Pneumatic Compression Devices

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➲ Instructions for Use

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- Durable Medical Equipment, Orthotics, Medical Supplies, and Repairs/Replacements

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Application

UnitedHealthcare Commercial

This Medical Policy applies to UnitedHealthcare Commercial benefit plans.

UnitedHealthcare Individual Exchange

This Medical Policy applies to Individual Exchange benefit plans.

Coverage Rationale

Advanced intermittent pneumatic compression devices (e.g., Flexitouch) for treating lymphedema of the head, face, or neck are considered unproven and not medically necessary.

Pneumatic compression devices (high pressure, rapid inflation/deflation cycle) for treating peripheral arterial disease (PAD) are considered unproven and not medically necessary.

Pneumatic compression devices are proven and medically necessary in certain circumstances for the treatment of lymphedema or chronic venous insufficiency with edema and nonhealing lower extremity ulcers. For medical necessity clinical coverage criteria, refer to the InterQual® CP: Durable Medical Equipment, Pneumatic Compression Devices.

Click here to view the InterQual® criteria.

Intermittent limb compression devices are proven and medically necessary in certain circumstances for the prevention of deep venous thrombosis. For medical necessity clinical coverage criteria, refer to the InterQual® CP: Durable Medical Equipment, Pneumatic Compression Devices.

Click here to view the InterQual® criteria.

When the medical necessity criteria in the InterQual® subset are met, intermittent limb compression devices are proven and medically necessary for the prevention of deep venous thrombosis.

Medical Records Documentation Used for Reviews

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. Medical records documentation may be required to assess whether the member meets the clinical criteria for coverage but does not guarantee coverage of the service requested; refer to the guidelines titled Medical Records Documentation Used for Reviews.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

HCPCS Code	Description
A4600	Sleeve for intermittent limb compression device, replacement only, each
E0650	Pneumatic compressor, nonsegmental home model
E0651	Pneumatic compressor, segmental home model without calibrated gradient pressure
E0652	Pneumatic compressor, segmental home model with calibrated gradient pressure
E0655	Nonsegmental pneumatic appliance for use with pneumatic compressor, half arm
E0658	Segmental pneumatic appliance for use with pneumatic compressor, integrated, 2 full arms and chest
E0659	Segmental pneumatic appliance for use with pneumatic compressor, integrated, head, neck and chest
E0660	Nonsegmental pneumatic appliance for use with pneumatic compressor, full leg
E0665	Nonsegmental pneumatic appliance for use with pneumatic compressor, full arm
E0666	Nonsegmental pneumatic appliance for use with pneumatic compressor, half leg
E0667	Segmental pneumatic appliance for use with pneumatic compressor, full leg
E0668	Segmental pneumatic appliance for use with pneumatic compressor, full arm
E0669	Segmental pneumatic appliance for use with pneumatic compressor, half leg
E0670	Segmental pneumatic appliance for use with pneumatic compressor, integrated, two full legs and trunk
E0671	Segmental gradient pressure pneumatic appliance, full leg
E0672	Segmental gradient pressure pneumatic appliance, full arm
E0673	Segmental gradient pressure pneumatic appliance, half leg
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

Description of Services

Pneumatic compression devices use an air compressor unit that attaches to a garment or series of garments that sequentially inflate and deflate, applying pressure against the skin, which results in a treatment effect. Pneumatic compression devices range from traditional single- or multi-chambered devices with limited adjustability to more complex, advanced devices with more garment options and a wide range of treatment selections and programmability to address different clinical needs such as fibrosis; edema to the head, face, neck, or trunk; chronic wounds; or localized swelling.

Intermittent pneumatic compression includes inflatable sleeves that are wrapped around the legs and secured by Velcro. These sleeves can be applied to the calf or to both the calf and thigh. They are inflated, one side at a time, to compress the legs at intervals. Some are inflated sequentially, first distally, then proximally to increase venous flow. Intermittent pneumatic compression is thought to reduce the risk of venous thrombosis by reducing stasis and stimulating the release of intrinsic fibrinolytic factors.

