

# Local Coverage Determination (LCD) for Pneumatic Compression Devices (L11503)

**[FUTURE]**

**Please note:** This is a Future LCD.

## Contractor Information

Contractor Name	Contract Number	Contract Type
NHIC, Corp.	16003	DME MAC

## LCD Information

### Document Information

**[FUTURE]**

**LCD Database ID Number**  
L11503

**LCD Title**  
Pneumatic Compression Devices

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### Jurisdiction

Connecticut  
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Delaware  
Massachusetts  
Maryland  
Maine  
New Hampshire  
New Jersey  
New York - Entire State  
Pennsylvania  
Rhode Island  
Vermont

### DME Region LCD Covers

Jurisdiction A

### Original Effective Date

For services performed on or after 10/01/1993

### Revision Effective Date

For services performed on or after 11/01/2014

### Revision Ending Date

N/A

### Retirement Date

N/A

### Notice Period Start Date

09/11/2014

### Notice Period End Date

10/31/2014

## CMS National Coverage Policy

CMS Pub. 100-3, (Medicare National Coverage Determinations Manual), Chapter 1, Section 280.6

### Coverage Guidance

#### Coverage Indications, Limitations and/or Medical Necessity

For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements. For the items addressed in this local coverage determination, the criteria for "reasonable and necessary", based on Social Security Act §1862(a)(1)(A) provisions, are defined by the following coverage indications, limitations and/or medical necessity.

#### PRESCRIPTIONS

For an item to be covered by Medicare, a detailed written order (DWO) must be received by the supplier before a claim is submitted. If the supplier bills for an item addressed in this policy without first receiving the completed DWO, the item will be denied as not reasonable and necessary.

For some items in this policy to be covered by Medicare, a written order prior to delivery (WOPD) is required. Refer to the DOCUMENTATION REQUIREMENTS section of this LCD and to the NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES section of the related Policy Article for information about WOPD prescription requirements.

Prescriptions for PCDs (E0650-E0652, E0675, E0676) are limited to Physicians (MD, DO) and physician extenders (NP, PA, & CNS) to the extent allowed by their applicable state scope-of-practice or other license requirements. Podiatrists (DPM) and other providers are excluded because applicable state scope-of-practice or other license requirements limit management of systemic conditions. Treatment of peripheral artery disease, lymphedema, chronic venous insufficiency with ulceration and complications related to the treatment of these conditions by use of PCDs, require consideration of diagnoses and management of systemic conditions that fall outside of these license limitations.

#### DEFINITIONS

For Medicare DMEPOS reimbursement purposes the following definitions are used in this policy.

##### Edema:

Edema is an 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 edema. Lymphedema arises from disorders of the lymphatic system. Edema from other causes is not classified as lymphedema for purposes of Medicare reimbursement for PCD (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:

- Congenital lymphedema due to lymphatic aplasia or hypoplasia
- Milroy's disease, an autosomal dominant familial form of congenital lymphedema
- Lymphedema praecox
- 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.

### Peripheral Arterial Disease (PAD)

Peripheral artery disease is a circulatory problem in which narrowed arteries reduce blood flow to limbs. The extremities don't receive enough blood flow to keep up with demand.

## GENERAL

Pneumatic compression devices (PCD) coded as E0650-E0652 are used only in the treatment of lymphedema or for the treatment of chronic venous insufficiency with venous stasis ulcers. Reimbursement for these items is based upon the criteria in the following sections. PCDs coded as E0675 are used in the treatment peripheral arterial disease. Claims for E0675 will be denied as not reasonable and necessary as outlined below.

### I. LYMPHEDEMA

A PCD coded as E0650 or E0651 is covered for both primary and secondary lymphedema in beneficiaries with "chronic and severe" lymphedema when all of the following three requirements are met:

1. The beneficiary has an accurate diagnosis of lymphedema as defined above, and
2. The beneficiary has documented persistence over a period of at least six months of "chronic and severe" lymphedema as identified by the documented presence of at least one of the following clinical findings over this six month period:
  - Marked hyperkeratosis with hyperplasia and hyperpigmentation,
  - Papillomatosis cutis lymphostatica,
  - Deformity of elephantiasis,
  - Persistent ulceration superimposed on chronic edema,
  - Skin breakdown with persisting lymphorrhea, and

3. In addition to this at least six months of documented persistence, the lymphedema is then documented to be unresponsive to other clinical treatment over the course of a required four-week trial (see below for trial guidelines)

A PCD coded as E0650 or E0651 used to treat lymphedema that does not meet all of the requirements above is not eligible for reimbursement. Claims will be denied as not reasonable and necessary.

A PCD coded as E0650 or E0651 used to treat edema from causes other than lymphedema is not eligible for reimbursement. Claims will be denied as not reasonable and necessary.

A PCD coded as E0652 is not covered for the treatment of lymphedema of the extremities alone even if the criteria in this section are met. Claims will be denied as not reasonable and necessary. Refer below to the sections III - LYMPHEDEMA EXTENDING ONTO THE CHEST, TRUNK AND/OR ABDOMEN and PCD Code Selection for additional information about the limited coverage for PCDs coded as E0652.

#### Four-Week Trial for Lymphedema

A four-week trial of conservative therapy demonstrating failed response to treatment is required. The four-week trial of conservative therapy must include all of the following:

- Use of an appropriate compression bandage system or compression garment to provide adequate graduated compression
  - Adequate compression is defined as (1) sufficient pressure at the lowest pressure point to cause fluid movement and (2) sufficient pressure across the gradient (from highest to lowest pressure point) to move fluid from distal to proximal. The compression used must not create a tourniquet effect at any point
  - The garment may be prefabricated or custom-fabricated but must provide adequate graduated compression
- Manual lymphatic drainage
- Medications as appropriate (e.g. diuretics and/or other treatment of congestive failure, etc.)
- Exercise
- Elevation of the limb

At the end of the four-week trial, if there has been improvement, then reimbursement for a PCD is not justified. Where improvement has occurred, the trial of conservative therapy must be continued with subsequent reassessment at four-week intervals. When no further improvement occurs and the coverage criteria above are still met, the lymphedema is considered to be "chronic and severe".

