Corporate Medical Policy

Compression Therapy

Description of Procedure or Service
The concept of compression therapy is the external application of a controlled pressure to an extremity to help increase the efficiency of the venous and lymphatic systems. This is done with a garment that has a specific amount of compression that is strongest around the ankle and gradually decreases up the extremity/garment. Depending on the pathology, compression therapy can be applied in different forms such as socks, stockings, pantyhose, or pneumatic compression devices.

Benefit Application
This medical policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits.

Policy Statement
GEHA will provide coverage for compression therapy when it is determined to be medically necessary because the medical criteria and guidelines as documented below have been demonstrated.

Two pairs of compression garments are considered medically necessary in the initial purchase.

Replacements of compression stockings are limited to four pairs per calendar year.

Lymphedema compression therapy for post-lymph node dissection relating to breast mastectomy or lumpectomy is covered as required by the Women’s Health and Cancer Rights Act (WHCRA) of 1998.

When treatment for Compression Therapy is covered

Compression Garments
Non-elastic binders, or individually fitted prescription graded compression stocking with greater than 20mmHg pressure, are considered medically necessary for members who have any of the following medical conditions:

A. Venous insufficiency
B. Chronic venous leg ulcer
C. Varicose veins
D. Phlebitis/Thrombophlebitis
E. Deep vein thrombosis prophylaxis
   1. Pregnancy
   2. Postpartum
3. Immobilization due to surgery, trauma or debilitation

F. Lymphedema
   1. Generalized/lower extremity
   2. Upper extremity related to lymph node dissection (usually post-mastectomy/lumpectomy)

G. Edema following surgery, fracture, burns or other trauma

H. Post sclerotherapy

I. Post-thrombotic syndrome (post-phlebitic syndrome)

J. Postural hypotension

**Pneumatic Compression Devices**

Pneumatic compression devices for home use are considered medically necessary durable medical equipment (DME) for the treatment of chronic venous insufficiency of the legs of members who have venous stasis ulcers that have failed to heal after a 6-month trial of conservative therapy. The trial of conservative therapy must include a compression bandage system or compression garment, appropriate dressings for the wound, exercise, and elevation of the limb.

Intermittent pneumatic compression devices of the lower extremities are considered medically necessary DME to stimulate circulation and reduce the chances of deep venous thromboses for members who are bedridden due to trauma, orthopedic surgery, neurosurgery or other circumstances preventing ambulation. Note: the presence of a cast or splint, the use of an assistive device (e.g., walker, crutches), or non-weight bearing status alone due to injury or surgery are not considered "bedridden" for the purpose of this policy.

Single use intermittent pneumatic compression devices are considered not medically necessary.

**When treatment for Compression Therapy is not covered**

A. Compression stockings purchased over the counter without a prescription which have a pressure of less than 20 mm Hg (e.g., elastic stockings, support hose, surgical leggings, anti-embolism stockings or pressure leotards) are considered experimental and investigational because these supplies have not been proven effective in preventing thromboembolism.

B. Compression stockings purchased for the purpose of air travel deep vein thrombosis prevention are considered experimental and investigational because these supplies have not been proven effective in preventing thromboembolism.

C. Presence of the following contraindications:
   1. Arterial disease of involved extremity (i.e., ankle-brachial index not less than 0.5)
   2. Deep vein thrombosis
   3. Recurrent cancer in affected area
4. Severe heart failure
5. Skin disease in involved extremity
6. Untreated cellulitis in involved extremity

Contraindications to compression stockings/sleeves (non-pneumatic compression)

1. Severe peripheral arterial disease (ankle-brachial index not less than 0.5)
2. Untreated cellulitis

**Physician documentation**

A. Compression garments may be indicated when a venous or lymphatic condition is present, as indicated by presented documentation of 1 or more of the following:

1. Venous insufficiency
2. Chronic venous leg ulcer
3. Varicose veins
4. Phlebitis/Thrombophlebitis
5. Deep vein thrombosis prophylaxis
   a. Pregnancy
   b. Postpartum
   c. Immobilization due to surgery, trauma or debilitation
6. Lymphedema
   a. Generalized/lower extremity
   b. Upper extremity related to lymph node dissection (usually post-mastectomy/lumpectomy)
7. Edema following surgery, fracture, burns or other trauma
8. Post sclerotherapy
9. Post-thrombotic syndrome (post-phlebitic syndrome)
10. Postural hypotension