Lymphedema of the Head, Face, or Neck

There is insufficient evidence in the peer-reviewed, medical literature to establish the efficacy, clinical value, and safety of advanced pneumatic compression devices (APCDs) for treating lymphedema of the head, face, or neck. Additional research is needed to define the role of APCDs in treating lymphedema of the head, face, or neck.

De-la-Cruz-Fernández, et al. (2025) conducted a systematic review of randomized controlled trials (RCTs) on physical therapy interventions for the treatment of secondary lymphedema in patients with head and neck cancer. Randomized controlled trials (RCTs) in which physical therapy was applied to treat lymphedema in head and neck cancer were included. Reviewers blinded, screened the articles retrieved, scored methodological quality, and extracted data. Risk of bias assessment was performed using the Cochrane tools. A total of four randomized controlled trials (RCTs) were included. They comprised 167 individuals, and only one of the studies achieved a low risk of bias. Interventions were Kinesio taping, compression therapy, manual lymphatic drainage, and/or exercise applied in combination with skin care and self-management. Some adverse effects related to intervention were mild and transitory. The authors concluded that the findings revealed that an exercise program plus manual lymphatic drainage supplemented with Kinesio taping or compression therapy could be beneficial for external lymphedema. Neither therapy achieved an improvement in internal lymphedema. This study has several limitations. First, all the studies included had small sample sizes. The predominance of individuals with stage IB lymphedema (56.7%) made it difficult to extrapolate the results as individuals with higher stages might not improve with the treatments included in the SR. There was no homogeneity between the different studies in terms of therapies, treatment protocols, and duration of interventions. There was inconsistency between the methods of lymphedema assessment, with only one study with a low overall risk of bias rating. In addition, there was a high heterogeneity of studies, precluding a systematic quantitative analysis. Well designed, comparative studies with larger patient populations are needed to further describe safety and clinical outcomes.

Cheng et al. (2023) conducted a systematic review on the rehabilitation interventions for head and neck cancer (HNC)–associated lymphedema. Overall, 23 studies (n = 2,147) were eligible for inclusion [six randomized controlled trials (RCTs) and 17 observational studies]. The studies were categorized by intervention type, including standard lymphedema therapy and adjunct therapy. Adjunct therapy interventions included APCDs (one RCT; five observational studies), kinesio taping, photobiomodulation, acupuncture/moxibustion, and sodium selenite. The one RCT for APCD therapy (Rider et al., 2021, described in detail below) compared a 2-month intervention with a waitlist control condition and found improvement in the APCD group in clinician-rated external lymphedema but no improvement in endoscopic assessment of internal lymphedema. Of the observational studies for APCDs, early studies showed that one treatment session improved objective tape measurements in 44 individuals and lymphatic flow in 10 individuals. Adverse events were either not found or not reported. The authors concluded that standard lymphedema therapy with kinesio taping and APCDs appears to be safe and beneficial and that low-quality evidence also suggests that APCDs may be beneficial. However, more prospective, controlled, and adequately powered studies are needed to establish treatment guidelines. Limitations of the studies include the sample size, study type, possible conflict of interest, and limited geography.

In 2021 (updated 2024) Hayes conducted an Evolving Evidence Review on the Flexitouch Plus System for head and neck lymphedema (HNL). The evidence base was limited to four clinical studies (one controlled study; three uncontrolled studies), and no relevant systematic reviews were identified. The data showed no severe device-related adverse events, with short-term improvement in lymphedema symptoms and patient-reported soft tissue symptoms as well as suggestive benefits in pain control. The report concluded that there is minimal support for the use of the Flexitouch Plus System for treating lymphedema of the head and neck. The summary of findings showed no clinical practice guidelines specifically addressing the use of the Flexitouch Plus System for the treatment of HNL. Limitations of the studies include the nonvalidated assessment tools, small sample sizes, short-term follow-up, and poor statistical analyses.

