACD) (distance at which pain is too great to continue walking), and quality of life (QOL). Secondary outcome measures include: hemodynamic measures, such as ankle-brachial index (ABI), transcutaneous oxygen tension (TcPO2), peak systolic velocity (PSV), and flow volume (FV). Studies investigating the use of IPC for more advanced cases of IPC had limb salvage and mortality as primary measures. The review found that some evidence suggests that IPC may be an effective and reasonably safe therapy for improving walking ability, limb salvage, and QOL in patients with PAD. IPC may improve walking ability and hemodynamic measures compared with no treatment, and may improve walking ability when provided in addition to exercise and aspirin, clopidogrel, and propionyl-L-carnitine (PLC). There is some evidence from poor-quality studies suggests that IPC may also increase limb salvage and decrease rest pain in patients with critical limb ischemia (CLI) who are not candidates for revascularization. IPC appeared inferior to compression stockings for postoperative edema following femoropopliteal bypass surgery in patients with PAD. Both the number of studies and their sample sizes were small, and some studies provided low-quality evidence.

Literature Review–Other Indications

There is a paucity of randomized controlled or comparative trials in the peer-reviewed medical literature supporting the efficacy of pneumatic compression devices for the treatment of other indications in the home setting, including but not limited to, fracture and soft-tissue healing and restless leg syndrome. No standardization of devices exists with the mode of compression, the flow rate, or the type of sleeve. Many of the studies of compression devices are on small groups of patients using more than a single modality (Khanna, et al., 2008; Eliasson and Lettieri, 2007; Handoll, et al., 2006; Labropoulos, et al., 2002).

Restless Leg Syndrome (RLS): In a prospective, randomized, double-blinded, sham-controlled trial (n=35), Lettieri and Eliasson (2009) evaluated the effectiveness of pneumatic compression devices (PCDs) as a non-pharmacologic treatment for restless legs syndrome (RLS). Devices were provided to subjects who were enrolled for home use. Subjects wore a therapeutic or sham device prior to the usual onset of symptoms for a minimum of one hour daily. Measures of severity of illness, quality of life, daytime sleepiness, and fatigue were compared at baseline and after one month of therapy. Groups were similar at baseline. Therapeutic PCDs significantly improved all measured variables more than shams. Restless legs severity score improved from 14.1
+/- 3.9 to 8.4 +/- 3.4 (p=0.006) and Johns Hopkins restless legs scale improved from 2.2 +/- 0.5 to 1.2 +/- 0.7 (p=0.01). All quality of life domains improved more with therapeutic than sham devices (social function 14% versus 1%, respectively; p=0.03; daytime function 21% versus 6%, respectively, p=0.02; sleep quality 16% versus 8%, respectively, p=0.05; emotional well-being 17% versus 10%, respectively, p=0.15). Both Epworth sleepiness scale (6.5 +/- 4.0 versus 11.3 +/- 3.9, respectively, p=0.04) and fatigue (4.1 +/- 2.1 versus 6.9 +/- 2.0, respectively, p=0.01) improved more with therapeutic devices than sham devices. Complete relief occurred in one-third of subjects using therapeutic and in no subjects using sham devices. The authors reported that PCDs resulted in clinically significant improvements in symptoms of RLS in comparison to the use of sham devices and may be an effective adjunctive or alternative therapy for RLS. Moreover, the authors stated that before PCD therapy is ready for more widespread use, it will be important to see validating studies in various populations of RLS patients. This study did not report long-term outcomes. Additionally the authors reported that while effective for RLS treatment, the role of PCDs may be limited. RLS medications are effective, relatively safe, and usually well tolerated. Additionally, medications are obviously easier to use than PCDs, which require patients to remain immobile for one hour each day.

Fracture and Soft-Tissue Healing: In a review of the literature, Khanna et al. (2008) stated that current methods of fracture care use various adjuncts to try and decrease time to fracture union, improve fracture union rates and enhance functional recovery; and one such modality is IPC. A total of nine studies on the use of IPC in fracture and soft-tissue healing (e.g., distal radius, ankle, calcaneal fractures, acute ankle sprains) were identified. These studies demonstrated that IPC facilitates both fracture and soft-tissue healing with rapid functional recovery. The authors reported that IPC appears to be an effective modality to enhance fracture and soft-tissue healing however the number of subjects is small, and adequately powered randomized controlled trials are needed to produce stronger clinically relevant evidence.

