

Local Coverage Determination (LCD): Pneumatic Compression Devices (L33829)

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Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
CGS Administrators, LLC	DME MAC	17013 - DME MAC	J-B	Illinois Indiana Kentucky Michigan Minnesota Ohio Wisconsin
CGS Administrators, LLC	DME MAC	18003 - DME MAC	J-C	Alabama Arkansas Colorado Florida Georgia Louisiana Mississippi New Mexico North Carolina Oklahoma Puerto Rico South Carolina Tennessee Texas Virgin Islands Virginia West Virginia
Noridian Healthcare Solutions, LLC	DME MAC	16013 - DME MAC	J-A	Connecticut Delaware District of Columbia Maine Maryland Massachusetts New Hampshire New Jersey New York - Entire State Pennsylvania Rhode Island Vermont

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
Noridian Healthcare Solutions, LLC	DME MAC	19003 - DME MAC	J-D	Alaska American Samoa Arizona California - Entire State Guam Hawaii Idaho Iowa Kansas Missouri - Entire State Montana Nebraska Nevada North Dakota Northern Mariana Islands Oregon South Dakota Utah Washington Wyoming

LCD Information

Document Information

LCD ID

L33829

Original Effective Date

For services performed on or after 10/01/2015

LCD Title

Pneumatic Compression Devices

Revision Effective Date

For services performed on or after 01/01/2020

Proposed LCD in Comment Period

N/A

Revision Ending Date

N/A

Source Proposed LCD

N/A

Retirement Date

N/A

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Notice Period Start Date

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CMS National Coverage Policy

CMS Pub. 100-03, (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.

The purpose of a Local Coverage Determination (LCD) is to provide information regarding “reasonable and necessary” criteria based on Social Security Act § 1862(a)(1)(A) provisions.

In addition to the “reasonable and necessary” criteria contained in this LCD there are other payment rules, which are discussed in the following documents, that must also be met prior to Medicare reimbursement:

- The LCD-related Standard Documentation Requirements Article, located at the bottom of this policy under the Related Local Coverage Documents section.

- The LCD-related Policy Article, located at the bottom of this policy under the Related Local Coverage Documents section.
- Refer to the Supplier Manual for additional information on documentation requirements.
- Refer to the DME MAC web sites for additional bulletin articles and other publications related to this LCD.

For the items addressed in this LCD, the “reasonable and necessary” criteria, based on Social Security Act § 1862(a)(1)(A) provisions, are defined by the following coverage indications, limitations and/or medical necessity.

PRESCRIPTIONS

Prescriptions for Pneumatic Compression Devices (PCDs) (E0650, E0651, E0652, E0675, E0676) are limited to Physicians (MD, DO, DPM) and physician extenders (NP, PA, CNS) to the extent allowed by their applicable state scope-of-practice and other license requirements. Providers must use care because the treatment of lymphedema, chronic venous insufficiency with ulceration and complications related to the treatment of these conditions by use of PCDs, commonly require consideration of diagnoses and management of systemic conditions. In no event should a provider order PCDs or PCD appliances that are to be used for or are to be applied to areas of the body that fall outside of their state scope of practice and other license limitations.

DEFINITIONS

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

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, E0651, 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. 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.

GENERAL

PCDs coded as E0650, E0651, 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. PCD coded as E0675 is used in the treatment of 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 a diagnosis of lymphedema as defined above, and
2. The beneficiary has persistence of chronic and severe lymphedema as identified by the documented presence of at least one of the following clinical findings:
 - Marked hyperkeratosis with hyperplasia and hyperpigmentation,
 - Papillomatosis cutis lymphostatica,
 - Deformity of elephantiasis,
 - Skin breakdown with persisting lymphorrhea,
 - Detailed measurements over time confirming the persistence of the lymphedema with a history evidencing a likely etiology, and
3. In addition to this 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 PCD 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:

- Regular and compliant 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 starting with a minimum of 30 mmHg distally.
- Regular exercise
- Elevation of the limb

When available, manual lymphatic drainage is a key component of conservative treatment as is appropriate medication treatment when there is concurrent congestive failure.

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 intervals at least a week apart. Only when no significant improvement has occurred in the most recent four weeks and the coverage criteria above are still met, may the lymphedema be considered unresponsive to conservative therapy, and coverage for a PCD considered.

The medical necessity determination for a PCD by the treating practitioner must include symptoms and objective findings, including measurements, to establish the severity of the condition.