At a minimum, this must include detailed measurements, obtained in the same manner and with reference to the same anatomic landmarks, prior to and at the conclusion of the various trials and therapy, with bilateral comparisons where appropriate.

## II. CHRONIC VENOUS INSUFFICIENCY WITH VENOUS STASIS ULCERS (CVI)

A PCD coded as E0650 or E0651 is covered for the treatment of CVI of the lower extremities only if the patient has all of the following:

- Edema in the affected lower extremity
- One or more venous stasis ulcer(s)

- The ulcer(s) have failed to heal after a six-month trial of conservative therapy directed by the treating physician. (See below for trial guidelines)

A PCD coded as E0650 or E0651 used to treat CVI that does not meet all of the requirements above is not eligible for reimbursement. Claims will be denied as not reasonable and necessary.

A PCD coded as E0650 or E0651 used to treat ulcers in locations other than the lower extremity or ulcers and wounds from other causes is not eligible for reimbursement. Claims will be denied as not reasonable and necessary.

A PCD coded as E0652 is not covered for the treatment of CVI even if the criteria in this section are met. Claims will be denied as not reasonable and necessary. Refer below to the sections III - LYMPHEDEMA EXTENDING ONTO THE CHEST, TRUNK AND/OR ABDOMEN and [PCD Code Selection](#) for additional information about the limited coverage for PCDs coded as E0652.

### Six-Month Trial for CVI

A six-month trial of conservative therapy demonstrating failed response to treatment is required. The six-month trial of conservative therapy must include all of the following:

- Use of an appropriate compression bandage system or compression garment to provide adequate graduated compression
  - Adequate compression is defined as (1) sufficient pressure at the lowest pressure point to cause fluid movement and (2) sufficient pressure across the gradient (from highest to lowest pressure point) to move fluid from distal to proximal. The compression used must not create a tourniquet effect at any point
  - The garment may be prefabricated or custom-fabricated but must provide adequate graduated compression
- Medications as appropriate (e.g. diuretics and/or other treatment of congestive failure, etc.)
- Exercise
- Elevation of the limb
- Appropriate wound care for the ulcer

At the end of the six-month trial, if there has been improvement, then reimbursement for a PCD is not justified. Where improvement has occurred, the trial of conservative therapy must be continued with subsequent reassessments. When no further improvement has occurred for a continuous period of six months and the coverage criteria above are still met, then the CVI is eligible for reimbursement.

### III. LYMPHEDEMA EXTENDING ONTO THE CHEST, TRUNK AND/OR ABDOMEN

A PCD coded as E0652, is covered for the treatment of lymphedema extending onto the chest, trunk and/or abdomen when all of the following are met:

- The beneficiary has lymphedema of an extremity as defined above
- The coverage criteria for an E0650 or E0651 are met
- The beneficiary has lymphedema extending onto the chest, trunk and/or abdomen that extends past the limits of a standard compression sleeve, and the chest, trunk and/or abdominal lymphedema has failed to improve with a four-week trial. (See below for trial guidelines)

A PCD coded as E0652 used to treat lymphedema extending onto the chest, trunk and/or abdomen that does not meet all of the requirements above is not eligible for reimbursement. Claims will be denied as not reasonable and necessary.

A PCD coded as E0652 used to treat lymphedema not extending onto the chest, trunk and/or abdomen or CVI is not eligible for reimbursement. Claims will be denied as not reasonable and necessary.

#### Four-Week Trial For Lymphedema Extending Onto The Chest, Trunk and/or Abdomen

A four-week trial of conservative therapy demonstrating failed response to treatment with and E0650 or E0651 is required. The four-week trial of conservative therapy must include all of the following:

- At least four weeks of regular, daily, multiple-hour home usage of the E0650 or E0651 after careful, in-person fitting, training and supervision by a technician who is skilled in and who regularly and successfully uses the appliance provided
- Use of an appropriate compression bandage system or compression garment to provide adequate graduated compression
  - Adequate compression is defined as (1) sufficient pressure at the lowest pressure point to cause fluid movement and (2) sufficient pressure across the gradient (from highest to lowest pressure point) to move fluid from distal to proximal. The compression used must not create a tourniquet effect at any point
  - The garment may be prefabricated or custom-fabricated but must provide adequate graduated compression
- Exercise
- Elevation of the limb
- Manual lymphatic drainage
- Dietary change
- Medications as appropriate (e.g. diuretics and/or other treatment of congestive failure, etc.)
- Correction (where possible) of anemia and/or hypoproteinemia

At the end of the four-week trial, if there has been improvement of the lymphedema extending onto the chest, trunk and/or abdomen, then reimbursement for a E0652 is not justified. Where improvement has occurred, the trial of conservative therapy must be continued with subsequent reassessment at four-week intervals. When and only when no further improvement occurs and the coverage criteria above are still met, an E0652 is eligible for reimbursement.

#### IV. PERIPHERAL ARTERY DISEASE (PAD)

A PCD coded as E0675 to treat PAD is not eligible for reimbursement. There is insufficient evidence to demonstrate that reimbursement is justified. Claims for E0675 will be denied as not reasonable and necessary.

#### V. DEEP VENOUS THROMBOSIS PROPHYLAXIS

A PCD coded as E0676 is used only to treat and or prevent venous thrombosis. Refer to the related Policy Article NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES section for information about coverage of devices used for prophylaxis of venous thrombosis.

#### ACCESSORIES

PCD related accessories (E0655-E0673) are eligible for reimbursement only when the appropriate, related base PCD (E0650-E0651, E0675) meets the applicable coverage criteria for that type of PCD. If the base PCD is not covered, related accessories are not eligible for reimbursement. Claims for related items will be denied as not reasonable and necessary.