In a Cochrane review, Handoll et al. (2006) examined the effects of rehabilitation interventions in adults with conservatively or surgically treated distal radial fractures. Of the fifteen trials one trial included the use of intermittent pneumatic compression. The authors reported that there was not enough evidence available to determine the best form of rehabilitation for people with wrist fractures.

Compression Garments
Lymphedema or compression garments for the extremities have been widely used in the treatment of lymphedema. Compression garments may be elastic and non-elastic and may be used alone or in combination with other treatments, including lymphedema pumps and complex lymphedema treatment (CLT). They are used for the purpose of preventing an increase in lymphedema and maintaining the reduction of lymphedema after treatment. A sleeve may be needed for lymphedema of the arm and a glove or gauntlet may also be used if lymphedema is present in the hand. If there is lymphedema of the lower extremity, a compression stocking may be needed. The garment may need replacement when elasticity is lost, approximately every 4–6 months.

Elastic garments may be custom-fitted or prefabricated and have varying degrees of elasticity. The type of sleeve used is dependent on the size needed and whether the patient correctly fits the parameters of the prefabricated garment. It is important that the garment fit correctly and provide adequate, graduated compression.

Compression garments include:
- Jobst® Armsleeve (BSN-JOBST, Inc., Charlotte, NC)
- Juzo® compression arm sleeves, gauntlets, stockings (Juzo, Cuyahoga Falls, OH)
- FarrowWrap® (Farrow Medical Innovations, Bryan, TX) includes stockings, arm sleeves, gauntlet
- Mediven® lymphedema garments (Medi, Whitsett, NC) available in arm sleeve, gauntlet, stockings, combination styles, and glove
- Tribute® (Solaris, West Allis, WI) includes upper and lower extremity garments

Non-elastic Compression Garments: Non-elastic compression garments utilize a non-elastic textile that is fastened by adjustable hooks and loops to provide compression. They can be worn during the day or night. Both custom-made and prefabricated garments are available.

Non-elastic compression garments include:
• ReidSleeve®, and Optiflow® sleeves (Peninsula Medical, Inc., Scotts Valley, CA)
• ArmAssist® and LegAssist® (BiaCare, Zeeland, MI)
• CircAid® (CircAid Medical Products Inc., San Diego, CA)
• ReadyWrap® (Solaris, West Allis, WI) includes upper and lower extremity garments. They are considered low-stretch.

Compression Garments for Chest or Trunk: The role of chest and trunk garments in the treatment of lymphedema is unclear. These garments include a vest, such as the made-to-order JoViPak® vest (JoViPak, Kent, WA), and the Tribute® vest or torso garment (Solaris, West Allis, WI). Evidence supporting the use of trunk or chest compression garments is lacking. The impact on meaningful health outcomes through the use of these garments is not known at this time. Which patients would most benefit from these devices has not been clearly defined in the literature.

U.S. Food and Drug Administration (FDA): The FDA classifies compression sleeves as Class I devices, therapeutic medical binders. They are exempt from the premarket notification procedure.

Professional Societies/Organizations
American Academy of Orthopaedic Surgeons (AAOS): AAOS published guidelines for preventing venous thromboembolic disease in patients undergoing elective hip and knee arthroplasty. The guidelines are not specific to the home setting. The guidelines include these recommendations:

• Suggest the use of pharmacologic agents and/or mechanical compressive devices for the prevention of venous thromboembolism in patients undergoing elective hip or knee arthroplasty, and who are not at elevated risk beyond that of the surgery itself for venous thromboembolism or bleeding.
  Grade of Recommendation: Moderate
• Current evidence is unclear about which prophylactic strategy (or strategies) is/are optimal or suboptimal. Therefore, we are unable to recommend for or against specific prophylactics in these patients.
  Grade of Recommendation: Inconclusive
• In the absence of reliable evidence about how long to employ these prophylactic strategies, it is the opinion of this work group that patients and physicians discuss the duration of prophylaxis.
  Grade of Recommendation: Consensus
• In the absence of reliable evidence, it is the opinion of this work group that patients undergoing elective hip or knee arthroplasty, and who have also had a previous venous thromboembolism, receive pharmacologic prophylaxis and mechanical compressive devices.
  Grade of Recommendation: Consensus
• In the absence of reliable evidence, it is the opinion of this work group that patients undergoing elective hip or knee arthroplasty, and who also have a known bleeding disorder (e.g., hemophilia) and/or active liver disease, use mechanical compressive devices for preventing venous thromboembolism.
  Grade of Recommendation: Consensus