Ridner et al. (2021) conducted an open-label, multisite, stratified randomized, waitlist control, pilot study to evaluate the feasibility and efficacy regarding the use of the Flexitouch or advanced compression device in survivors of HNC with lymphedema. Eligible participants had completed treatment for HNC, were disease free, and had lymphedema at enrollment. Participants were randomized to waitlist lymphedema self-management (standard of care) or lymphedema self-management plus the use of the Flexitouch twice daily. Safety and feasibility were the primary end points; the secondary end points included efficacy measured by objective examination and participant-reported outcomes (symptoms, quality of life, and function), adherence barriers, and satisfaction. Assessments were conducted at baseline and weeks 4 and 8. Overall, 49 participants were enrolled (waitlist, n = 25; intervention, n = 24). In total, 43 participants completed the study. No device-related serious adverse events were reported. Most participants used the advanced compression device once per day instead of the prescribed twice per day, mentioning time-related factors as barriers to use. Advanced compression device use was associated with significant improvement in the perceived ability to control

lymphedema (p = 0.003) and visible external swelling (front view p < 0.001; right view p = 0.004; left p = 0.005) as well as less reported pain. The feasibility of, adherence to, and safety of the Flexitouch were the primary outcomes, with efficacy included to generate initial estimates of effect for larger future trials. Given the involvedness and clinical impact of HNL, the feasibility of a more aggressive, twice-daily treatment regimen was tested. The adherence to the twice-daily regimen was low. This result was expected, as participants who were adherent to twice-daily treatments had available time to spend up to 1.5 hours daily using their device. Time limitations were mostly due to nonadherence. On the other hand, the data demonstrated that a once-daily regimen was reasonable. Therefore, future studies should investigate a once-daily treatment regimen. This study also noted a decrease in lymphedema symptoms; future studies should explore the underlying mechanism related to this improvement. The authors noted that this trial supports the safety and feasibility of the advanced compression device for the treatment of secondary lymphedema in individuals with HNC. In addition, initial data support efficacy. Additional research, with larger RCTs, is needed to confirm these findings. In particular, the sample size may have been too small to detect important but infrequent adverse events.

Gutiérrez et al. (2020), in an observational study, evaluated HNC survivors' experiences with HNL treatment. The authors explored the self-reported outcomes and satisfaction of participants with HNC receiving treatment for HNL with an advanced APCD. The study population included 205 participants with HNC-related HNL. Participants were predominantly male (152; 74%), with a mean age of 60 years (range, 13-83 years); the majority had squamous cell carcinoma. Participants were prescribed an at-home Flexitouch head and neck APCD and completed pretreatment and post-treatment self-reported assessments addressing efficacy, function, and symptoms. Pre-post responses for ≥ 25 days of use were assessed via the nonparametric Wilcoxon Signed Rank Test. An analysis revealed a statistically significant improvement in all symptoms and all function items (p < 0.00001). Adherence to prescribed therapy (at least 30 minutes daily) was high, with 71% of participants reporting daily use and 87% reporting overall satisfaction. Despite the number of participants included, study limitations include the lack of a control group, which does not allow for conclusions on efficacy. The authors noted that the reported improvements in function and symptoms and high adherence rate provide a rationale for a subsequent RCT.

Maryovitz et al. (2018) conducted a case series to assess the functional usage of an APCD (Flexitouch System) for the treatment of cancer-related HNL as well as to identify potential clinical benefits. The primary purpose of this prospective functional feasibility study was to assess the ease of application, garment fit and comfort, and treatment comfort of an advanced pneumatic compression system specifically designed to treat individuals with HNL. The secondary purpose was to assess safety and acute edema changes after a single treatment. Participant-reported comfort and other treatment aspects were evaluated, and multiple face and neck measurements were obtained from 44 participants with HNL before and after one treatment session to assess usability and treatment-related lymphedema changes. The majority of participants (82%) reported that the treatment was comfortable; most participants (61%) reported feeling better after treatment, and 93% reported that they would be likely to use this therapy at home. One treatment produced overall small but highly statistically significant reductions in composite metrics (mean ±SD) of the face (82.5 ±4.3 cm vs 80.9 ±4.1 cm; p < 0.001) and neck (120.4 ±12.2 cm vs 119.2 ±12.1 cm; p < 0.001), with no adverse events. The authors indicated that results found the treatment to be safe, easy to use, and well tolerated while demonstrating edema reduction after a single initial treatment. Larger, more robust studies are needed to validate these preliminary findings, as this study was limited by the short follow-up and lack of a comparison group.