## PCD CODE Selection (E0650-E0652, E0675, E0676)

A PCD coded as E0650 or E0651 is used for lymphedema or CVI. An E0650 compressor with a segmented appliance/sleeve (E0671- E0673) is considered functionally equivalent to an E0651 compressor with a segmented appliance/sleeve (E0667-E0669).

A PCD coded as E0652 has limited coverage. The NCD for Pneumatic Compression Devices (IOM 100-03, §280.6) provides:

"The only time that a segmented, calibrated gradient pneumatic compression device (HCPCs code E0652) would be covered is when the individual has unique characteristics that prevent them from receiving satisfactory pneumatic compression treatment using a nonsegmented device in conjunction with a segmented appliance or a segmented compression device without manual control of pressure in each chamber."

The only "unique characteristics" identified in the clinical literature that requires the use of an E0652 device is lymphedema extending onto the chest, trunk and/or abdomen which has remained unresponsive to all other therapies.

A PCD coded as E0675 is used only for peripheral artery disease. Other PCD codes are not used for this condition.

A PCD coded as E0676 is used only for the prophylaxis of venous thrombosis.

## Coding Information

**[FUTURE]**

### **Bill Type Codes:**

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

### **Revenue Codes:**

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

### **CPT/HCPCS Codes**

**Group 1 Paragraph:** The appearance of a code in this section does not necessarily indicate coverage.

### **HCPCS MODIFIERS:**

EY - No physician or other health care provider order for this item or service

GA - Waiver of liability statement issued as required by payer policy, individual case

GZ - Item or service expected to be denied as not reasonable and necessary

KX - Requirements specified in the medical policy have been met

**Group 1 Codes:**

- E0650 PNEUMATIC COMPRESSOR, NON-SEGMENTAL HOME MODEL
- E0651 PNEUMATIC COMPRESSOR, SEGMENTAL HOME MODEL WITHOUT CALIBRATED GRADIENT PRESSURE
- E0652 PNEUMATIC COMPRESSOR, SEGMENTAL HOME MODEL WITH CALIBRATED GRADIENT PRESSURE
- E0655 NON-SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, HALF ARM
- E0656 SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, TRUNK
- E0657 SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, CHEST
- E0660 NON-SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, FULL LEG
- E0665 NON-SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, FULL ARM
- E0666 NON-SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, HALF LEG
- E0667 SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, FULL LEG
- E0668 SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, FULL ARM
- E0669 SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, HALF LEG
- E0670 SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, INTEGRATED, 2 FULL LEGS AND TRUNK
- E0671 SEGMENTAL GRADIENT PRESSURE PNEUMATIC APPLIANCE, FULL LEG
- E0672 SEGMENTAL GRADIENT PRESSURE PNEUMATIC APPLIANCE, FULL ARM
- E0673 SEGMENTAL GRADIENT PRESSURE PNEUMATIC APPLIANCE, HALF LEG
- 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

**ICD-9 Codes that Support Medical Necessity**

**Group 1 Paragraph:** Not specified.

**Group 1 Codes:**

**Group 1 Asterisk:** N/A

## ICD-9 Codes that DO NOT Support Medical Necessity

Not specified.



## General Information

### Associated Information

#### DOCUMENTATION REQUIREMENTS

Section 1833(e) of the Social Security Act precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider". It is expected that the beneficiary's medical records will reflect the need for the care provided. The beneficiary's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be available upon request.

#### PRESCRIPTION (ORDER) REQUIREMENTS

##### GENERAL (PIM 5.2.1)

All items billed to Medicare require a prescription. An order for each item billed must be signed and dated by the treating physician, kept on file by the supplier, and made available upon request. Items dispensed and/or billed that do not meet these prescription requirements and those below must be submitted with an EY modifier added to each affected HCPCS code.

##### DISPENSING ORDERS (PIM 5.2.2)

Equipment and supplies may be delivered upon receipt of a dispensing order except for those items that require a written order prior to delivery. A dispensing order may be verbal or written. The supplier must keep a record of the dispensing order on file. It must contain:

- Description of the item
- Beneficiary's name
- Prescribing Physician's name
- Date of the order and the start date, if the start date is different from the date of the order
- Physician signature (if a written order) or supplier signature (if verbal order)
- For the "Date of the order" described above, use the date the supplier is contacted by the physician (for verbal orders) or the date entered by the physician (for written dispensing orders).

Signature and date stamps are not allowed. Signatures must comply with the CMS signature requirements outlined in PIM 3.3.2.4.

The dispensing order must be available upon request.

For items that are provided based on a dispensing order, the supplier must obtain a detailed written order before submitting a claim.

##### WRITTEN ORDERS PRIOR TO DELIVERY (PIM 5.2.3.1)

A detailed written order prior to delivery (WOPD) is required for the HCPCS codes listed below. The supplier must have received a complete WOPD that has been both signed and dated by the treating physician and meets the requirements for a DWO before dispensing the item. Refer the related Policy Article NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES section for information about the statutory requirements associated with a WOPD.

#### DETAILED WRITTEN ORDERS (PIM 5.2.3)

A detailed written order (DWO) is required before billing. Someone other than the ordering physician may produce the DWO. However, the ordering physician must review the content and sign and date the document. It must contain:

- Beneficiary's name
- Physician's name
- Date of the order and the start date, if start date is different from the date of the order
- Detailed description of the item(s) (see below for specific requirements for selected items)
- Physician signature and signature date

For items provided on a periodic basis, including drugs, the written order must include:

- Item(s) to be dispensed
- Dosage or concentration, if applicable
- Route of Administration
- Frequency of use
- Duration of infusion, if applicable
- Quantity to be dispensed
- Number of refills

For the "Date of the order" described above, use the date the supplier is contacted by the physician (for verbal orders) or the date entered by the physician (for written dispensing orders).

Frequency of use information on orders must contain detailed instructions for use and specific amounts to be dispensed. Reimbursement shall be based on the specific utilization amount only. Orders that only state "PRN" or "as needed" utilization estimates for replacement frequency, use, or consumption are not acceptable. (PIM 5.9)

The detailed description in the written order may be either a narrative description or a brand name/model number.