The documentation by the treating practitioner of the medical necessity of a pneumatic compression device must include:

- The patient's diagnosis and prognosis;
- Symptoms and objective findings, including measurements which establish the severity of the condition;
- The reason the device is required, including the treatments which have been tried and failed; and
- The clinical response to an initial treatment with the device

At a minimum, re-assessments conducted for a trial 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.

The trial of conservative therapy must be documented in the beneficiary's medical record before prescribing any type of pneumatic compression device (E0650, E0651, E0652). This assessment may be performed by the treating practitioner or any other licensed/certified medical professional (LCMP) directly involved in the beneficiary's lymphedema treatment. The LCMP may not have any financial relationship with the DMEPOS supplier providing the

device. If the assessment is performed by an LCMP, the treating practitioner must receive and review the report of the evaluation. In addition, the treating practitioner must sign and date the report, and state concurrence or disagreement with the assessment. The signature date must be on or before the prescription date.

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 practitioner. (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 PCD 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:

- Compliant 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 starting with a minimum of 30 mmHg distally.
- Medications as appropriate (e.g. diuretics and/or other treatment of congestive failure, etc.)
- Regular exercise
- Elevation of the limb
- Appropriate wound care for the ulcer (including sharp debridement where appropriate)

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

The trial of conservative therapy must be documented in the beneficiary's medical record before prescribing any type of pneumatic compression device (E0650, E0651, E0652). This assessment may be performed by the treating practitioner or any other licensed/certified medical professional (LCMP) directly involved in the beneficiary's CVI treatment. The LCMP may not have any financial relationship with the DMEPOS supplier providing the device. If the assessment is performed by an LCMP, the treating practitioner must receive and review the report of the evaluation. In addition, the treating practitioner must sign and date the report, and state concurrence or disagreement with the assessment. The signature date must be on or before the prescription date.

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

A segmented, calibrated gradient pneumatic compression device (HCPCS code E0652) is only covered when the individual has unique characteristics which prevent them from receiving adequate satisfactory pneumatic compression treatment using a nonsegmented device along with a segmented appliance or compression device without manual control of the pressure in each chamber.

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
- Compliant 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 starting with a minimum of 30 mmHg distally.
- Regular exercise

- Elevation where appropriate
- Manual lymphatic drainage (where available) and self-manual lymphatic drainage (MLD) for at least 30 minutes per day
- Evaluation of diet and implementation of any necessary 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 an E0652 is not justified. Where improvement has occurred, the trial of conservative therapy must be continued with subsequent reassessment at intervals at least a week apart. When and only when no significant improvement has occurred in the most recent four weeks and the coverage criteria above are still met, an E0652 is eligible for reimbursement.

The trial of conservative therapy must be documented in the beneficiary's medical record before prescribing any type of pneumatic compression device (E0650, E0651, E0652). This assessment may be performed by the treating practitioner or any other licensed/certified medical professional (LCMP) directly involved in the beneficiary's lymphedema treatment. The LCMP may not have any financial relationship with the DMEPOS supplier providing the device. If the assessment is performed by an LCMP, the treating practitioner must receive and review the report of the evaluation. In addition, the treating practitioner must sign and date the report, and state concurrence or disagreement with the assessment. The signature date must be on or before the prescription date.

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 PREVENTION

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

ACCESSORIES

PCD related accessories (E0655, E0656, E0657, E0660, E0665, E0666, E0667, E0668, E0669, E0670, E0671, E0672, E0673) are eligible for reimbursement only when the appropriate, related base PCDs (E0650, E0651, E0652, 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, E0651, 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, E0672, E0673) is considered functionally equivalent to an E0651 compressor with a segmented appliance/sleeve (E0667, E0668, E0669).

A segmented, calibrated gradient pneumatic compression device (HCPCS code E0652) is only covered when the individual has unique characteristics which prevent them from receiving adequate satisfactory pneumatic compression treatment using a nonsegmented device along with a segmented appliance or compression device

without manual control of the 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 prevention of venous thrombosis. 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.

GENERAL

A Standard Written Order (SWO) must be communicated to the supplier before a claim is submitted. If the supplier bills for an item addressed in this policy without first receiving a completed SWO, the claim shall be denied as not reasonable and necessary.

For Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) base items that require a Written Order Prior to Delivery (WOPD), the supplier must have received a signed SWO before the DMEPOS item is delivered to a beneficiary. If a supplier delivers a DMEPOS item without first receiving a WOPD, the claim shall be denied as not reasonable and necessary. Refer to the LCD-related Policy Article, located at the bottom of this policy under the Related Local Coverage Documents section.

For DMEPOS base items that require a WOPD, and also require separately billed associated options, accessories, and/or supplies, the supplier must have received a WOPD which lists the base item and which may list all the associated options, accessories, and/or supplies that are separately billed prior to the delivery of the items. In this scenario, if the supplier separately bills for associated options, accessories, and/or supplies without first receiving a completed and signed WOPD of the base item prior to delivery, the claim(s) shall be denied as not reasonable and necessary.

An item/service is correctly coded when it meets all the coding guidelines listed in CMS HCPCS guidelines, LCDs, LCD-related Policy Articles, or DME MAC articles. Claims that do not meet coding guidelines shall be denied as not reasonable and necessary/incorrectly coded.

Proof of delivery (POD) is a Supplier Standard and DMEPOS suppliers are required to maintain POD documentation in their files. Proof of delivery documentation must be made available to the Medicare contractor upon request. All services that do not have appropriate proof of delivery from the supplier shall be denied as not reasonable and necessary.

Summary of Evidence

NA

**Analysis of Evidence
(Rationale for Determination)**

NA

Coding Information

CPT/HCPCS Codes

Group 1 Paragraph:

The appearance of a code in this section does not necessarily indicate coverage.

HCPCS MODIFIER:

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

HCPCS CODES:

Group 1 Codes:

CODE	DESCRIPTION
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,

CODE	DESCRIPTION
	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

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 treating practitioner'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.

GENERAL DOCUMENTATION REQUIREMENTS

In order to justify payment for DMEPOS items, suppliers must meet the following requirements:

- SWO
- Medical Record Information (including continued need/use if applicable)
- Correct Coding
- Proof of Delivery

Refer to the LCD-related Standard Documentation Requirements article, located at the bottom of this policy under the Related Local Coverage Documents section for additional information regarding these requirements.

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

Refer to the DME MAC web sites for additional bulletin articles and other publications related to this LCD.

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS

Items covered in this LCD have additional policy-specific requirements that must be met prior to Medicare reimbursement.

Refer to the LCD-related Policy article, located at the bottom of this policy under the Related Local Coverage Documents section for additional information.

Miscellaneous

Appendices

Utilization Guidelines

Refer to Coverage Indications, Limitations and/or Medical Necessity

Sources of Information

N/A

Bibliography

NA

Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
01/01/2020	R10	Revision Effective Date: 01/01/2020 COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Revised: "prescribing physician" to "treating practitioner" Revised: "physician" to "practitioner" Revised: Format of HCPCS code references, from code spans to individually-listed HCPCS GENERAL: Revised: Order information as a result of Final Rule 1713 CODING INFORMATION: Removed: Field titled "Bill Type" Removed: Field titled "Revenue Codes" Removed: Field titled "ICD-10 Codes that Support Medical Necessity"	<ul style="list-style-type: none">• Provider Education/Guidance• Other

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
		<p>Removed: Field titled "ICD-10 Codes that DO NOT Support Medical Necessity"</p> <p>Removed: Field titled "Additional ICD-10 Information"</p> <p>DOCUMENTATION REQUIREMENTS:</p> <p>Revised: "physician's" to "treating practitioner's"</p> <p>GENERAL DOCUMENTATION REQUIREMENTS:</p> <p>Revised: "Prescriptions (orders)" to "SWO"</p> <p><i>02/20/2020: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because they are due to non-discretionary coverage updates reflective of CMS FR-1713, HCPCS code changes, and non-substantive corrections (listing individual HCPCS codes instead of a HCPCS code-span).</i></p>	
01/01/2019	R9	<p>Revision Effective Date: 01/01/2019</p> <p>COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:</p> <p>Removed: All references to NCD 280.6</p> <p>Added: Clarifying language to four-week trial for lymphedema under Group I, clarifying language to Group III coverage, and clarifying language to PCD code selection section</p>	<ul style="list-style-type: none"> Other (Removed NCD references)
01/01/2017	R8	<p>Revision Effective Date: 01/01/2017</p> <p>COVERAGE INDICATIONS, INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:</p> <p>Removed: Standard Documentation Language</p> <p>Added: New reference language and directions to Standard Documentation Requirements</p> <p>Added: General Requirements</p> <p>DOCUMENTATION REQUIREMENTS:</p> <p>Removed: Standard Documentation Language</p> <p>Added: General Documentation Requirements</p> <p>Added: New reference language and directions to Standard Documentation Requirements</p> <p>POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:</p> <p>Removed: Standard Documentation Language</p> <p>Added: Direction to Standard Documentation Requirements</p> <p>Removed: Supplier manual reference under Miscellaneous</p> <p>Removed: PIM reference under Appendices</p>	<ul style="list-style-type: none"> Provider Education/Guidance