B. No documented contraindications to compression stockings/sleeves (non-pneumatic compression):

1. Severe peripheral arterial disease (ankle-brachial index not less than 0.5)
2. Untreated cellulitis
Policy Guidelines

The 2014 joint guidelines from the Society for Vascular Surgery and the American Venous Forum on the management of venous ulcers included the following statement on pneumatic compression: “We suggest use of intermittent pneumatic compression when other compression options are not available, cannot be used, or have failed to aid in venous leg ulcer healing after prolonged compression therapy. [GRADE - 2; LEVEL OF EVIDENCE - C]”

A 2013 consensus statement from the International Union of Phlebology indicated that primary lymphedema could be managed effectively by a sequenced and targeted management program based on a combination of decongestive lymphatic therapy and compression therapy. Treatment should include compression garments, self-massage, skin care, exercises, and, if desired, pneumatic compression therapy applied in the home.

The American Academy of Orthopaedic Surgeons (AAOS) published guidelines for preventing venous thromboembolic disease in patients undergoing elective hip and knee arthroplasty (AAOS, 2011). The guidelines are not specific to the home setting and suggest the use of pharmacologic agents and/or mechanical compressive devices for the prevention of venous thromboembolism in patients undergoing elective hip or knee arthroplasty, and who are not at elevated risk beyond that of the surgery itself for venous thromboembolism or bleeding.

The National Lymphedema Network (NLN) released a position statement including compression garment recommendations. The compression garment should be well-fitting and support the at-risk limb with a compression garment for strenuous activity (i.e. weight lifting, prolonged standing, and running) except in patients with open wounds or with poor circulation in the at-risk limb. Patients with lymphedema should consider wearing a well-fitting compression garment for air travel. The NLN does not specifically recommend compression garments for prophylaxis in at-risk patients (NLN, 2012).

In 2012, the Australasian Lymphology Association (ALA) endorsed the use of compression garments as an essential treatment modality for the management of lymphedema.

Background

Compression therapy is often prescribed to increase venous return, reduce the risk of deep vein thrombosis and reduce edema. There are various forms of compression therapy, each providing a range of various degrees of compression. Low compression refers to a pressure of less than 20mmHg and is often available over the counter without a physician prescription. Medium compression ranges between 20-30mmHg and often requires measurements of the extremity and a physician prescription. High compression is any pressure greater than 30mmHg and require physician prescription. The overall pressure is affected by factors such as the elasticity and stiffness of stocking material, the size and shape of the wearer’s legs, and the movements and activities of the wearer (Lim et al., 2014).

Ideal compression in the upright position should range from 60-100mmHg in the lower leg. However, patient pressure tolerance must be considered. For example if the level is 10mmHg it would require 50-100mmHg to obtain ideal pressure. These pressure levels are not tolerable and lead to noncompliance. The prescriber should consider an adjusted pressure of 40mmHg. Any pressure is better than no pressure (Partsch et al., 2016).
The various types of compression therapy include graduated compression stockings, antiembolism stockings, nonmedical support stockings and intermittent pneumatic compression. Graduated compression stockings exert the greatest degree of compression at the ankle, and the level of compression gradually decreases up the garment toward the proximal point. They are often used to treat chronic venous disease and edema. They are designed for ambulatory patients and are manufactured under strict medical and technical specifications, including consistency and durability, to provide a specific level of ankle pressure and graduation of compression. Antiembolism stockings are used to reduce the risk of deep vein thrombosis. Like graduation compression stockings, they provide gradient compression. They are designed for bedridden patients and do not meet the technical specifications for use by ambulatory patients. Although the terms “antiembolism stockings” and “graduated compression hosiery” are often used interchangeably, they have different levels of compression and indications. Nonmedical support hosiery, including flight socks and elastic support stockings, are often used to provide relief for tired, heavy and aching legs. They usually exert considerably less compression than graduated compression stockings. The compression is uniform and not graduated. They do not need to meet the strict medical and technical specifications as those of graduated compression stockings and can often be bought over the counter without a prescription (Lim et al., 2014).

Compression garments are generally applied in at the start of the day and taken off while lying supine. For severe cases, the higher pressure garments may be applied during the wake hours and a lower gradient pressure garment applied when supine. Graduated compression stockings should be replaced every 4-6 months as they lose their elasticity (Rabbia, 2012).

Intermittent pneumatic compression is a technique that pumps air into inflatable sleeves, gloves or boots that are applied to the extremities. The airflow causes an increase in external pressure assisting with venous return and thus resulting in a decrease in edema and risk of deep vein thrombosis. The compression is applied intermittently to simulate the natural increase of pressure exerted with muscle contraction involved in ambulation (Management, 2014).