Grade of recommendation:
Moderate: Evidence from two or more “Moderate” strength studies with consistent findings, or evidence from a single "High" quality study for recommending for or against the intervention. A Moderate recommendation means that the benefits exceed the potential harm (or that the potential harm clearly exceeds the benefits in the case of a negative recommendation), but the strength of the supporting evidence is not as strong.
Implications: Practitioners should generally follow a Moderate recommendation but remain alert to new information and be sensitive to patient preferences.
Inconclusive: Evidence from a single low quality study or conflicting findings that do not allow a recommendation for or against the intervention. An Inconclusive recommendation means that there is a lack of compelling evidence resulting in an unclear balance between benefits and potential harm.
Implications: Practitioners should feel little constraint in following a recommendation labeled as Inconclusive, exercise clinical judgment, and be alert for emerging evidence that clarifies or helps to determine the balance between benefits and potential harm. Patient preference should have a substantial influencing role.
Consensus: The supporting evidence is lacking and requires the work group to make a recommendation based on expert opinion by considering the known potential harm and benefits associated with the treatment. A
Consensus recommendation means that expert opinion supports the guideline recommendation even though there is no available empirical evidence that meets the inclusion criteria of the guideline’s systematic review. Implications: Practitioners should be flexible in deciding whether to follow a recommendation classified as Consensus, although they may give it preference over alternatives. Patient preference should have a substantial influencing role.

**American College of Cardiology/American Heart Association (AHA/ACC):** these organizations published clinical practice guidelines on the management of patients with lower extremity peripheral artery disease (Gerhard-Herman, et al., 2016). The recommendations note that, "In patients with critical limb ischemia (CLI), intermittent pneumatic compression (arterial pump) devices may be considered to augment wound healing and/or ameliorate severe ischemic rest pain"

- **Class (strength) of recommendation (COR):** IIb
- **Level of evidence (LOE):** B-NR

**Recommendation system:**
- (COR) Class (strength) of recommendation:
  - IIb: weak
- (LOE) Level (quality) of evidence B-NR:
  - moderate quality evidence from one or more well-designed well-executed nonrandomized studies, observational studies or registry studies
  - meta-analyses of such studies

**American College of Chest Physicians:** This organization published clinical practice guidelines for prevention of VTE in orthopedic surgery patients (Falck-Ytter, et al., 2012). The guidelines recommend for patients undergoing major orthopedic surgery: total hip arthroplasty (THA), total knee arthroplasty (TKA), hip fracture surgery (HFS):

- Thromboprophylaxis Compared with No Prophylaxis: In patients undergoing THA or TKA, the panel recommends use of one of the following for a minimum of 10 to 14 days rather than no antithrombotic prophylaxis: low-molecular-weight heparin (LMWH), fondaparinux, apixaban, dabigatran, rivaroxaban, low-dose unfractionated heparin (LDUH), adjusted-dose vitamin K antagonist (VKA), aspirin (all Grade 1B), or an intermittent pneumatic compression device (IPCD) (Grade 1C).

**Grade 1C: Strong recommendation, low- or very-low-quality evidence**

**National Lymphedema Network (NLN):** The NLN published a position statement regarding treatment of lymphedema (NLN, 2011). This consensus document indicates that complete decongestive therapy (CDT) is the current international standard of treatment for managing lymphedema. Regarding the use of lymphedema pumps, it is noted that:

- Intermittent Pneumatic Compression Therapy (IPC), also known as compression pump therapy, can be useful in some patients as an adjunct to Phase I CDT or a necessary component of a successful home program
- IPC is not considered a “standalone” treatment. It is utilized along with standard CDT to maintain control of lymphedema at home. To maintain edema control, a compression garment, or short stretch bandages, should be worn between pump treatments and also when IPC therapy is discontinued.
- Patients who require IPC may need a pump that treats the trunk of the body and not just the limb with the swelling.
- Compression garments are essential for long-term control of lymphedema volume. The patient should be fitted with a compression garment following maximal volume reduction resulting from Phase I of complex lymphedema treatment (CLT).

