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Kaiser Foundation Health Plan of Washington

Clinical Review Criteria

Pneumatic Compression Devices

- Treatment of Lymphedema and Chronic Venous Insufficiency
- Prevention of Deep Vein Thrombosis

Intermittent Pneumatic Compression for the Treatment of Peripheral Arterial Occlusive Disease

- ArtAssist Device
- ArterialFlowTM System
- Flow MedicTM System

Criteria

For Medicare Members

Source	Policy
CMS Coverage Manuals	None
National Coverage Determinations (NCD)	Pneumatic Compression Devices (280.6) For the Prevention of Post-Operative Deep Vein Thrombosis in the outpatient setting Pneumatic compression for the VTE prophylaxis (E0676, A4600) has generally not been considered medically necessary as evidenced in the retired Pneumatic Compression Devices (L33829) and Pneumatic Compression Devices (A52488). Devices for the prevention of disease or illness are statutorily non-covered under Social Security Act §1862(a)(1)(A). Refer to the Medicare Benefit Policy Manual, Chapter 16, §20 – Services Not Reasonable and Necessary. For the treatment of lymphedema or for the treatment of chronic insufficiency of the lower extremity, refer to the above NCD for Pneumatic Compression Devices (280.6).
Local Coverage Determinations (LCD)	11/14/2024 Noridian retired Pneumatic Compression Devices (L33829)**.** These services still need to meet medical necessity as outlined in the LCD and will require review. LCDs are retired due to lack of evidence of current problems, or in some cases because the material is addressed by a National Coverage Decision (NCD), a coverage provision in a CMS interpretative manual or an article. Most LCDs are not retired because they are incorrect. Therefore, continue to use LCD L33829 in addition to NCD 280.6 for determining medical necessity. Pneumatic compression for the VTE prophylaxis (E0676) has generally not been considered medically necessary as

Back to Top

	evidenced in the retired Pneumatic Compression Devices (L33829) and Pneumatic Compression Devices (A52488). Refer to the related Policy Article NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES section for information about lack of a Medicare benefit for devices used for prophylaxis of venous thrombosis.
Local Coverage Article	Pneumatic Compression Devices (A52488) 11/14/2024 Noridian retired Pneumatic Compression Devices (A52488)**.** These services still need to meet medical necessity as outlined in the LCD and will require review. LCDs are retired due to lack of evidence of current problems, or in some cases because the material is addressed by a National Coverage Decision (NCD), a coverage provision in a CMS interpretative manual or an article. Most LCDs are not retired because they are incorrect. Therefore, continue to use LCD L33829 in addition to NCD 280.6 for determining medical necessity

For Non-Medicare Members

Service	Criteria
Pneumatic Compression Device	Pneumatic Compression Devices (280.6) 11/14/2024 Noridian retired Pneumatic Compression Devices (L33829)**.** These services still need to meet medical necessity as outlined in the LCD and will require review. LCDs are retired due to lack of evidence of current problems, or in some cases because the material is addressed by a National Coverage Decision (NCD), a coverage provision in a CMS interpretative manual or an article. Most LCDs are not retired because they are incorrect. Therefore, continue to use LCD L33829 in addition to NCD 280.6 for determining medical necessity
Intermittent Pneumatic Compression for the Treatment of Peripheral Arterial Occlusive Disease • ArtAssist Device • ArterialFlowTM System • Flow MedicTM System	Pneumatic compression for the indication of PAD (E0675) has generally not been considered medically necessary as evidenced in the retired Pneumatic Compression Devices (L33829) and Pneumatic Compression Devices (A52488)
Prevention of Post-Operative Deep Vein Thrombosis in the outpatient setting	There is insufficient evidence in the published medical literature to show that this service/therapy is as safe as standard services/therapies and/or provides better long-term outcomes than current standard services/therapies. Pneumatic compression for the VTE prophylaxis (E0676, A4600) has generally not been considered medically necessary as evidenced in the retired Pneumatic Compression Devices (L33829) and Pneumatic Compression Devices (A52488). Devices for the prevention of disease or illness are statutorily non-covered under Social Security Act §1862(a)(1)(A). Refer to the Medicare Benefit Policy Manual, Chapter 16, §20 – Services Not Reasonable and Necessary. For the treatment of lymphedema or for the treatment of chronic insufficiency of the lower extremity, refer to the above

Back to Top

	NCD for Pneumatic Compression Devices (280.6).