**Indications for Compression Therapy**

**Venous insufficiency**

Chronic venous insufficiency (CVI) is a very common problem, with varicose veins affecting more than 25 million adults in the United States and more than 6 million with more advanced venous disease. Chronic Venous insufficiency causes various pathologies, including pain, edema, skin changes, and ulcerations. CVI often indicates the more advanced forms of venous disorders, including manifestations such as hyperpigmentation, venous eczema, lipodermatosclerosis, atrophy blanch, and healed or active ulcers.

Compression therapy is considered first-line therapy for symptomatic venous insufficiency. Several studies have investigated the hemodynamic benefits of compression therapy in patients with CVI. Compression stockings have been shown to reduce the residual volume fraction, which is an indicator of improving the calf muscle pump function, and reduce reflux in vein segments. Recently, studies evaluating reverse compression (antigraduated stockings or progressive elastic compression with higher pressure in the calf than the ankle), found improved calf muscle pump function on ambulation and reduced edema in severe CVI (Eberhardt, RT. & Rafetto, JD., 2014).
Varicose veins

Seven studies involving 356 participants with varicose veins and who had not experienced venous ulceration were included in this review. One study assessed compression hosiery versus no compression hosiery. The other six compared different types or pressures of stockings, ranging from 10 to 50 mmHg. The methodological quality of the included trials was unclear and not all studies assessed the same outcomes. One study included only pregnant women whilst other studies included participants who were on surgical waiting lists, that is, people who had sought medical intervention for their varicose veins.

The participants' subjective symptoms, and foot swelling and blood flow (physiological measures) improved in all of the studies that assessed these outcomes when stockings were worn (Shingler et al., 2013).

Stockings with compression pressure between 20 and 30 mmHg are recommended for patients with varicose veins with or without edema (Gloviczki et al., 2011).

Pregnancy

A 2017 study, which determined that wearing stockings of 22 mm Hg for 6 months helped to control leg swelling during pregnancy in people with varicose veins. However, the authors noted that an oral medication called pycnogenol was more effective than using stockings (Belcaro et al., 2017).

A study by Buchtemann et al., (1999) assessed the effect of compression therapy on venous hemodynamics in pregnant women and postpartum. Blood flow velocity, flow volume and vessel diameter in the superficial femoral vein were measured by duplex sonography. All examinations were performed with and without applied compression stockings (25-32 mmHg) at two different stages of gestation and after delivery. In addition, subjective symptoms were graded. Venous pump function improved and refilling time lengthened significantly when compression was used during gestation and postnatally. Duplex sonography showed an increase in blood flow velocity and flow volume in the superficial femoral vein with applied compression; the vessel diameter increased slightly. Subjective symptoms of the leg, graded on an arbitrary scale, were reduced by regular compression therapy. Results indicate that compression improves the clinical symptoms of venous congestion and the venous hemodynamics of the legs during pregnancy and in the postpartum period. Thus, the regular use of compression during pregnancy and the puerperium may reduce the incidence of thromboembolic events.

Venous Leg Ulcers

Venous leg ulcers (open wounds on the lower leg) can be caused by a blockage or breakdown in the veins of the legs. Compression, using bandages or hosiery (stockings), can help heal most of these ulcers and is also widely used after healing to prevent ulcers returning. One small trial confirms that compression reduces ulcer recurrence compared with no compression. There is some evidence that people wearing high rather than moderate-compression hosiery are less likely to get a new ulcer (Nelson, E. & Bell-Syer, S., 2014). Stockings with a pressure between 30 and 40 mmHg are recommended for patients with advanced venous skin change or an ulcer.
patients with a recurrent ulcer, stockings with a pressure between 40 and 50 mmHg are recommended (Gloviczki et al., 2011).

In a systematic review of literature, it was shown that intermittent pneumatic compression improved healing when compared with dressings alone, reinforcing the finding that compression is better than no compression for venous ulcer healing (Nelson, E., Hillman, A., & Thomas, K., 2014).

**DVT prophylaxis**

**Post-surgical**

In a review of literature (Hayes, 2018), it was shown that pneumatic compression combined with a low molecular weight heparin (LMWH) given to patients postoperatively following knee arthroplasty is more effective for preventing deep vein thrombosis than pneumatic compression or LMWH alone. A similar study was reviewed (Hayes, 2011) demonstrating deep vein thrombosis prevention postoperatively following hip surgery. Pneumatic compression is associated with few adverse effects and appears to be effective in reducing the incidence of DVT in hip surgery patients. However, it remains to be proven that pneumatic compression has comparable or better efficacy compared with warfarin.

