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Intermittent Pneumatic Compression Devices MP9119

Covered Service: Yes

Prior Authorization Required: No

Additional Information: None

Medicare Policy: Prior authorization is dependent on the member's Medicare coverage. Prior authorization is not required for Medicare Cost (Dean Care Gold) and Medicare Supplement (Select) when this service is provided by participating providers. Prior authorization is required if a member has Medicare primary and Dean Health Plan secondary coverage. This policy is not applicable to our Medicare Replacement product (Dean Advantage).

BadgerCare Plus Policy: Dean Health Plan covers when BadgerCare Plus also covers the benefit

Dean Health Plan Medical Policy:

1.0 Home use of a segmental (multicompartmental) or non-segmental (unicompartmental) intermittent pneumatic compression device **does not require** prior authorization and is considered medically necessary in the home setting for **ANY** of the following indications:

1.1 For treatment of chronic and/or severe lymphedema when **ALL** of the following criteria are met:

1.1.1 Lymphedema is symptomatic with **ONE or more** of the following:

1.1.1.1 Discomfort

1.1.1.2 Heaviness

1.1.1.3 Pain

1.1.1.4 Recurrent skin infections

1.1.1.5 Reduced function

1.1.2 Member is unable to perform other compression interventions (e.g. compression garment, bandage, manual lymph drainage) **or** failure of other compression intervention to relieve symptoms after four (4) or more weeks of treatment (e.g. use of an appropriate compression bandage system or compression garment, exercise, and elevation of the limb)

1.2 Venous leg ulcers, when other compression interventions are inappropriate as indicated by **ONE or more** of the following:

1.2.1 Failure of other compression intervention (e.g. stockings, bandages) to heal ulcer after six (6) or more months of treatment, and member is not a candidate for other interventions (e.g. saphenous vein ablation);

1.2.2 Member is unable or unwilling to use all other compression interventions

1.3 Deep venous thrombosis prevention for the immobile member

2.0 Pneumatic segmented compression device with calibrated (multi-chamber programmable) gradient pressure pumps **does not require** prior authorization and are considered medically necessary for the treatment of lymphedema extending onto the chest, trunk and/or abdominal lymphedema in the home setting if **ALL** the following criteria are met:

2.1 Lymphedema meets the criteria in (1.1); **AND**

2.2 Lymphedema extends past the limits of a standard compression sleeve

3.0 Home use of a segmental (multicompartmental) or non-segmental (unicompartmental) intermittent pneumatic compression device are considered experimental and investigational, and therefore not medically necessary for the treatment of **ANY** of the following (not an all-inclusive list):

3.1 Critical limb ischemia

3.2 Intermittent claudication

3.3 Post-thrombotic syndrome

3.4 Restless leg syndrome

	Committee/Source	**Date(s)**
Document Created:	Utilization Management Committee/ Health Services	October 13, 1999
Revised:	Utilization Management Committee/ Medical Affairs Department/ HAYES 10/98	March 14, 2001
	Utilization Management Committee/ Medical Affairs	September 12, 2001
	Utilization Management Committee/ Medical Affairs	May 8, 2002
	Utilization Management Committee/ Medical Affairs/ Referral Department/Provider Services	November 12, 2003
	Utilization Management Committee/ Medical Affairs/	June 11, 2008
	Utilization Management Committee/ Medical Affairs	April 14, 2010
	Medical Director Committee/Medical Affairs	July 27, 2011
	Medical Director Committee/Medical Affairs	July 17, 2013
	Medical Policy Committee/Quality and Care Management Division	July 20, 2016

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	Committee/Source	Date(s)
Revised:	Medical Policy Committee/Quality and Care Management Division	July 19, 2017
	Medical Policy Committee/Health Services Division	August 15, 2018
	Medical Policy Committee/Health Services Division	July 17, 2019
	Medical Policy Committee/Health Services Division	October 16, 2019
	Medical Policy Committee/Health Services Division	July 15, 2020
	Medical Policy Committee/Health Services Division	July 21, 2021
	Medical Policy Committee/Health Services Division	July 19, 2023
Reviewed:	Managed Care Division/ Medical Affairs Department	March 20, 2000
	Managed Care Division / Medical Affairs Department	April 11, 2001
	Utilization Management Committee/ HAYES July 2001	October 10, 2001
	Utilization Management Committee/CMO/Director UM	March 13, 2002
	UM Committee (UMC)/Director UM/ UMC Chair	March 12, 2003
	Utilization Management Committee/Medical Affairs/ Medicare Part B, 12/2003	January 14, 2004
	Utilization Management Committee/CMO/Director UM	March 10, 2004
	UM Committee (UMC)/Director UM/ UMC Chair	March 9, 2005
	Reformatted	October 2005
	UM Committee (UMC)/Director UM/UMC Chair	March 9, 2005
	UM Committee (UMC)/Director UM/UMC Chair	March 8, 2006
	UM Committee (UMC)/Director UM/UMC Chair	March 14, 2007
	UM Committee (UMC)/Director UM/UMC Chair	March 12, 2008
	UM Committee (UMC)/Director UM/UMC Chair	April 8, 2009
	Medical Director Committee/Medical Affairs	July 21, 2010
	Medical Director Committee/Medical Affairs	July 27, 2011
	Medical Director Committee/Medical Affairs	July 18, 2012
	Medical Director Committee/Medical Affairs	August 15, 2012
	Medical Director Committee/Medical Affairs	July 17, 2013
	Medical Director Committee/Medical Affairs	July 16, 2014
	Medical Director Committee/Medical Affairs	July 15, 2015
	Medical Policy Committee/Quality and Care Management Division	July 20, 2016
	Medical Policy Committee/Quality and Care Management Division	July 19, 2017
	Medical Policy Committee/Health Services Division	August 15, 2018
	Medical Policy Committee/Health Services Division	July 17, 2019
	Medical Policy Committee/Health Services Division	October 16, 2019
	Medical Policy Committee/Health Services Division	July 15, 2020
	Medical Policy Committee/Health Services Division	July 21, 2021
	Medical Policy Committee/Health Services Division	July 20, 2022
	Medical Policy Committee/Health Services Division	July 19, 2023

Published: 09/01/2023
Effective: 09/01/2023