Treatment of Peripheral Arterial Disease

The evidence on the relative benefits of pneumatic compression devices for the treatment of peripheral arterial disease (PAD) is inconsistent; evidence for the benefit of treatment on patient-centered outcomes is lacking. The evidence is insufficient to determine the safety and efficacy of treatment for high-pressure compression devices on arterial insufficiency.

In 2021, ECRI conducted a Clinical Evidence Assessment on intermittent pneumatic compression (IPC) for treating PAD. The assessment included evidence from two systematic reviews, one RCT, one before-and-after study, and one case series. The assessment indicated that IPC improves walking distance, intermittent claudication, and resting pain in individuals with critical limb ischemia (CLI). Evidence from one systematic review that did not synthesize data in a meta-analysis, one RCT, and one case series also suggested that IPC may improve wound healing and reduce amputation risks in individuals with CLI. However, these studies are at a high risk of bias, and additional controlled studies are needed to enable conclusions. Studies varied in IPC treatment regimens and duration, and additional RCTs are needed to determine appropriate IPC use. Guidance from U.S. and international medical societies recommend considering IPC in individuals with intractable, severe PAD.

Oresanya et al. (2018) conducted a systematic review and meta-analysis to evaluate the efficacy of high-pressure intermittent limb compression as an alternative treatment modality for disabling intermittent claudication. Eight RCTs (n = 290) measured the primary outcome of absolute claudication distance (ACD). The study data demonstrated an increase in

walking distance for individuals receiving compression therapy. The mean difference of ACD from baseline to follow-up among individuals receiving compression compared with controls was 125 m (95% CI, 58.38-191.63 m; $p < 0.01$). This increase in ACD seen in individuals is comparable to the benefit seen for other modalities used to treat intermittent claudication. However, it is not yet clearly identified what regimen is most effective in terms of device, session, and total treatment length. The authors concluded that the results suggest that intermittent limb compression could be beneficial in improving ACD, along with supervised exercise and surgical intervention. Broader studies comparing limb compression with alternative treatment strategies would help better define its role in the multimodal management of PAD. The study limitations include the small sample size, low-quality studies, risk of bias, significant heterogeneity between studies, and limited generalizability of results. (This study is included in the ECRI 2021 Clinical Evidence Assessment.)

Williams et al. (2017) conducted a systematic review to identify and analyze noninvasive hemodynamic devices in the management of PAD. The devices that were identified and included in the study (n = 22) were IPC, electronic nerve or muscle stimulators, and galvanic electrical dressings. The results showed that in individuals with intermittent claudication, IPC devices increased popliteal artery velocity (49%-70%) and flow (49%-84%). Over 4.5 to 6 months, IPC increased intermittent claudication distance (97%-150%) and absolute walking distance (84%-112%). In individuals with CLI, IPC reduced rest pain in 40% to 100% and was associated with ulcer healing rates of 26%. IPC had an early limb salvage rate of 58% to 83% and 58% to 94% at 1.5 to 3.5 years. The authors concluded that there is evidence to support the use of IPC in the management of claudication and CLI; however, there is a need for more robust research in the form of RCTs. Also, there is limited evidence to support the use of electrical stimulators to date for PAD. These devices may be of benefit to those with limited exercise capacity and in nonreconstructable CLI. Limitations of the study include the small sample size, low quality of studies, and heterogeneity. (This study is included in the ECRI 2021 Clinical Evidence Assessment.)