**Travel**

Five prospective studies have investigated the incidence of development of DVT following travel. In these studies the subjects were evaluated before travelling using objective methods to exclude DVT and were investigated after travel using objective methods to diagnose DVT (Scurr et al, 2001; Schwarz et al, 2002, 2003; Hughes et al, 2003; Jacobson et al, 2003). The travelers in these studies were deemed by the authors to be of low to intermediate risk for development of venous thromboembolism (VTE). Four excluded individuals with a history of previous VTE (Scurr et al, 2001; Hughes et al, 2003; Jacobson et al, 2003; Schwarz et al, 2003). In a study of 8775 employees of international companies who flew regularly, the rate of development of VTE was 1 in 4656 flights of >4 hours (Kuipers et al, 2007). Early symptomatic PE is rare with an incidence of <0.5 per million for all flyers and 1 in 115 million for individuals flying for less than 6 hours. (Clerel & Caillard, 1999; Lapostolle et al, 2001; Perez-Rodriguez et al, 2003; Philbrick et al, 2007). Most travelers who developed pulmonary embolism (PE) had pre-existing risk factors for the development of VTE and had flown over 8 hours.

In a study by Hughes et al. (2003), the rate of development of DVT was 4/146 (2.7%) in passengers wearing compression stockings, 5/275 (1.8%) in those taking aspirin and 3/466 (0.6%) in those using neither.

Global use of compression stockings and anticoagulants for long distance travel is not indicated (Watson, H. & Baglin, T., 2010)

**Lymphedema**

Lymphedema occurs from damage or abnormalities of the lymph system. Lymphedema is often progressive but can be managed when properly diagnosed and treated. Complete Decongestive therapy is also called Combined, Complex or Comprehensive Decongestive Therapy. All refer to the same
method known as CDT. CDT is the main treatment for lymphedema. Experts who treat lymphedema consider CDT the “gold standard” of treatment. CDT has been shown to be safe and effective. CDT consists of an initial reductive phase (Phase I) followed by a maintenance phase (Phase II). In Phase I, the main goals are reducing the size of the affected part and improving the skin. After Phase I, the person with lymphedema needs to continue into Phase II, an ongoing, individualized self-management phase to make sure the gains of Phase I are maintained long term (NLN, MAC., 2016).

A. Effects of CDT are to:

1. decrease swelling
2. increase lymph drainage from the congested areas
3. reduce skin fibrosis and improve the skin condition
4. enhance patient’s functional status
5. relieve discomfort and improve quality of life
6. reduce the risk of cellulitis and Stewart-Treves-Syndrome, a rare form of angiosarcoma

B. Components of CDT

1. manual lymph drainage (MLD)
2. multi-layer, short-stretch compression bandaging
3. lymphatic exercise
4. skin care
5. education in lymphedema self-management, and elastic compression garments (NLN, MAC., 2016)

Following achievement of maximal volume reduction with Phase I CDT, patients should be fitted with a compression garment. The patient should receive two garments at a time for each affected body part: one to wear and one to wash and dry. Having two garments insures that the patient does not wear a dirty or wet garment which promotes bacterial or fungal infection. Garments may be sleeves, stockings, bras, compression shorts, face or neck compression wear, etc. Garment style and compression strength should be prescribed according to the patient’s ability to manage the garment and maintain the best volume control and skin health. Garments should be washed daily so the garment lasts as long as possible and does not lose its compression strength. Manufacturer instructions must be followed for washing and drying to prolong the life of the garment. Most daily garments must be replaced every 4-6 months to maintain compression strength. Compression garments for children must be replaced when growth necessitates, which is usually multiple times per year for babies and younger children. Some patients with more severe forms of lymphedema will need night garments or advanced day garments to maintain the reductions obtained in Phase I. There are a variety of options for advanced and night garments that may be required for control of lymphedema, such as Velcro closure garments and specialized foam compression garments (NLN, MAC., 2016).
Intermittent Pneumatic Compression Therapy (IPC) may be used during both phases of CDT. Single chamber pumps are no longer used for lymphedema. These have been replaced with multiple chamber pumps. Multiple chamber pumps have a sequential pressure delivery with the chambers compressing in a specific pattern determined individually for the patient’s diagnosis and pattern of lymphedema. IPC recommended pressures range from 30-60 mmHg, although the pressure displayed on the pump may not accurately reflect the pressure applied to the skin surface. Pressures should be controlled based on an individual indication. IPC treatment is generally applied for 1 hour. IPC is not a “stand alone” treatment and should be used in conjunction with compression garments between IPC therapies.