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
		SOURCES OF INFORMATION AND BASIS FOR DECISION: Removed: Links RELATED LOCAL COVERAGE DOCUMENTS: Added: LCD-related Standard Documentation Requirements article	
07/01/2016	R7	Revision Effective Date: 07/01/2016 Links for Sources of Information and Basis for Decision updated.	<ul style="list-style-type: none"> • Typographical Error
07/01/2016	R6	Revision Effective Date: 07/01/2016 Links for Sources of Information and Basis for Decision updated.	<ul style="list-style-type: none"> • Typographical Error
07/01/2016	R5	Effective July 1, 2016 oversight for DME MAC LCDs is the responsibility of CGS Administrators, LLC 18003 and 17013 and Noridian Healthcare Solutions, LLC 19003 and 16013. No other changes have been made to the LCDs.	<ul style="list-style-type: none"> • Change in Assigned States or Affiliated Contract Numbers
12/01/2015	R4	Revision Effective Date: 12/01/2015 Links for Sources of Information and Basis for Decision updated.	<ul style="list-style-type: none"> • Typographical Error
12/01/2015	R3	Revision Effective Date: 12/01/2015 COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Revised: Trial requirements to reference "no significant improvement" rather than "no further improvement" for lymphedema, CVI, and for lymphedema extending on to the chest, trunk and/or abdomen Removed: Word "Any" from trial requirements for lymphedema of the chest, trunk and/or abdomen DOCUMENTATION REQUIREMENTS: Revised: Standard Documentation language to remove start date verbiage from Prescription Requirements (Effective 11/5/2015)	<ul style="list-style-type: none"> • Provider Education/Guidance
12/01/2015	R2	Revision Effective Date: 12/01/2015 COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Added: Explicit statement on E0675 non-coverage Added: E0676 benefit exclusion reference in related Policy Article Revised: Requirements for Four-Week Trial for	<ul style="list-style-type: none"> • Other (Draft Released to Final)

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
		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 Revised: Requirements for E0652 Added: E0675 to ACA 6407 requirements table	
10/01/2015	R1	Revision Effective Date: 10/31/2014 COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility DOCUMENTATION REQUIREMENTS: Replaced: WOPD with ACA 6407 WOPD instructions Revised: Standard Documentation Language to add who can enter date of delivery date on the POD Added: Instructions for Equipment Retained from a Prior Payer Revised: Standard Language Documentation verbiage for CMN Added: Repair/Replacement section	<ul style="list-style-type: none"> Provider Education/Guidance

Associated Documents

Attachments

CMS-846 — PCD CMN
(PDF - 108 KB)

Related Local Coverage Documents

Article(s)

A52488 - Pneumatic Compression Devices - Policy Article

A55426 - Standard Documentation Requirements for All Claims Submitted to DME MACs

Related National Coverage Documents

N/A

Public Version(s)

Updated on 02/14/2020 with effective dates 01/01/2020 - N/A

Updated on 02/22/2019 with effective dates 01/01/2019 - 12/31/2019

Some older versions have been archived. Please visit the MCD Archive Site to retrieve them.

Keywords

N/A

END OF LOCAL COVERAGE DETERMINATION

Per the Code of Federal Regulations, 42 C.F.R § 426. 325, only those portions of the currently effective Local Coverage Determination (LCD) that are based on section 1862(a)(1)(A) of the Social Security Act, may be challenged through an acceptable complaint as described in 42 C.F.R § 426.400. Also, per 42 C.F.R § 426.325 items that are not reviewable, and therefore cannot be challenged, include the Policy Article. Please note the distinction of the documents when reviewing the materials.

Local Coverage Article: Pneumatic Compression Devices - Policy Article (A52488)

Links in PDF documents are not guaranteed to work. To follow a web link, please use the MCD Website.

Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
CGS Administrators, LLC	DME MAC	17013 - DME MAC	J-B	Illinois Indiana Kentucky Michigan Minnesota Ohio Wisconsin
CGS Administrators, LLC	DME MAC	18003 - DME MAC	J-C	Alabama Arkansas Colorado Florida Georgia Louisiana Mississippi New Mexico North Carolina Oklahoma Puerto Rico South Carolina Tennessee Texas Virgin Islands Virginia West Virginia
Noridian Healthcare Solutions, LLC	DME MAC	16013 - DME MAC	J-A	Connecticut Delaware District of Columbia Maine Maryland Massachusetts New Hampshire New Jersey New York - Entire State Pennsylvania Rhode Island Vermont

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
Noridian Healthcare Solutions, LLC	DME MAC	19003 - DME MAC	J-D	Alaska American Samoa Arizona California - Entire State Guam Hawaii Idaho Iowa Kansas Missouri - Entire State Montana Nebraska Nevada North Dakota Northern Mariana Islands Oregon South Dakota Utah Washington Wyoming

Article Information

General Information

Article ID

A52488

Original Effective Date

10/01/2015

Original ICD-9 Article ID

[A37075](#)

[A24141](#)

[A47127](#)

[A37216](#)

Revision Effective Date

01/01/2020

Revision Ending Date

N/A

Article Title

Pneumatic Compression Devices - Policy Article

Retirement Date

N/A

Article Type

Article

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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 (PCDs) 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 PCD 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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Therefore, claims for E0676 will be statutorily denied as no Medicare benefit.

REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO Final Rule 1713 (84 Fed. Reg Vol 217)

Final Rule 1713 (84 Fed. Reg Vol 217) requires a face-to-face encounter and a Written Order Prior to Delivery (WOPD) for specified HCPCS codes. CMS and the DME MACs provide a list of the specified codes, which is periodically updated. The link will be located here once it is available.

Claims for the specified items subject to Final Rule 1713 (84 Fed. Reg Vol 217) that do not meet the face-to-face encounter and WOPD requirements specified in the LCD-related Standard Documentation Requirements Article (A55426) will be denied as not reasonable and necessary.

If a supplier delivers an item prior to receipt of a WOPD, it will be denied as not reasonable and necessary. If the WOPD is not obtained prior to delivery, payment will not be made for that item even if a WOPD is subsequently obtained by the supplier. If a similar item is subsequently provided by an unrelated supplier who has obtained a WOPD, it will be eligible for coverage.

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS

In addition to policy specific documentation requirements, there are general documentation requirements that are applicable to all DMEPOS policies. These general requirements are located in the DOCUMENTATION REQUIREMENTS section of the LCD.

Refer to the LCD-related Standard Documentation Requirements article, located at the bottom of this Policy Article under the Related Local Coverage Documents section for additional information regarding GENERAL DOCUMENTATION REQUIREMENTS and the POLICY SPECIFIC DOCUMENTATION REQUIREMENTS discussed below.

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)

A Certificate of Medical Necessity (CMN) which has been completed, signed, and dated by the treating practitioner must be kept on file by the supplier and made available upon request. The CMN may act as a substitute for the standard written order (SWO) if it contains the same information as required in a SWO. The CMN for pneumatic compression pumps is CMS Form 846. The initial claim must include an electronic copy of the CMN. In addition to the order information that the treating practitioner enters in Section B, the supplier can use the space in Section C for a written confirmation of other details of the order or the treating practitioner can enter the other details directly.

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 practitioner visits for treatment of venous stasis ulcer(s) during the past 6 months.

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

CODING GUIDELINES

PCDs consist of an electrical pneumatic pump and an inflatable appliance that encloses the applicable body part. The pump fills the appliance with compressed air to predetermined pressures and intermittently alternates inflation and deflation to preset cycle times. The pressures and cycles vary between devices and, in some devices, are user-adjustable.