*Definitions

***Edema**:* Edema is a non-specific term for the accumulation of fluid in tissue, most often in the extremities. There are numerous causes for edema, ranging from systemic disorders (e.g. congestive heart failure, etc.) to local conditions (post-surgery, congenital abnormalities, etc.). (Examples are not all-inclusive).

Lymphedema, as discussed below, is just one group of conditions that can be a cause of accumulation of fluid in the tissue. Lymphedema arises from disorders of the lymphatic system. It is essential to rule out other causes of edema in order to diagnose lymphedema. Edema from other causes is not classified as lymphedema for purposes of Medicare reimbursement for PCDs (E0650-E0652).

Primary lymphedema: Primary lymphedema is a disorder of the lymphatic system that occurs on its own. It is inherited and uncommon. Examples (not all-inclusive) are:

A. Congenital lymphedema due to lymphatic aplasia or hypoplasia
B. Milroy's disease, an autosomal dominant familial form of congenital lymphedema
C. Lymphedema praecox
D. Lymphedema tarda

Secondary lymphedema: Secondary lymphedema is a disorder of lymphatic flow that is caused by some other disease or condition. It is more common than primary lymphedema. It is most commonly caused by surgery (especially lymph node dissection, such as for breast cancer), radiation therapy (especially axillary or inguinal), trauma, lymphatic obstruction by tumor, and, in developing countries, lymphatic filariasis. Secondary lymphedema may also result from compression of the lymphatic and venous channels resulting from leakage of fluid into interstitial tissues in patients with chronic venous insufficiency. (See below)

Chronic Venous Insufficiency (CVI): Lymphedema may also be caused by CVI when fluid leaks into the tissues from the venous system. CVI of the lower extremities is a condition caused by abnormalities of the venous wall and valves, leading to obstruction or reflux of blood flow in the veins. Signs of CVI include hyperpigmentation, stasis dermatitis, chronic edema, and venous ulcers. The incidence of lymphedema from CVI is not well established.

Peripheral Arterial Disease (PAD): Peripheral artery disease is a circulatory problem in which narrowed arteries reduce blood flow to limbs, resulting in compromised blood flow to the distal tissue and failure to keep up with oxygen demands.

If requesting these services, please send the following documentation to support medical necessity:

- Last 6 months of clinical notes from requesting provider &/or specialist
- Last 6 months of radiology notes if applicable

The following information was used in the development of this document and is provided as background only. It is provided for historical purposes and does not necessarily reflect the most current published literature. When significant new articles are published that impact treatment option, Kaiser Permanente will review as needed. This information is not to be used as coverage criteria. Please only refer to the criteria listed above for coverage determinations.

Background

Pneumatic Compression Device

Thromboembolic disease is a common complication following surgery particularly total joint replacement arthroplasty. It has been reported that without prophylaxis the rate of deep vein thrombosis (DVT) is as high as 88% after total knee arthroplasty and as high as 50% after total hip arthroplasty. It is also reported that lower extremity DVT is the origin of 90% of symptomatic pulmonary embolism (PE). Prophylaxis for DVT has become the standard of care for total joint arthroplasty. Chemical prophylaxis with warfarin or low-molecular weight heparin effectively reduces the incidence of DVT but carries a risk of bleeding. Orthopedic surgeons thus often

 Back to Top

use mechanical methods of prophylaxis as an alternative to chemoprophylaxis in patients with higher bleeding risk. Other surgeons also use it in standard risk patients in conjunction with the anticoagulant-based prophylaxis (Edwards 2008, Zywiel 2010).

Graduated compression stockings (GCSs) and intermittent pneumatic compression (IPC) are the two predominant mechanical methods used for DVT prevention. These have quite different methods of action; graduated compression stockings apply a constant pressure to the limb with the aim of maintaining a reduced venous caliber and preventing the static accumulation of blood. Intermittent pneumatic compression actively empties the deep veins of the limb in a predetermined cycle of pressure, producing a pulse of blood that travels proximally preventing stasis. On deflation of the cuff, the veins will refill, the intermittent nature of the system will insure periodic blood flow through the deep veins, as long as there is a supply. The IPC cuffs are normally wrapped around a limb, secured by velcro, and attached with tubes to an electric pump to regulate the pressure applied (Morris 2004, Morris 2010, Sobieraj-Teague 2011).