Alvarez et al. (2015) conducted an RCT on the effects of high-pressure intermittent limb compression for the treatment of PAD and CLI in participants without a surgical option. Overall, 34 participants with symptomatic PAD or CLI who were experiencing claudication pain, chronic rest pain, numbness, and ischemic lower leg/foot ulceration were randomized into two treatment groups. In total, 18 participants received treatment with high-pressure IPC (HPIPC) for 60 minutes twice daily for 16 weeks; 16 participants received standard care consisting of an exercise regimen of walking for 20 minutes twice daily for 16 weeks. The participant-centered outcomes measured peak walking time (PWT), defined as the time to maximally tolerated claudication pain, change in resting Ankle-Brachial Index, ulcer healing, relief of resting/wound pain, and quality-of-life index. The study showed no significant change in the PWT treatment groups at week 4 or 8. At week 16, the percent change in treatment groups was more significant (35.5% for the standard care group and 54.7% for the HPIPC group). In addition, the HPIPC group reported an increased reduction of wound surface area and greater pain relief and physical function at 16 weeks. The authors concluded that therapy consisting of HPIPC for 2 hours daily for a period of 16 weeks significantly improved PWT, reduced resting pain, and improved healing rates, physical function, and bodily pain. The authors concluded that HPIPC is safe and effective and should be considered for individuals who are not candidates for endovascular or surgical procedures. The study limitations include a small sample size, single-center focus, and lack of blinding. (This study is included in the ECRI 2021 Clinical Evidence Assessment.)

In 2013 (updated 2017) Hayes published a Health Technology Assessment on IPCs for PAD. The assessment concluded that IPCs appear to be safe, with many of the studies reporting no complications and only minor complications such as calf pain or discomfort. The evidence for IPC for PAD was moderate in size and quality, with five small sample size RCTs included. The studies provided low-quality evidence, small sample sizes, lack of blinding, lack of randomization, lack of a control group, incomplete reporting of the study population characteristics, lack of statistical analysis results, and brief or no posttreatment follow-up period. The report concluded that there is some potential benefit for IPC for individuals with PAD; however, there is substantial uncertainty about the safety and impact on health outcomes because of poor-quality, sparse data and conflicting study results. Published evidence shows no proven benefit for IPC for decreasing edema compared with compression stockings in individuals with PAD following peripheral bypass surgery. In addition, there is insufficient evidence for IPC for individuals with CLI who are not candidates for revascularization. Future studies should investigate at what point in the PAD disease continuum IPC provides the most benefit.

Clinical Practice Guidelines

European Society for Vascular Surgery (ESVS)

In 2019 (Conte et al.), the World Federation of Vascular Societies and ESVS provided guidelines on the management of chronic limb-threatening ischemia. The published studies supporting the guidelines did not show robust evidence from high-quality trials. The guideline states:

- Consider IPC therapy in carefully selected patients (e.g., rest pain, minor tissue loss) for whom revascularization is not possible (grade 2B).

American Heart Association (AHA)/American College of Cardiology (ACC)

In a 2024 update (Gornick et al.), the AHA/ACC provided guidelines on the management of patients with lower extremity PAD. The guideline for IPC states:

- In patients with chronic limb-threatening ischemia for whom revascularization is not an option, arterial IPC devices may be considered to augment wound healing or ameliorate ischemic rest pain (grade 2B).

Treatment of Lymphedema or Chronic Venous Insufficiency With Edema and Nonhealing Lower Extremity Ulcers

Alvarez et al. (2020) conducted a prospective, randomized controlled, parallel-group, comparative trial to investigate whether IPC assisted the healing of venous ulcers in participants with lymphedema who were already receiving standard compression with short-stretch or multilayered compression therapy. The study included 52 participants with chronic venous insufficiency and hard-to-heal lower leg ulceration (> 1 year old and > 20-cm^2 surface area) who were treated with either intermittent, gradient, pneumatic compression (n = 27) plus standard compression therapy or compression therapy alone (control). The median time to wound closure by 9 months was 141 days in the IPC-treated group and 211 days in the control group ($p = 0.031$). The rate of healing was 0.8 ±0.4 mm/d in the control group and 2.1 ±0.8 mm/d in the group treated with IPC ($p < 0.05$). When compared with participants treated with standard care, the group treated with IPC reported less pain at each evaluation point for the first 6 weeks of the trial. At weeks 1, 2, and 3, the visual analog pain scores were significantly lower in the IPC-treated group ($p < 0.05$). The authors concluded that the results suggest that IPC is a valuable adjunct to compression therapy in the management of large or painful venous ulcers. Limitations of the study include the small sample size, short-term follow-up, and lack of masking using a sham device.