Patients being considered for IPC therapy must be evaluated by a physician or health-care provider with expertise in lymphedema. It is important to insure safe selection of the proper device and appropriateness of IPC. The prescription must include the intensity of pressure and pattern of pressure needed, taking into consideration several aspects of the patient’s situation including determination of need for programmable pressure to treat fibrotic areas, address treatment of ulcers, and adjust for patient’s level of pain and skin sensitivity. If trunk, chest or genital swelling is present, the physician must determine whether a pump that provides appliances to treat those areas is necessary or if the patient can manage the trunk swelling through compression garments. If a pump with only extremity attachments is used, close monitoring should be instituted to detect an increase in edema or fibrotic (hard) tissue above the device sleeve, called a fibroscelerotic ring. If this occurs, consideration should be given to using a device that treats the trunk in addition to the extremities. Additionally, the physician or health-care provider must evaluate the impact of various other medical conditions that are usually considered contraindications for pneumatic compression therapy, including acute infection, severe arterial vascular disease, acute superficial or deep vein phlebitis (inflammation or clot), recurrent cancer in the affected area, or uncompensated congestive heart failure (NLN, MAC., 2016).

**Following invasive saphenous vein procedure**

In a study done by Ye et al. (2016), a total of 400 patients (200 patients in each group) were included and analyzed. It was concluded that the use of an ECS does not prove to be of greater benefit in the quality of life and the mean time to return to work; ECS therapy does reduce the severity of pain and edema during the first week after surgery in patients with uncomplicated varicose veins.


**Guideline 1.1:** Compression after thermal ablation or stripping of the saphenous veins. When possible, we suggest compression (elastic stockings or wraps) should be used after surgical or thermal procedures to eliminate varicose veins. [GRADE - 2; LEVEL OF EVIDENCE - C]

**Guideline 1.2:** Dose of compression after thermal ablation or stripping of the varicose veins. If compression dressings are to be used post-procedurally in patients undergoing ablation or surgical procedures on the saphenous veins, those providing pressures >20mmHg together with eccentric pads placed directly over the vein ablated or operated on provide the greatest reduction in postoperative pain. [GRADE - 2; LEVEL OF EVIDENCE - B]
Guideline 2.1: Duration of compression therapy after thermal ablation or stripping of the saphenous veins. In the absence of convincing evidence, we recommend best clinical judgment to determine the duration of compression therapy after treatment. [BEST PRACTICE]

Guideline 3.1: Compression therapy after sclerotherapy. We suggest compression therapy immediately after treatment of superficial veins with sclerotherapy to improve outcomes of sclerotherapy. [GRADE - 2; LEVEL OF EVIDENCE - C]

Guideline 3.2: Duration of compression therapy after sclerotherapy. In the absence of convincing evidence, we recommend best clinical judgment to determine the duration of compression therapy after sclerotherapy. [BEST PRACTICE]

Guideline 4.1: Compression after superficial vein treatment in patients with a venous leg ulcer.

In a patient with a venous leg ulcer, we recommend compression therapy over no compression therapy to increase venous leg ulcer healing rate and to decrease the risk of ulcer recurrence. [GRADE - 1; LEVEL OF EVIDENCE - B]

Guideline 4.2: Compression after superficial vein treatment in patients with a mixed arterial and venous leg ulcer. In a patient with a venous leg ulcer and underlying arterial disease, we suggest limiting the use of compression to patients with ankle-brachial index exceeding 0.5 or if absolute ankle pressure is >60 mm Hg. [GRADE - 2; LEVEL OF EVIDENCE - C]

Postural hypotension

Orthostatic hypotension is common, especially in the elderly, and it is strongly associated with discomfort and falls. Physicians may sometimes prescribe compression therapy, but the beneficial effect of this treatment in orthostatic hypotension is unclear. Smeenk et al. (2014) performed a systematic search of 1232 published reports relating to the effects of compression therapy on orthostatic hypotension. The review demonstrates that compression treatment should include the abdomen as this has the greatest beneficial effect. However, this review also displays the paucity of evidence for compression therapy for patients with orthostatic hypotension, and further investigation is certainly warranted.