GCSs do not require attachment to any device and allow the patient to move freely. They come in a range of sizes and the limb has to be measured accurately to prevent incorrect pressure gradients, which may increase the risk of DVT. Intermittent compression devices are available in different forms; the cuff can cover the whole leg, the calf, or just the feet, it may inflate uniformly or sequentially with graded pressure; and can have rapid or moderate inflation rates. These characteristics my influence patient compliance which is critical as the longer the device is used, the better is the protection. The major disadvantages for standard IPC devices used in hospitals are their size, weight, and reliance on external power source, all of which result in poor patient compliance and in turn limit the efficacy of the device (Morris 2004, Froimson 2009).

In an attempt to overcome the problem of poor patient compliance with traditional mechanical compression systems, several lightweight, portable, battery-powered devices were developed to allow their use by the patient while ambulating in the hospital or at home after discharge. Many of these devices have received FDA clearance.

Background

Intermittent Pneumatic Compression for the Treatment of Peripheral Arterial Occlusive Disease

Peripheral arterial disease (PAD) is a common condition that affects approximately 8-12 million people in the US. The prevalence of the disease increases rapidly with age and is associated with significant morbidity and mortality. PAD commonly affects the arteries supplying the leg and is mostly caused by atherosclerosis. Restriction of blood flow due to arterial stenosis or occlusion is commonly clinically presented as intermittent claudication which is pain in the calf muscles that occurs on walking or exercising and is rapidly relieved by resting.

The clinical course of patients with intermittent claudication is variable. Most patients either improve or have a stable condition, but over one fourth will experience deterioration in symptoms. These patients may eventually develop critical leg ischemia or gangrene which can lead to amputation. Fontaine classified chronic leg ischemia into four stages: Stage I: asymptomatic, stage II: intermittent claudication, stage III: ischemic rest pain, and stage IV: ulceration, gangrene, or both (Hirsch 2001, Leng 1993, Delis 2000, 2005, Beard 2000).

The treatment of PAD aims at increasing blood flow to alleviate symptoms and prevent arterial leg ulcers, critical leg ischemia, and major complications. Management options for claudication include a structured program of regular exercise, smoking cessation, control of risk factors or associated medical diseases, percutaneous transluminal angioplasty, and surgical revascularization. Drug therapy, even with the most effective agents, was found to result in only a modest improvement. Surgical bypass reconstruction is indicated for severe cases and after failure of other forms of conservative therapy. Patients with non-healing ulcers may not be suitable for revascularization for technical reasons, frail condition, or rejection of surgical intervention. Due to the limited non-operative treatment options, long-term graft failure, perioperative deaths, and imitations or contraindications to intervention, researchers have focused their attention on mechanical methods as potential means for augmenting arterial volume flow in lower limbs (Delis 2000, Montori 2002, 2005).

The concept of using mechanical means to increase blood flow to an ischemic limb dates back to 1930s when a group of investigators applied alternating external pressure to ischemic legs with advanced atherosclerotic peripheral vascular disease. They were however unable to measure blood flow or optimize pneumatic compression. The interest in using intermittent pneumatic compression was renewed in the late 1970s when researchers observed that intermittent pneumatic compression can temporarily increase the arterial blood flow to

Back to Top

the limbs. The devices developed apply high pressures by compression cuffs placed on the thigh, calf, and/or foot, intermittently inflate and deflate with cycle times and pressures that vary between devices.

The ArtAssist© Device (ACI Medical Inc., San Marcos, California), is a mechanical pneumatic pump consisting of an impulse generator and two plastic inflatable cuffs. It applies high pressure in a synchronized manner to the foot and calf. This outpatient treatment usually performed for three 1-hour sessions per day while the patient is sitting upright. According to the manufacturer, when the device compresses tissue below the knee, venous blood is emptied, and the venous pressure drops to near zero. The resultant increase in the arteriovenous pressure gradient increases arterial blood inflow. Another potential mechanism also described by the manufacturer involves the release of vasodilating substances as endothelial nitric oxide due to the decreased local vascular resistance. Stimulation of collateral blood vessel formation may also occur (ACI medical Inc. web site).