Signature and date stamps are not allowed. Signatures must comply with the CMS signature requirements outlined in PIM 3.3.2.4.

The DWO must be available upon request.

A prescription is not considered as part of the medical record. Medical information intended to demonstrate compliance with coverage criteria may be included on the prescription but must be corroborated by information contained in the medical record. (PIM 5.2.3)

#### **MEDICAL RECORD INFORMATION**

##### GENERAL (PIM 5.7 - 5.9)

The **Coverage Indications, Limitations and/or Medical Necessity** section of this LCD contains numerous reasonable and necessary (R&N) requirements. The **Non-Medical Necessity**

**Coverage and Payment Rules** section of the related Policy Article contains numerous non-reasonable and necessary, benefit category and statutory requirements that must be met in order for payment to be justified. Suppliers are reminded that:

- Supplier-produced records, even if signed by the ordering physician, and attestation letters (e.g. letters of medical necessity) are deemed not to be part of a medical record for Medicare payment purposes.
- Templates and forms, including CMS Certificates of Medical Necessity, are subject to corroboration with information in the medical record.

Information contained directly in the contemporaneous medical record is the source required to justify payment except as noted elsewhere for prescriptions and CMNs. The medical record is not limited to physician's office records but may include records from hospitals, nursing facilities, home health agencies, other healthcare professionals, etc. (not all-inclusive). Records from suppliers or healthcare professionals with a financial interest in the claim outcome are not considered sufficient by themselves for the purpose of determining that an item is reasonable and necessary.

#### CONTINUED MEDICAL NEED

For all Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items, the initial justification for medical need is established at the time the item(s) is first ordered; therefore, beneficiary medical records demonstrating that the item is reasonable and necessary are created just prior to, or at the time of, the creation of the initial prescription. For purchased items, initial months of a rental item or for initial months of ongoing supplies or drugs, information justifying reimbursement will come from this initial time period. Entries in the beneficiary's medical record must have been created prior to, or at the time of, the initial DOS to establish whether the initial reimbursement was justified based upon the applicable coverage policy.

For ongoing supplies and rental DME items, in addition to information described above that justifies the initial provision of the item(s) and/or supplies, there must be information in the beneficiary's medical record to support that the item continues to be used by the beneficiary and remains reasonable and necessary. Information used to justify continued medical need must be timely for the DOS under review. Any of the following may serve as documentation justifying continued medical need:

- A recent order by the treating physician for refills
- A recent change in prescription
- A properly completed CMN or DIF with an appropriate length of need specified
- Timely documentation in the beneficiary's medical record showing usage of the item.

Timely documentation is defined as a record in the preceding 12 months unless otherwise specified elsewhere in the policy.

#### CONTINUED USE

Continued use describes the ongoing utilization of supplies or a rental item by a beneficiary.

Suppliers are responsible for monitoring utilization of DMEPOS rental items and supplies. No monitoring of purchased items or capped rental items that have converted to a purchase is required. Suppliers must discontinue billing Medicare when rental items or ongoing supply items are no longer being used by the beneficiary.

Beneficiary medical records or supplier records may be used to confirm that a DMEPOS item continues to be used by the beneficiary. Any of the following may serve as documentation that an item submitted for reimbursement continues to be used by the beneficiary:

- Timely documentation in the beneficiary's medical record showing usage of the item, related option/accessories and supplies
- Supplier records documenting the request for refill/replacement of supplies in compliance with the Refill Documentation Requirements (This is deemed to be sufficient to document continued use for the base item, as well)
- Supplier records documenting beneficiary confirmation of continued use of a rental item

Timely documentation is defined as a record in the preceding 12 months unless otherwise specified elsewhere in this policy.

#### PROOF OF DELIVERY (PIM 4.26, 5.8)

Proof of delivery (POD) is a Supplier Standard and DMEPOS suppliers are required to maintain POD documentation in their files. For medical review purposes, POD serves to assist in determining correct coding and billing information for claims submitted for Medicare reimbursement. Regardless of the method of delivery, the contractor must be able to determine from delivery documentation that the supplier properly coded the item(s), that the item(s) delivered are the same item(s) submitted for Medicare reimbursement and that the item(s) are intended for, and received by, a specific Medicare beneficiary.

Suppliers, their employees, or anyone else having a financial interest in the delivery of the item are prohibited from signing and accepting an item on behalf of a beneficiary (i.e., acting as a designee on behalf of the beneficiary). The signature and date the beneficiary or designee accepted delivery must be legible.

For the purpose of the delivery methods noted below, designee is defined as any person who can sign and accept the delivery of durable medical equipment on behalf of the beneficiary.

Proof of delivery documentation must be available to the Medicare contractor on request. All services that do not have appropriate proof of delivery from the supplier will be denied and overpayments will be requested. Suppliers who consistently fail to provide documentation to support their services may be referred to the OIG for imposition of Civil Monetary Penalties or other administrative sanctions.

Suppliers are required to maintain POD documentation in their files. For items addressed in this policy there are two methods of delivery:

1. Delivery directly to the beneficiary or authorized representative
2. Delivery via shipping or delivery service

#### Method 1—Direct Delivery to the Beneficiary by the Supplier

Suppliers may deliver directly to the beneficiary or the designee. In this case, POD to a beneficiary must be a signed and dated delivery slip. The POD record must include:

- Beneficiary's name
- Delivery address
- Sufficiently detailed description to identify the item(s) being delivered (e.g., brand name, serial number, narrative description)
- Quantity delivered
- Date delivered
- Beneficiary (or designee) signature and date of signature

The date of signature on the delivery slip must be the date that the DMEPOS item was received by the beneficiary or designee. In instances where the item is delivered directly by the supplier, the date the beneficiary received the DMEPOS item must be the date of service on the claim.