PCDs for the Treatment of Lymphedema or Chronic Venous Insufficiency (CVI) With Ulcers

PCDs used for the treatment of lymphedema or CVI with ulcers are coded based on the characteristics of the compression pump. The only HCPCS codes for PCDs used to treat lymphedema or CVI with ulcers 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

The HCPCS codes used for the inflatable appliances used with PCDs E0650 - E0652 are:

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

A non-segmented pneumatic compressor (E0650) is a device that has a single outflow port on the compressor. Pressurized air from the single outflow port is transmitted to an appliance with single or multiple segments. The segment(s) inflate and deflate based on the compressor-specified pressure and cycle times. The number of segments contained in the appliance does not affect HCPCS coding of the compressor. Appliances appropriate for use with an E0650 PCD are E0655, E0660, E0665, E0666, E0671, E0672 and E0673.

Segmental gradient pressure pneumatic appliances (E0671, E0672, 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 segmented pneumatic compressor (E0651, E0652) is a device that has multiple outflow ports on the compressor. The pressurized air from each outflow ports is transmitted to corresponding segments on the appliance. The segments inflate and deflate based on the compressor-specified pressures and cycle times.

A segmented device without calibrated gradient pressure (E0651) is one in which either the same pressure is present in each segment or there is a predetermined pressure gradient in successive segments. E0651 PCDs cannot individually set or adjust pressures in separate appliance segments. In an E0651 PCD, the pressure is usually set by a single control on the distal segment. Appliances appropriate for use with an E0651 PCD are E0667, E0668, E0669.

A segmented device with calibrated gradient pressure (E0652) is characterized by manual control on at least three outflow ports that can deliver an individually determined pressure to each corresponding appliance segment. Use of

tubing and/or appliances that can create a pressure gradient independently from the compressor does not qualify to classify the compressor as E0652. These methods are not considered as calibrated gradient pressure. Appliances appropriate for use with an E0652 PCD are E0656, E0657, E0667, E0668, E0669 and E0670.

All limb appliances (E0655, E0660, E0665, E0667, E0668, E0669, E0670, E0671, E0672, E0673) used with PCDs E0650, E0651, E0652 must enclose the affected limb(s) sufficiently to prevent retrograde edema fluid flow (distally). All limb appliances (E0655, E0660, E0665, E0667, E0668, E0669, E0670, E0671, E0672, E0673) used with PCDs E0650, E0651, E0652 must avoid a tourniquet effect during compression that would prevent distal fluid from moving proximally. Appliances that create a tourniquet effect or cause retrograde flow of edema fluid must be coded A4600 - SLEEVE FOR INTERMITTENT LIMB COMPRESSION DEVICE, REPLACEMENT ONLY, EACH.

PCDs for the Treatment of Peripheral Artery Disease

The only HCPCS code for PCDs used for the treatment of peripheral artery disease is:

E0675 - PNEUMATIC COMPRESSION DEVICE, HIGH PRESSURE, RAPID INFLATION/DEFLATION CYCLE, FOR ARTERIAL INSUFFICIENCY (UNILATERAL AND BILATERAL SYSTEM)

The HCPCS codes used for the inflatable appliances used with PCD E0675 are:

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

An E0675 is a PCD that delivers high pressure and rapid inflation/deflation cycles for the treatment of arterial insufficiency (peripheral artery disease). HCPCS code E0675 is all-inclusive, i.e. all product variations in pressures, cycle characteristics, timing, control systems, appliance configurations, etc. (not all-inclusive) are considered as described by the code. Appliances appropriate for use with an E0675 PCD are E0667, E0668, E0669.

PCDs for Deep Venous Thrombosis (DVT)

The only HCPCS code for PCDs used for the prevention of DVT is:

E0676 - INTERMITTENT LIMB COMPRESSION DEVICE (INCLUDES All ACCESSORIES), NOT OTHERWISE SPECIFIED

An E0676 is a PCD that delivers pressure and inflation/deflation cycles for the prevention of deep venous thrombosis. HCPCS code E0676 is all-inclusive, i.e. all product variations in pressures, cycle characteristics, timing, control systems, appliance configurations, etc. (not all-inclusive) are considered as described by the code.

The appliance(s) and any other accessories, options, and supplies used with PCD E0676 are included in the payment for HCPCS code E0676 at the time of initial issue and must not be billed separately to Medicare. If a supplier chooses to bill separately for these items at the time of initial issue, then HCPCS code A9900 - MISCELLANEOUS DME

SUPPLY, ACCESSORY, AND/OR SERVICE COMPONENT OF ANOTHER HCPCS CODE must be used to bill Medicare for the item(s).