The ArtAssist device as well as the Flow MedicTM system, and ArterialFlowTM system are all FDA approved for use to improve blood circulation in the lower extremities to help prevent and reduce complications of poor circulation.

Medical Technology Assessment Committee (MTAC)

Portable Compression Devices for Prevention of Post op DVT

4/16/2012: MTAC REVIEW

Evidence Conclusion: The published trials on the use of portable compression devices for the prophylaxis against DVT mainly compared the devices to chemoprophylaxis. Generally, patients randomized to the portable compression devices also received chemoprophylaxis, and in one study they also used graduated compression stockings (GCS). There were no head-to-head trials that compared the portable devices to the GCS. The trials reviewed were randomized and controlled, but were not blinded, used different definitions of major bleeds, and were financially supported by the manufacturers of the devices. Colwell and colleagues, 2010 (Evidence table 1) compared a new portable intermittent calf compression device (Continuous Enhanced Circulation Therapy Plus Synchronized Flow Technology [CECT+SFT]) versus a low molecular weight heparin (LMWH), for the prevention of thromboembolic disease after total hip replacement in 410 patients. The compression device was applied preoperatively and the LMWH was started the morning after the surgery. Patients in the compression group were allowed to receive 81mg of aspirin daily after surgery according to the surgeon's discretion. Both treatments were continued for 10 days, and the patients were followed-up clinically for 10 weeks. Bleeding was the primary outcome of the trial and rate of thromboembolic events was a secondary outcome. Overall, the results of the trials showed that the rate of major bleeds was significantly lower among the patients randomized to the portable compression group. There was no difference in the rate of thromboembolic events, but this was a secondary outcome and the study was not designed to determine equivalence. Edwards and colleagues, 2008 (Evidence table 2) compared an earlier version of the portable intermittent calf compression device (CECT) given together with LMWH versus LMWH alone in the prevention of VTE in patients undergoing either total hip or total knee arthroplasty. Patients randomized to the CECT group had the device applied in the operating room and continued during hospitalization, and the two groups received a LMWH for 7-8 days after surgery. The results of the study showed a significantly lower rate of DVT in patients in the portable compression device plus LMWH after a total knee arthroplasty compared to those using chemoprophylaxis alone, with a NNT of 8. No such significant difference was observed among those who underwent total hip replacement. In a similar trial Gelfer and colleagues (2006) compared prophylaxis with the CECT and aspirin versus LMWH and showed significant reduction in the incidence of DVT in the compression group vs. the LMWH group. In a more recent RCT, Sobieraj-Teague and colleagues, 2012 (Evidence table 3) examined the efficacy and tolerability of a new portable intermittent calf compression device (Venowave) in high risk neurosurgical patients. Patients were randomized to usual care alone or in addition to the portable compression device, and all participants in the two groups were prescribed below the knee graduated compression stockings. They could also receive pharmacological prophylaxis (aspirin, LMWH, or unfractionated heparin) according to the discretion of the neurosurgeon. The overall results indicate the rate of DVT was significantly lower in the study group that used a portable compression device in addition to the graduated compression stocking and chemoprophylaxis as needed in this high risk neurosurgical patients. The portable devices used in the trials had an average compliance rate around 80%, and the associated side effects were mainly discomfort especially at night, pruritis, and sweating.