#### Method 2—Delivery via Shipping or Delivery Service Directly to a Beneficiary

If the supplier utilizes a shipping service or mail order, the POD documentation must be a complete record tracking the item(s) from the DMEPOS supplier to the beneficiary. An example of acceptable proof of delivery would include both the supplier's own detailed shipping invoice and the delivery service's tracking information. The supplier's record must be linked to the delivery service record by some clear method like the delivery service's package identification number or supplier's invoice number for the package sent to the beneficiary. The POD record must include:

- Beneficiary's name
- Delivery address
- Delivery service's package identification number, supplier invoice number or alternative method that links the supplier's delivery documents with the delivery service's records.
- Sufficiently detailed description to identify the item(s) being delivered (e.g., brand name, serial number, narrative description)
- Quantity delivered
- Date delivered
- Evidence of delivery

If a supplier utilizes a shipping service or mail order, suppliers must use the shipping date as the date of service on the claim.

Suppliers may also utilize a return postage-paid delivery invoice from the beneficiary or designee as a POD. This type of POD record must contain the information specified above.

### **POLICY SPECIFIC DOCUMENTATION REQUIREMENTS**

#### General

For PCDs coded E0650 or E0651 the medical record must contain sufficient detailed and specific information to show that the applicable coverage criteria for I - LYMPHEDEMA or II - CHRONIC VENOUS INSUFFICIENCY WITH VENOUS STASIS ULCERS (CVI) are met.

For PCDs coded as E0652 the medical record must contain sufficient detailed and specific information to show that the applicable coverage criteria in III - LYMPHEDEMA EXTENDING ONTO THE CHEST, TRUNK AND/OR ABDOMEN are met.

The documentation for each of the above must include careful, detailed records of measurements, obtained in the same manner and with reference to the same anatomic landmarks, prior to, at periodic times during and at the conclusion of the various trials and therapy, with bilateral comparisons where appropriate.

#### Certificate of Medical Necessity (CMN) (PIM 5.3)

A Certificate of Medical Necessity (CMN) which has been completed, signed, and dated by the treating physician must be kept on file by the supplier and made available upon request. The CMN may act as a substitute for a written order if it contains all of the required elements of an

order. The CMN for pneumatic compression pumps is CMS Form 846 (DME Form 04.04B). The initial claim must include an electronic copy of the CMN.

If question #1 on the CMN ("Does the beneficiary have chronic venous insufficiency with venous stasis ulcers?") is answered "Yes", documentation reflecting all of the following must be in the beneficiary's medical record and made available upon request:

1. The location of venous stasis ulcer(s),
2. How long each ulcer has been continuously present,
3. Previous treatment with a compression bandage system or compression garment, appropriate dressings for the ulcer(s), exercise and limb elevation for at least the past 6 months,
4. Evidence of regular physician visits for treatment of venous stasis ulcer(s) during the past 6 months.

Refer to the Supplier Manual for more information on documentation requirements.

### **AFFORDABLE CARE ACT (ACA) 6407 REQUIREMENTS**

ACA 6407 contains provisions that are applicable to certain specified items in this policy. In this policy the specified items are:

E0650	PNEUMATIC COMPRESSOR, NON-SEGMENTAL HOME MODEL
E0651	PNEUMATIC COMPRESSOR, SEGMENTAL HOME MODEL WITHOUT CALIBRATED GRADIENT PRESSURE
E0652	PNEUMATIC COMPRESSOR, SEGMENTAL HOME MODEL WITH CALIBRATED GRADIENT PRESSURE
E0655	NON-SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, HALF ARM
E0656	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, TRUNK
E0657	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, CHEST
E0660	NON-SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, FULL LEG
E0665	NON-SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, FULL ARM
E0666	NON-SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, HALF LEG
E0667	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, FULL LEG
E0668	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, FULL ARM
E0669	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, HALF LEG
E0671	SEGMENTAL GRADIENT PRESSURE PNEUMATIC APPLIANCE, FULL LEG
E0672	SEGMENTAL GRADIENT PRESSURE PNEUMATIC APPLIANCE, FULL ARM
E0673	SEGMENTAL GRADIENT PRESSURE PNEUMATIC APPLIANCE, HALF LEG
E0675	PNEUMATIC COMPRESSION DEVICE, HIGH PRESSURE, RAPID INFLATION/DEFLATION

These items require an in-person or face-to-face interaction between the beneficiary and their treating physician prior to prescribing the item, specifically to document that the beneficiary was evaluated and/or treated for a condition that supports the need for the item(s) of DME ordered. A dispensing order is not sufficient to provide these items. A Written Order Prior to Delivery (WOPD) is required. Refer to the related Policy Article NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES section for information about these statutory requirements.

The DMEPOS supplier must have documentation of both the face-to-face visit and the completed WOPD in their file prior to the delivery of these items.

Suppliers are reminded that all Medicare coverage and documentation requirements for DMEPOS also apply. There must be sufficient information included in the medical record to demonstrate that all of the applicable coverage criteria are met. This information must be available upon request.

### **Appendices**

PIM citations above denote references to CMS Program Integrity Manual, Internet Only Manual 100-8

### **Utilization Guidelines**

Refer to Coverage Indications, Limitations and/or Medical Necessity

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## Revision History Information

**Please note:** The Revision History information included in this LCD prior to 1/24/2013 will now display with a Revision History Number of "R1" at the bottom of this table. All new Revision History information entries completed on or after 1/24/2013 will display as a row in the Revision History section of the LCD and numbering will begin with "R2".

Revision History Date	Revision History Number	Revision History Explanation	Reason(s) for Change
11/01/2014	R5	<b>Revision Effective Date: 11/01/2014</b> HCPCS CODES AND MODIFIERS: Restored: E0670	Revisions Due To CPT/HCPCS Code Changes
11/01/2014	R4	<b>Revision Effective Date: 11/01/2014</b> Draft LCD Released to Final COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Added: Explicit statement on E0675 non-coverage Revised: Requirements for Four-Week Trial for Lymphedema Revised: Requirements for Six-Month Trial for Chronic Venous Insufficiency Revised: E0652 requirements HCPCS CODES AND MODIFIERS: Added: E0675 and E0676 POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:	Provider Education/Guidance Reconsideration Request Other: This LCD version was created as a result of DL11503 being released to a Final LCD.