HCPCS code A4600 – SLEEVE FOR INTERMITTENT LIMB COMPRESSION DEVICE, REPLACEMENT ONLY, EACH is used only when the appliance used with an E0676 device is being replaced. HCPCS codes E0655, E0656, E0657, E0660, E0665, E0666, E0667, E0668, E0669, E0670, E0671, E0672, E0673 must not be used when billing for appliances used with E0676 devices.

Miscellaneous

When a foot or hand segment is used in conjunction with any leg or arm appliance respectively, there must be no separate billing 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, E0652 and E0675 are those for which the Pricing, Data Analysis, and Coding (PDAC) contractor has completed a Coding Verification Review. The coding determination subsequently is 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 website or by contacting the PDAC.

Coding Information

CPT/HCPCS Codes

N/A

ICD-10 Codes that Support Medical Necessity

N/A

ICD-10 Codes that DO NOT Support Medical Necessity

N/A

Additional ICD-10 Information

N/A

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.

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 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.

N/A

Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
01/01/2020	R8	<p>Revision Effective Date: 01/01/2020</p> <p>REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO 42 CFR 410.38(g):</p> <p>Remove: Entire section based on Final Rule 1713</p> <p>REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 Fed. Reg Vol 217):</p> <p>Added: Section and related information based on Final Rule 1713</p> <p>CERTIFICATE OF MEDICAL NECESSITY (CMN):</p> <p>Revised: Section header to remove PIM reference</p> <p>Revised: "physician" to "treating practitioner"</p> <p>Revised: Detailed Written Order to SWO</p> <p>Removed: CMN DME form version number</p> <p>CODING GUIDELINES:</p> <p>Revised: Format of HCPCS code references, from code spans to individually-listed HCPCS</p> <p>ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY:</p> <p>Revised: Section header "ICD-10 Codes that are Covered" updated to "ICD-10 Codes that Support Medical Necessity"</p> <p>ICD-10 CODES THAT DO NOT SUPPORT MEDICAL NECESSITY:</p> <p>Revised: Section header "ICD-10 Codes that are Not Covered" updated to "ICD-10 Codes that DO NOT Support Medical Necessity"</p> <p><i>02/20/2020: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.</i></p>

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
01/01/2017	R7	<i>02/28/2019: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This is an article and not a local coverage determination.</i>
01/01/2017	R6	<p>Revision Effective Date: 01/01/2017 CODING GUIDELINES: Revised: Coding guidelines for clarification</p> <p><i>04/12/2018: At this time 21st Century Cures Act applies to new and revised LCDs that restrict coverage, which require comment and notice. This revision is to an article that is not a local coverage determination.</i></p>
01/01/2017	R5	<p>Revision Effective Date: 01/01/2017 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added: 42 CFR 410.38(g) POLICY SPECIFIC DOCUMENTATION REQUIREMENTS: Added: General and CMN requirements CODING GUIDELINES: RELATED LOCAL COVERAGE DOCUMENTS: Added: LCD-related Standard Documentation Requirements Language Article</p>
07/01/2016	R4	Effective July 1, 2016 oversight for DME MAC Articles is the responsibility of CGS Administrators, LLC 18003 and 17013 and Noridian Healthcare Solutions, LLC 19003 and 16013. No other changes have been made to the Articles.
12/01/2015	R3	<p>Revision Effective Date: 12/01/2015 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Removed: Start date verbiage from Prescription Requirements (Effective 11/05/2015)</p>
12/01/2015	R2	<p>Revision Effective Date: 12/01/2015 (Draft Released to Final) NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added: Prevention of Venous Thrombolism exclusion from coverage Added: Statutorily denial language for E0676 Added: E0675 to ACA 6407 requirements table CODING GUIDELINES: Added: Coding instructions for Sleeves E0656 and E0657 Added: Coding instructions for E0675 Added: E0675 to the Coding Verification Review</p>
10/01/2015	R1	<p>Revision Effective Date: 10/31/2014 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Removed: "When required by state law" from ACA new prescription requirements</p>

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
		Revised: Face-to-Face Requirements for treating practitioner

Associated Documents

Related Local Coverage Document(s)

Article(s)

A55426 - Standard Documentation Requirements for All Claims Submitted to DME MACs

LCD(s)

L33829 - Pneumatic Compression Devices

Related National Coverage Document(s)

N/A

Statutory Requirements URL(s)

N/A

Rules and Regulations URL(s)

N/A

CMS Manual Explanations URL(s)

N/A

Other URL(s)

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Keywords

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