**Society for Vascular Surgery (SVS) and the American Venous Forum (AVF):** these organizations published clinical practice guidelines for management of venous leg ulcers. The guidelines recommend the use of intermittent pneumatic compression when other compression options are not available, cannot be used, or have failed to aid in venous leg ulcer healing after prolonged compression therapy (O'Donnell, et al., 2014).
Use Outside of the US

International Society of Lymphology (ISL): In 2013 the ISL published an updated consensus document regarding the diagnosis and treatment of peripheral lymphedema (ISL, 2013). The document makes the following comments regarding lymphedema treatment:

- Treatment of peripheral lymphedema is divided into conservative (i.e., nonoperative methods) and operative methods. Both methods include an understanding that meticulous skin hygiene and care is of extreme importance to the success of all treatment approaches.
- Intermittent pneumatic compression is included in the document as a standard treatment for lymphedema. After external compression therapy, form-fitting stockings or sleeves are used to maintain edema reduction.
- Newer devices that simulate manual massage and design improvements for area of coverage, ease of use, and sequence/actions may increase patient compliance.
- An assessment should be made of limb volume before, during and after treatment. Treatment outcomes should be reported in standardized manner in order to assess effectiveness of treatment protocols.

European Federation of Neurological Societies, European Neurological Society, European Sleep Research Society: Joint guidelines from these organizations on management of restless legs syndrome do not include the use of pneumatic compression pump for treatment of restless legs syndrome (Garcia-Borreguero, et al., 2012).

Coding/Billing Information

Note: 1) This list of codes may not be all-inclusive.

  2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

**Lymphedema compression garments**

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4465</td>
<td>Non-elastic binder for extremity</td>
</tr>
<tr>
<td>A6530</td>
<td>Gradient compression stocking, below knee, 18-30 mmhg, each</td>
</tr>
<tr>
<td>A6531</td>
<td>Gradient compression stocking, below knee, 30-40 mmhg, each</td>
</tr>
<tr>
<td>A6532</td>
<td>Gradient compression stocking, below knee, 40-50 mmhg, each</td>
</tr>
<tr>
<td>A6533</td>
<td>Gradient compression stocking, thigh length, 18-30 mmhg, each</td>
</tr>
<tr>
<td>A6534</td>
<td>Gradient compression stocking, thigh length, 30-40 mmhg, each</td>
</tr>
<tr>
<td>A6535</td>
<td>Gradient compression stocking, thigh length, 40-50 mmhg, each</td>
</tr>
<tr>
<td>A6536</td>
<td>Gradient compression stocking, full length/chap style, 18-30 mmhg, each</td>
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<td>Gradient compression stocking, full length/chap style, 30-40 mmhg, each</td>
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<tr>
<td>A6539</td>
<td>Gradient compression stocking, waist length, 18-30 mmhg, each</td>
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<td>A6540</td>
<td>Gradient compression stocking, waist length, 30-40 mmhg, each</td>
</tr>
<tr>
<td>A6541</td>
<td>Gradient compression stocking, waist length, 40-50 mmhg, each</td>
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<tr>
<td>S8420</td>
<td>Gradient pressure aid (sleeve and glove combination), custom made</td>
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<tr>
<td>S8421</td>
<td>Gradient pressure aid (sleeve and glove combination), ready made</td>
</tr>
<tr>
<td>S8422</td>
<td>Gradient pressure aid (sleeve), custom made, medium weight</td>
</tr>
<tr>
<td>S8423</td>
<td>Gradient pressure aid (sleeve), custom made, heavy weight</td>
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<tr>
<td>S8424</td>
<td>Gradient pressure aid (sleeve), ready made</td>
</tr>
<tr>
<td>S8425</td>
<td>Gradient pressure aid (glove), custom made, medium weight</td>
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<tr>
<td>S8426</td>
<td>Gradient pressure aid (glove), custom made, heavy weight</td>
</tr>
<tr>
<td>S8427</td>
<td>Gradient pressure aid (glove), ready made</td>
</tr>
</tbody>
</table>
Gradient pressure aid (gauntlet), ready made