Revision History Date	Revision History Number	Revision History Explanation	Reason(s) for Change
07/01/2013	R3	<p>Added: E0652 requirements            Added: E0675 to ACA 6407 requirements table</p> <p><b>Revision Effective Date: 07/01/2013</b>            COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:            Added: Information that item(s) in policy are subject to ACA 6407 requirements            POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:            Added: ACA 6407 information</p>	<p>Provider Education/Guidance</p>
01/01/2013	R2	<p><b>Revision Effective Date: 01/01/2013</b>            COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:            Revised: Order requirement language to specify a "detailed written order"            Changed: Word "Patient" to "Beneficiary"            HCPCS CODES AND MODIFIERS:            Added: E0670            DOCUMENTATION REQUIREMENTS:            (Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference)            Added: Standard Language            Changed: Word "Patient" to "Beneficiary"</p>	<p>Provider Education/Guidance Revisions Due To CPT/HCPCS Code Changes</p>
02/04/2011	R1	<p><b>Revision Effective Date: 02/04/2011</b>            INDICATIONS AND LIMITATIONS OF COVERAGE:            Deleted: Least Costly Alternative for HCPCS code E0652</p> <p>Revision Effective Date: 01/01/2009            INDICATIONS AND LIMITATIONS OF COVERAGE:            Added: Statement regarding appliances for the chest and trunk.            HCPCS CODES AND MODIFIERS:            Added: E0656 and E0657</p> <p>03/01/2008- In accordance with Section 911 of the Medicare Modernization Act, this policy was transitioned to DME MAC NHIC (16003) LCD L11503 from DME PSC TriCenturion (77011) LCD L11503.</p>	<p>Maintenance (annual review with new changes, formatting, etc.)</p>

Revision History Date	Revision History Number	Revision History Explanation	Reason(s) for Change
		<p>06/01/2007 - In accordance with Section 911 of the Medicare Modernization Act of 2003, Virginia and West Virginia were transitioned from DME PSC TriCenturion (77011) to DME PSC TrustSolutions (77012).</p>	
		<p>Revision Effective Date: 01/01/2007  DOCUMENTATION REQUIREMENTS:  Added revised CMN form changes and information.  LCD ATTACHMENTS:  Removed previous CMN  Added new CMN</p>	
		<p>03/01/2006 - In accordance with Section 911 of the Medicare Modernization Act of 2003, this policy was transitioned to DME PSC TriCenturion (77011) from DMERC Tricenturion (77011).</p>	
		<p>Revision Effective Date: 01/01/2006  LMRP converted to LCD and Policy Article  DOCUMENTATIONS REQUIREMENTS:  Removed requirement of extra documentation to be sent in with claim if E0652 and/or question #3 or #4 of the CMN is answered yes.</p>	
		<p>Revised effective date: 04/01/2003  HCPCS CODES AND MODIFIERS:  Added EY modifier to HCPCS Modifier array.  INDICATIONS AND LIMITATIONS OF COVERAGE:  Added standard language concerning coverage of items without an order.  DOCUMENTATION:  Added EY verbiage  OTHER COMMENTS:  Moved definitions of lymphedema and CVI here.</p>	
		<p>The revision dates listed below are the dates the revisions were published and not necessarily the effective dates for the revisions.</p>	
		<p>04/01/2002 - Based on a CMS National Coverage Decision, the distinction between lymphedema and chronic venous</p>	

Revision History Date	Revision History Number	Revision History Explanation	Reason(s) for Change
		insufficiency and the respective coverage and payment rules for use of these devices for either condition is further clarified.	
		03/01/1998 – Removed HCPCS code E0670 and removed language for that code in Coding Guidelines section.	
		10/01/1995 – Revised descriptions for HCPCS codes and added codes E0669-E0673. Revised to clarify (1) that nonsegmented and segmented pump with manual control of pressure in each chamber is considered the least costly alternative that meets the clinical needs of the individual for this type of durable medical equipment (HCPCS codes E0650 and E0651), unless there is documentation that warrants payment of the more costly manual control pump (HCPCS code E0652); (2) the documentation needed for determination of the type of pump to be used for the treatment of lymphedema; and (3) which pneumatic compression pump is appropriate for chronic venous insufficiency.	

## Associated Documents

### Attachments

PCD CMN CMS-846 (41 KB)

PCD Response to Comments - Comment and Response (84 KB)

### Related Local Coverage Documents

Article(s)

A37216 - Pneumatic Compression Devices - Policy Article - Effective November 2014

### Related National Coverage Documents

### All Versions

Updated on 09/05/2014 with effective dates 11/01/2014 - N/A

Updated on 09/05/2014 with effective dates 11/01/2014 - N/A

Updated on 03/21/2014 with effective dates 07/01/2013 - 10/31/2014

Updated on 03/15/2013 with effective dates 01/01/2013 - 06/30/2013

Updated on 03/07/2012 with effective dates 02/04/2011 - 12/31/2012

Updated on 12/10/2010 with effective dates 02/04/2011 - N/A

Updated on 11/26/2008 with effective dates 01/01/2009 - 02/03/2011

Updated on 11/24/2008 with effective dates 01/01/2009 - N/A

Updated on 02/19/2008 with effective dates 06/01/2007 - 12/31/2008

### Keywords

N/A

# Local Coverage Article for Pneumatic Compression Devices - Policy Article - Effective November 2014 (A37216)

[FUTURE]

**Please note:** This is a Future Article.

## Contractor Information

Contractor Name	Contract Number	Contract Type
NHIC, Corp.	16003	DME MAC

## Article Information

### General Information

[FUTURE]

**Article ID**  
A37216

**Article Title**  
Pneumatic Compression Devices - Policy Article - Effective November 2014

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### Jurisdiction

Connecticut  
District of Columbia  
Delaware  
Massachusetts  
Maryland  
Maine  
New Hampshire  
New Jersey  
New York - Entire State  
Pennsylvania  
Rhode Island  
Vermont

**Original Effective Date**  
01/01/2006

**Revision Effective Date**  
11/01/2014

**Revision Ending Date**  
N/A

**Retirement Date**  
N/A

## Article Guidance

### Article Text:

#### NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES

For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements. Information provided in this policy article relates to determinations other than those based on Social Security Act §1862(a)(1)(A) provisions (i.e. “reasonable and necessary”).