Articles: The literature search revealed a number of earlier RCTs that compared the graduated compression stockings to intermittent compression therapy. However, IPC systems used in these studies were the standard devices used in the hospitals and not the portable IPCs which are the focus of this review. There were three RCTs that compared the use chemoprophylaxis given alone or with IPC using portable devices after total joint arthroplasty, and one trial that evaluated the efficacy of using a portable compression device in addition to

 Back to Top

graduated compression stockings and chemoprophylaxis in high risk neurosurgical patients. The following studies were selected for critical appraisal;
Colwell CW Jr, Froimson MI, Mont MA, et al. Thrombosis prevention after total hip arthroplasty: a prospective, randomized trial comparing a mobile compression device with low-molecular-weight heparin. J Bone Joint Surg Am. 2010; 92:527-535. See Evidence Table
Edwards JZ, Pulido PA, Ezzet K A, et al. Portable compression device and low-molecular-weight heparin compared with low-molecular-weight heparin for thromboprophylaxis after total joint arthroplasty. J Arthroplasty. 2008; 23:1122-1127. See Evidence Table
Sobieraj-Teague M, Hirsh J, Yip G, Gastaldo F, et al. Randomized controlled trial of a new portable calf compression device (Venowave) for prevention of venous thrombosis in high-risk neurosurgical patients. J Thromb Haemost. 2012; 10:229-235. See Evidence Table

The use of portable compression devices does not meet the *Kaiser Permanente Medical Technology Assessment Criteria.*

Portable Compression Devices

BACKGROUND
Thromboembolic disease is a common complication following surgery particularly total joint replacement arthroplasty. It has been reported that without prophylaxis the rate of deep vein thrombosis (DVT) is as high as 88% after total knee arthroplasty and as high as 50% after total hip arthroplasty. It is also reported that lower extremity DVT is the origin of 90% of symptomatic pulmonary embolism (PE). Prophylaxis for DVT has become the standard of care for total joint arthroplasty. Chemical prophylaxis with warfarin or low-molecular weight heparin effectively reduces the incidence of DVT but carries a risk of bleeding. Orthopedic surgeons thus often use mechanical methods of prophylaxis as an alternative to chemoprophylaxis in patients with higher bleeding risk. Other surgeons also use it in standard risk patients in conjunction with the anticoagulant-based prophylaxis (Edwards 2008, Zywiel 2010). Graduated compression stockings (GCSs) and intermittent pneumatic compression (IPC) are the two predominant mechanical methods used for DVT prevention. These have quite different methods of action; graduated compression stockings apply a constant pressure to the limb with the aim of maintaining a reduced venous caliber and preventing the static accumulation of blood. Intermittent pneumatic compression actively empties the deep veins of the limb in a predetermined cycle of pressure, producing a pulse of blood that travels proximally preventing stasis. On deflation of the cuff, the veins will refill, the intermittent nature of the system will ensure periodic blood flow through the deep veins, as long as there is a supply. The IPC cuffs are normally wrapped around a limb, secured by velcro, and attached with tubes to an electric pump to regulate the pressure applied (Morris 2004, Morris 2010, Sobieraj-Teague 2011). GCSs do not require attachment to any device and allow the patient to move freely. They come in a range of sizes and the limb has to be measured accurately to prevent incorrect pressure gradients, which may increase the risk of DVT. Intermittent compression devices are available in different forms; the cuff can cover the whole leg, the calf, or just the feet, it may inflate uniformly or sequentially with graded pressure; and can have rapid or moderate inflation rates. These characteristics my influence patient compliance which is critical as the longer the device is used, the better is the protection. The major disadvantages for standard IPC devices used in hospitals are their size, weight, and reliance on external power source, all of which result in poor patient compliance and in turn limit the efficacy of the device (Morris 2004, Froimson 2009). In an attempt to overcome the problem of poor patient compliance with traditional mechanical compression systems, several lightweight, portable, battery-powered devices were developed to allow their use by the patient while ambulating in the hospital or at home after discharge. Many of these devices have received FDA clearance.

04/16/2012: MTAC REVIEW
Portable Compression Devices
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 Back to Top

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The following studies were selected for critical appraisal; Colwell CW Jr, Froimson MI, Mont MA, et al. Thrombosis prevention after total hip arthroplasty: a prospective, randomized trial comparing a mobile compression device with low-molecular-weight heparin. J Bone Joint Surg Am. 2010; 92:527-535. See Evidence Table. Edwards JZ, Pulido PA, Ezzet K A, et al. Portable compression device and low-molecular-weight heparin compared with low-molecular-weight heparin for thromboprophylaxis after total joint arthroplasty. J Arthroplasty. 2008; 23:1122-1127. See Evidence Table. Sobieraj-Teague M, Hirsh J, Yip G, Gastaldo F, et al. Randomized controlled trial of a new portable calf compression device (Venowave) for prevention of venous thrombosis in high-risk neurosurgical patients. J Thromb Haemost. 2012; 10:229-235. See Evidence Table.