**Standard pneumatic compression pumps**

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>E0650</td>
<td>Pneumatic compressor; nonsegmental home model</td>
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<tr>
<td>E0651</td>
<td>Pneumatic compressor; segmental home model without calibrated gradient pressure</td>
</tr>
<tr>
<td>E0652</td>
<td>Pneumatic compressor; segmental home model with calibrated gradient pressure</td>
</tr>
<tr>
<td>E0655</td>
<td>Nonsegmental pneumatic appliance for use with pneumatic compressor; half arm</td>
</tr>
<tr>
<td>E0660</td>
<td>Nonsegmental pneumatic appliance for use with pneumatic compressor; full leg</td>
</tr>
<tr>
<td>E0665</td>
<td>Nonsegmental pneumatic appliance for use with pneumatic compressor; full arm</td>
</tr>
<tr>
<td>E0666</td>
<td>Nonsegmental pneumatic appliance for use with pneumatic compressor; half leg</td>
</tr>
<tr>
<td>E0667</td>
<td>Segmental pneumatic appliance for use with pneumatic compressor; full leg</td>
</tr>
<tr>
<td>E0668</td>
<td>Segmental pneumatic appliance for use with pneumatic compressor; full arm</td>
</tr>
<tr>
<td>E0669</td>
<td>Segmental pneumatic appliance for use with pneumatic compressor; half leg</td>
</tr>
<tr>
<td>E0671</td>
<td>Segmental gradient pressure pneumatic appliance; full leg</td>
</tr>
<tr>
<td>E0672</td>
<td>Segmental gradient pressure pneumatic appliance; full arm</td>
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<tr>
<td>E0673</td>
<td>Segmental gradient pressure pneumatic appliance; half leg</td>
</tr>
<tr>
<td>E0676</td>
<td>Intermittent limb compression device (includes all accessories), not otherwise specified</td>
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</table>

<table>
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<tr>
<th>ICD-9-CM Diagnosis Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>454.0</td>
<td>Varicose veins of lower extremity with ulcer</td>
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<td>454.2</td>
<td>Varicose veins of lower extremity with ulcer and inflammation</td>
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<tr>
<td>457.0</td>
<td>Post-mastectomy lymphedema syndrome</td>
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<tr>
<td>457.1</td>
<td>Other lymphedema</td>
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<td>457.2</td>
<td>Lymphangitis</td>
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<td>459.2</td>
<td>Compression of vein</td>
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<tr>
<td>459.81</td>
<td>Venous (peripheral) insufficiency, unspecified</td>
</tr>
<tr>
<td>707.10-707.19</td>
<td>Ulcer of lower limbs, except pressure ulcer</td>
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<td>757.0</td>
<td>Hereditary edema of legs</td>
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<table>
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<th>ICD-10-CM Diagnosis Codes</th>
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<tr>
<td>I83.001-183.029</td>
<td>Varicose veins of lower extremity with ulcer</td>
</tr>
<tr>
<td>I83.201-183.229</td>
<td>Varicose veins of lower extremity with both ulcer and inflammation</td>
</tr>
<tr>
<td>I87.1</td>
<td>Compression of vein</td>
</tr>
<tr>
<td>I87.2</td>
<td>Venous insufficiency (chronic) (peripheral)</td>
</tr>
<tr>
<td>I89.0</td>
<td>Lymphedema, not elsewhere classified</td>
</tr>
<tr>
<td>I89.1</td>
<td>Lymphangitis</td>
</tr>
<tr>
<td>I97.2</td>
<td>Postmastectomy lymphedema syndrome</td>
</tr>
<tr>
<td>L97.101-</td>
<td>Non-pressure chronic ulcer of lower extremity</td>
</tr>
</tbody>
</table>
Considered Experimental/Investigational/Unproven:

<table>
<thead>
<tr>
<th>ICD-9-CM Diagnosis Codes</th>
<th>Description</th>
</tr>
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<tbody>
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<td>All other codes</td>
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</table>

<table>
<thead>
<tr>
<th>ICD-10-CM Diagnosis Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Considered Experimental/Investigational/Unproven when used to report chest and/or trunk pneumatic appliances for use with pneumatic compression pumps or compression garments for the trunk and/or chest:

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0656</td>
<td>Segmental pneumatic appliance for use with pneumatic compressor, trunk</td>
</tr>
<tr>
<td>E0657</td>
<td>Segmental pneumatic appliance for use with pneumatic compressor, chest</td>
</tr>
<tr>
<td>E0670</td>
<td>Segmental pneumatic appliance for use with pneumatic compressor, integrated, 2 full legs and trunk</td>
</tr>
<tr>
<td>E1399</td>
<td>Durable medical equipment, miscellaneous</td>
</tr>
</tbody>
</table>

Pneumatic Compression devices for arterial insufficiency

Considered Experimental/Investigational/Unproven when used to report pneumatic compression device for arterial insufficiency:

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
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<tr>
<td>E0675</td>
<td>Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency (unilateral or bilateral system)</td>
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<th>ICD-9-CM Diagnosis Codes</th>
<th>Description</th>
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<th>ICD-10-CM Diagnosis Codes</th>
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References


69. Neschis DG. Clinical features and diagnosis of lower extremity peripheral artery disease. In: UpToDate, Post TW (Ed), UpToDate, Waltham, MA. (Accessed on August 29, 2017).