Pneumatic compression devices are covered under the Durable Medical Equipment benefit (Social Security Act §1861(s)(6)). In order for a beneficiary’s equipment to be eligible for reimbursement, the reasonable and necessary (R&N) requirements set out in the related Local Coverage Determination must be met. In addition, there are specific statutory payment policy requirements, discussed below, that also must be met.

#### PREVENTION OF VENOUS THROMBOEMBOLISM

A pneumatic compression device that provides intermittent limb compression for the purpose of prevention of venous thromboembolism (E0676) is a preventive service. Items that are used for a preventative service or function are excluded from coverage under the Medicare DME benefit.

E0676	INTERMITTENT LIMB COMPRESSION DEVICE (INCLUDES ALL ACCESSORIES), NOT OTHERWISE SPECIFIED
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Claims for E0676 will be statutorily denied as no Medicare benefit.

#### AFFORDABLE CARE ACT (ACA) 6407 REQUIREMENTS

ACA 6407 contains provisions that are applicable to specified items in this policy. In this policy the specified items are:

E0650	PNEUMATIC COMPRESSOR, NON-SEGMENTAL HOME MODEL
E0651	PNEUMATIC COMPRESSOR, SEGMENTAL HOME MODEL WITHOUT CALIBRATED GRADIENT PRESSURE
E0652	PNEUMATIC COMPRESSOR, SEGMENTAL HOME MODEL WITH CALIBRATED GRADIENT PRESSURE
E0655	NON-SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, HALF ARM
E0656	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, TRUNK
E0657	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, CHEST
E0660	NON-SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, FULL LEG
E0665	NON-SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, FULL ARM

E0666	NON-SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, HALF LEG
E0667	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, FULL LEG
E0668	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, FULL ARM
E0669	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, HALF LEG
E0671	SEGMENTAL GRADIENT PRESSURE PNEUMATIC APPLIANCE, FULL LEG
E0672	SEGMENTAL GRADIENT PRESSURE PNEUMATIC APPLIANCE, FULL ARM
E0673	SEGMENTAL GRADIENT PRESSURE PNEUMATIC APPLIANCE, HALF LEG
E0675	PNEUMATIC COMPRESSION DEVICE, HIGH PRESSURE, RAPID INFLATION/DEFLATION CYCLE, FOR ARTERIAL INSUFFICIENCY (UNILATERAL OR BILATERAL SYSTEM)

#### Face-to-Face Visit Requirements:

As a condition for payment, Section 6407 of the Affordable Care Act (ACA) requires that a physician (MD, DO or DPM), physician assistant (PA), nurse practitioner (NP) or clinical nurse specialist (CNS) has had a face-to-face examination with a beneficiary that meets all of the following requirements:

- The treating physician must have an in-person examination with the beneficiary within the six (6) months prior to the date of the written order prior to delivery (WOPD).
- This examination must document that the beneficiary was evaluated and/or treated for a condition that supports the need for the item(s) of DME ordered.

A new face-to-face examination is required each time a new prescription for one of the specified items is ordered. A new prescription is required by Medicare:

- For all claims for purchases or initial rentals
- When there is a change in the prescription for the accessory, supply, drug, etc.
- If a local coverage determination (LCD) requires periodic prescription renewal (i.e., policy requires a new prescription on a scheduled or periodic basis)
- When an item is replaced
- When there is a change in the supplier
- When required by state law

The first bullet, "For all claims for purchases or initial rentals", includes all claims for payment of purchases and initial rentals for items not originally covered (reimbursed) by Medicare Part B. Claims for items obtained outside of Medicare Part B, e.g. from another payer prior to Medicare participation (including Medicare Advantage plans), are considered to be new initial claims for Medicare payment purposes.

#### Prescription Requirements:

A WOPD is a standard Medicare Detailed Written Order, which must be completed, including the prescribing physician's signature and signature date, and must be in the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) supplier's possession BEFORE the item is delivered. The WOPD must include all of the items below:

- Beneficiary's name
- Physician's Name

- Date of the order and the start date, if start date is different from the date of the order
- Detailed description of the item(s)
- The prescribing practitioner's National Provider Identifier (NPI)
- The signature of the ordering practitioner
- Signature date

For any of the specified items provided on a periodic basis, including drugs, the written order must include, in addition to the above:

- Item(s) to be dispensed
- Dosage or concentration, if applicable
- Route of Administration, if applicable
- Frequency of use
- Duration of infusion, if applicable
- Quantity to be dispensed
- Number of refills, if applicable

Note that prescriptions for these specified DME items require the National Provider Identifier to be included on the prescription. Prescriptions for other DMEPOS items do not have this NPI requirement. Suppliers should pay particular attention to orders that include a mix of items, to assure that these ACA order requirements are met.

The treating practitioner that conducted the face-to-face examination does not need to be the prescriber for the DME item. However the prescriber must:

- Verify that the in-person visit occurred within the 6-months prior to the date of their prescription, and
- Have documentation of the face-to-face examination that was conducted, and
- Provide the DMEPOS supplier with copies of the in-person visit records.

#### Date and Timing Requirements

There are specific date and timing requirements:

- The date of the face-to-face examination must be on or before the date of the written order (prescription) and may be no older than 6 months prior to the prescription date.
- The date of the face-to-face examination must be on or before the date of delivery for the item(s) prescribed.
- The date of the written order must be on or before the date of delivery.
- The DMEPOS supplier must have documentation of both the face-to-face visit and the completed WOPD in their file prior to the delivery of these items.