The use of portable compression devices does not meet the *Kaiser Permanente Medical Technology Assessment Criteria.*

Intermittent Pneumatic Compression

02/04/2008: MTAC Review

Evidence Conclusion: In conclusion there is insufficient evidence to determine the efficacy of pneumatic compression devices for the treatment intermittent claudication, or more severe symptoms among patients with peripheral artery occlusive disease.

Articles: There were five small RCTs, one nonrandomized controlled study, and several prospective and retrospective small case series with no control or comparison groups. The majority of trials were conducted among patients with stable claudication. There was a small trial, with intermediate outcomes that compared three modes of IPC in healthy limbs as well as those with successful grafts. The literature search did not reveal RCT that evaluated the IPC use for patients with more severe condition or those who failed revascularization. *Studies with an appropriate comparison group and/or longer follow-up duration were selected for critical appraisal:* Kakkos SK, Geroulakos G, Nicolaides AN. Improvement of the walking ability in intermittent claudication due to superficial femoral artery occlusion with supervised exercise and pneumatic foot and calf compression: A randomized controlled trial. Eur J Vasc Endovasc Surg. 2005; 30:164-175. **See** Evidence Table

Ramaswami G, D'ayala M, Hollier LH, et al., rapid foot and calf compression increases walking distance in patients with intermittent claudication: Results of a randomized study. J Vasc Surg. 2005; 41:794-801. **See** Evidence Table Delis KT, Nicolaides AN. Effect of intermittent pneumatic compression on foot and calf on walking distance, hemodynamics, and quality of life in patients with arterial claudication. A prospective randomized controlled study with 1-year follow-up. Ann Surg 2005;241:431-441 **See** Evidence Table

Back to Top

The use of Intermittent pneumatic compression in the treatment of peripheral arterial occlusive disease does not meet the *Kaiser Permanente Medical Technology Assessment Criteria.*

Applicable Codes

Medicare & Non-Medicare: Considered Medically Necessary when criteria in the applicable policy statements listed above are met

HCPC Codes	Description
E0650	Pneumatic compressor, nonsegmental home mode
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

Medicare & Non-Medicare: Considered not medically necessary

HCPC Codes	Description
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
A4600	Sleeve for intermittent limb compression device, replacement only, each *(used for devices described by E0676)*

***Note:** Codes may not be all-inclusive. Deleted codes and codes not in effect at the time of service may not be covered.

****To verify authorization requirements for a specific code by plan type, please use the **Pre-authorization Code Check**.

Date Created	Date Reviewed	Date Last Revised
05/01/2012	05/01/2012[MDCRPC], 06/05/2012[MDCRPC], 04/02/2013[MDCRPC], 02/04/2014 [MPC], 12/02/2014[MPC], 10/06/2015[MPC], 08/02/2016[MPC], 06/06/2017[MPC], 04/03/2018[MPC], 04/02/2019[MPC], 04/07/2020[MPC], 04/06/2021[MPC], 04/05/2022[MPC], 04/04/2023[MPC], 04/04/2023[MPC], 01/02/2024[MPC], 01/14/2025[MPC]	11/25/2024

[MDCRPC] Medical Director Clinical Review and Policy Committee
[MPC] Medical Policy Committee

Revision History	Description
07/21/2015	Title Change
03/08/2016	Updated Medicare links
05/08/2018	Added Policy article language for non-coverage of E0676

Back to Top

7/10/2018	Added new review criteria for pneumatic devices for Non-Medicare members with effective date 10/15/2018
04/05/2022	Updated applicable codes
04/18/2023	Updated Medicare Pneumatic Compression Devices – Policy Article A52488
01/09/2024	MPC approved to adopt the Medicare LCD Pneumatic compression devices L33829 for commercial members. Requires 60-day notice, effective June 1st, 2024. Merged Intermittent Pneumatic Compression Device with this criteria set.
11/25/2024	Noridian retired Pneumatic Compression Devices (A52488) and (L33829); Effective 11/14/2024.

Back to Top