A study by Kim & Kim (2018) was conducted to assess the effects of elastic compression stockings in dialysis patients with hypotension. Results indicated the decrease in systolic blood pressure in the experimental group was less than that in the control group. Hypotension symptom scores were significantly decreased in the experimental group. Considering these results, the application of elastic compression stockings can be regarded as an effective nursing intervention to help prevent intradialytic hypotension in patients undergoing hemodialysis.

Restless Leg Syndrome

Restless legs syndrome (RLS) is defined as an irresistible urge to move the legs, which is usually accompanied by paresthesia or dysesthesias at least twice weekly, and affects 2%–4% of adults in Europe and North America. A systematic review to assess the current complementary and alternative options for RLS concluded that pneumatic compression devices along with exercise, light therapy, acupuncture and others improved sleep quality and quality of life (Xiao-Min, et al., 2018).
The American Academy of Neurology established guidelines for treatment of restless leg syndrome (RLS) in adults (Winkelman et al., 2016) including the nonpharmacological use of pneumatic compression.

Letteieri & Eliasson (2009) performed a prospective, randomized, double-blinded, sham-controlled trial of individuals with RLS. Subjects wore a therapeutic or sham device prior to the usual onset of symptoms for a minimum of 1 h daily. Measures of severity of illness, quality of life, daytime sleepiness, and fatigue were compared at baseline and after 1 month of therapy. Thirty-five subjects were enrolled. Groups were similar at baseline. Therapeutic Pneumatic compression devices (PCDs) significantly improved all measured variables more than shams. Restless Legs Severity Score improved from 14.1 ± 3.9 to 8.4 ± 3.4 (p = 0.006) and Johns Hopkins Restless Legs Scale improved from 2.2 ± 0.5 to 1.2 ± 0.7 (p = 0.01). All quality of life domains improved more with therapeutic than sham devices (social function 14% vs 1%, respectively; p = 0.03; daytime function 21% vs 6%, respectively, p = 0.02; sleep quality 16% vs 8%, respectively, p = 0.05; emotional well-being 17% vs 10%, respectively, p = 0.15). Both Epworth sleepiness scale (6.5 ± 4.0 vs 11.3 ± 3.9, respectively, p = 0.04) and fatigue (4.1 ± 2.1 vs 6.9 ± 2.0, respectively, p = 0.01) improved more with therapeutic devices than sham devices. Complete relief occurred in one third of subjects using therapeutic and in no subjects using sham devices.

**Contraindications**

While compression therapy is considered a safe, effective treatment method, there are 20 guidelines, clinical pathways and consensus papers on compression therapy for venous leg ulcer treatment and for venous disease, were included. Guidelines agreed on the following absolute contraindications: Arterial occlusive disease, heart failure and ankle brachial pressure index (ABPI) <0.5 (Andriessen et al., 2017).

**Regulatory Status**

Devices and systems to perform pneumatic compression are regulated by the FDA as Class II devices. Medical stockings to prevent pooling of blood in legs are regulated by the FDA as Class II devices.

The following codes are for reference purposes only and do not imply that the service is covered or non-covered under the member’s benefit policy. Applicable codes may include but are not limited to:

<table>
<thead>
<tr>
<th>CPT codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>29581</td>
<td>Application of multi-layer compression system; leg (below knee), including ankle and foot</td>
</tr>
<tr>
<td>29582</td>
<td>thigh and leg, including ankle and foot, when performed</td>
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<table>
<thead>
<tr>
<th>HCPCS codes</th>
<th>Description</th>
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<tbody>
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<td>A4465</td>
<td>Non-elastic binder for extremity</td>
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<td>A6507</td>
<td>Compression burn garment, foot to knee length, custom fabricated</td>
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<tr>
<td>A6508</td>
<td>Compression burn garment, foot to thigh length, custom fabricated</td>
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<td>A6530 - A6549</td>
<td>Gradient compression stocking</td>
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<td>Pneumatic compressor, segmental home model without calibrated gradient pressure</td>
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<td>E0652</td>
<td>Pneumatic compressor, segmental home model with calibrated gradient pressure</td>
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<td>Non-segmental pneumatic appliance for use with pneumatic compressor, half arm</td>
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<td>E0656</td>
<td>Segmental pneumatic appliance for use with pneumatic compressor, trunk</td>
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<td>Segmental pneumatic appliance for use with pneumatic compressor, half leg</td>
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<td>Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency (unilateral or bilateral system)</td>
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<td>E0676</td>
<td>Intermittent limb compression device (includes all accessories), not otherwise specified [not covered for single patient use pneumatic compression device]</td>
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**Scientific References**