A date stamp (or similar) is required which clearly indicates the supplier's date of receipt of both the face-to-face record and the completed WOPD with the prescribing physician's signature and signature date. It is recommended that both documents be separately date-stamped to avoid any confusion regarding the receipt date of these documents.

#### Claim Denial

Claims for the specified items subject to ACA 6407 that do not meet the requirements specified above will be denied as statutorily noncovered – failed to meet statutory requirements.

If the supplier delivers the item prior to receipt of a written order, it will be denied as statutorily noncovered. If the written order is not obtained prior to delivery, payment will not be made for that item even if a written order is subsequently obtained. If a similar item is subsequently

provided by an unrelated supplier who has obtained a written order prior to delivery, it will be eligible for coverage.

## **CODING GUIDELINES**

Pneumatic compression devices consist of an inflatable garment for the arm or leg and an electrical pneumatic pump that fills the garment with compressed air. The garment is intermittently inflated and deflated with cycle times and pressures that vary between devices.

A non-segmented pneumatic compressor (E0650) is a device which has a single outflow port on the compressor. The fact that the air from the single tube may be transmitted to a sleeve/appliance with multiple compartments or segments (E0671-E0673) does not affect the coding of the compressor.

A segmented pneumatic compressor (E0651, E0652) is a device which has multiple outflow ports on the compressor which lead to distinct segments on the appliance which inflate sequentially. A segmented device without calibrated gradient pressure (E0651) 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 several segments. In an E0651 device the pressure is usually set by a single control on the distal segment. A segmented device with calibrated gradient pressure (E0652) is characterized by a manual control on at least three outflow ports which can deliver an individually determined pressure to each segmental unit. The fact that the tubing and/or appliance are capable of achieving a pressure gradient does not classify the compressor as E0652 because this is not a calibrated gradient pressure.

Segmental gradient pressure pneumatic appliances (E0671-E0673) are appliances/sleeves which are used with a non-segmented pneumatic compressor (E0650) but which achieve a pressure gradient through the design of the tubing and/or air chambers.

A non-segmented pneumatic compressor (E0650) is used with appliances/sleeves coded by E0655-E0666 or E0671-E0673. Segmented pneumatic compressors (E0651 or E0652) are used with appliances/sleeves coded by E0667-E0669. Sleeves E0656 and E0657 are only used with E0652.

An E0675 is a pneumatic compression device that delivers high pressure and rapid inflation/deflation cycles for the treatment arterial insufficiency. This code is all-inclusive, i.e. all variations in pressures, cycle characteristics, timing, control systems, sleeve configurations, etc. (not all-inclusive). Sleeves E0667-E0669 are used with E0675.

When a foot or hand segment is used in conjunction with a leg or arm appliance respectively, there should be no separate bill for this segment. It is considered included in the code for the leg or arm appliance.

The only products that may be billed to the DME MACs using codes E0650, E0651 and E0652 are those for which a Coding Verification Review has been made by the Pricing, Data Analysis, and Coding (PDAC) contractor and subsequently published on the appropriate Product Classification List. Information concerning the documentation that must be submitted to the PDAC for a Coding Verification Review can be found on the PDAC web site or by contacting the PDAC.

Suppliers should contact the PDAC Contractor on the correct coding for these items.

## Coding Information

[FUTURE]

### Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the article does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the article should be assumed to apply equally to all claims.

N/A

### Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the article services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the article should be assumed to apply equally to all Revenue Codes.

N/A

### CPT/HCPCS Codes

N/A

### Covered ICD-9 Codes

N/A

### Non-Covered ICD-9 Codes

N/A

## Revision History Information

Revision History Date	Revision History Number	Revision History Explanation
11/01/2014	R3	<b>Revision Effective Date: 11/01/2014</b> Draft Policy Article Released to Final NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added: E0675 & E0676 Added: Non-coverage of E0676 for prevention of venous thromboembolism Added: E0675 to ACA 6407 requirement table Added: Additional face-to-face requirement language under Affordable Care Act changes CODING GUIDELINES: Added: Coding instructions for E0675 & E0676 Added: E0675 to the Coding Verification Review
07/01/2013	R2	<b>Revision Effective Date: 07/01/2013</b> NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added: ACA 6407 information

Revision History Date	Revision History Number	Revision History Explanation
04/01/2013	R1	<p><b>Revision Effective Date: 04/01/2013</b>  NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES:  Added: Preamble and benefit category statement</p>
		<p><b>Revision Effective Date: 01/01/2009</b>  CODING GUIDELINES:  Changed: References from SADMERC to PDAC  References from DMERC to DME MAC</p>
		<p><b>03/01/2008</b> - In accordance with Section 911 of the Medicare Modernization Act, this policy was transitioned to DME MAC NHIC (16003) Article A37216 from DME PSC TriCenturion (77011) Article A37216.</p>
		<p><b>06/01/2007</b> - In accordance with Section 911 of the Medicare Modernization Act of 2003, Virginia and West Virginia were transitioned from DME PSC TriCenturion (77011) to DME PSC TrustSolutions (77012).</p>
		<p><b>03/01/2006</b> - In accordance with Section 911 of the Medicare Modernization Act of 2003, this article was transitioned to DME PSC TriCenturion (77011) from DMERC Tricenturion (77011).</p>
		<p><b>Revision Effective Date: 01/01/2006</b>  LMRP converted to LCD and Policy Article  CODING GUIDELINES:  Added requirement for Coding Verification Review by SADMERC for codes E0650, E0651 and E0652.</p>

## Associated Documents

### Related Local Coverage Document(s)

#### LCD(s)

- L11503 - Pneumatic Compression Devices
- DL11503 - Pneumatic Compression Devices

### Related National Coverage Documents

#### Statutory Requirements URL(s)

#### Rules and Regulations URL(s)

#### CMS Manual Explanations URL(s)

#### Other URL(s)

### Public Version(s)

- Updated on 09/05/2014 with effective dates 11/01/2014 - N/A
- Updated on 03/21/2014 with effective dates 07/01/2013 - 10/31/2014
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**Keywords**

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