Lurie et al. (2017) conducted a multicenter RCT focusing on participant outcomes with dual-action therapy pneumatic compression devices compared with those seen with compression stockings for participants with chronic venous disease (CVD). Overall, 89 participants (136 limbs) received either dual-action therapy (AT group) with compression or compression stockings. The results of the study showed that adherence with compression was not significantly different between the groups (100% vs 88%, AT and compression stocking groups, respectively, at 15 days; 87% vs 85% at the end of the study; $p = 0.97$). Daily use was not different either (10.7 hours in the AT group; 11.7 ±2.7 hours in the compression stocking group). At the 30-day visit, nearly one-third of all limbs decreased in volume ≥ 10% compared with the baseline volume. The AT group demonstrated a significant volume reduction advantage compared with the standard compression garment use in obese participants (body mass index > 30 kg/m^2). The authors concluded that use of dual-action therapy pneumatic compression devices is comparable to compression stockings in participant-centered outcomes. Limitations of the study include the limited techniques, participant variability, pilot investigation, and small sample size.

Clinical Practice Guidelines

European Society for Vascular Surgery (ESVS)

In 2022 (De Maeseneer et al.), the ESVS provided clinical practice guidelines on the management of CVD of the lower limbs. The guideline addresses the use of different compression modalities, which include elastic compression stockings, inelastic bandages (IBs), adjustable compression garments (ACGs), and IPC. The recommendations for venous leg ulceration (VLU) and CVD with compression therapy state:

- For patients with active VLU, compression therapy is recommended (grade 1A).
- For patients with active VLU, multilayer or IB or ACG, exerting a target pressure of at least 40 mm Hg at the ankle, is recommended to improve ulcer healing (grade 1A).
- For patients with active VLU, IPC should be considered when other compression options are not available, cannot be used, or have failed to promote ulcer healing. Grade 2a (weight of evidence/opinion is in favor of the usefulness/efficacy), level B.
- For patients with mixed ulcer due to coexisting arterial and venous disease, modified compression therapy under close clinical supervision, with a compression pressure of less than 40 mm Hg, may be considered, provided the ankle pressure is higher than 60 mm Hg. Grade 2b (usefulness/efficacy is less well established by evidence/opinion), level C.
- For patients with healed VLU, long-term compression therapy should be considered to reduce the risk of ulcer recurrence. Grade 2a (weight of evidence/opinion is in favor of the usefulness/efficacy), level B.
- For patients with symptomatic CVD, elastic compression stockings, exerting a pressure of at least 15 mm Hg at the ankle, are recommended to reduce venous symptoms (grade 1B).
- For patients with CVD and edema [Clinical Etiological Anatomical Pathophysiological (CEAP) clinical class C3], compression treatment, using below-knee elastic compression stockings, IB, or ACG, exerting a pressure of 20 to 40 mm Hg at the ankle, is recommended to reduce edema (grade 1B).

The ESVS clinical guideline also provided recommendations on compression after treatment interventions for venous incompetence. The ESVS stated that postprocedural compression is controversial, even if the vast majority of practitioners still use it in their daily practice.

In addition, several RCTs on postinterventional compression show conflicting evidence, and the duration of compression is equally controversial. In order to effectively compress the above-knee greater saphenous vein, eccentric compression is needed with a compression pad on top of the greater saphenous vein. The recommendation states:

- For patients with superficial venous incompetence undergoing intervention, the duration of postintervention compression, used to minimize postoperative local complications, should be decided on an individual basis (grade 1A).

American College of Phlebology (ACP)/American Vein and Lymphatic Society (AVLS)

In 2016, the American College of Phlebology and AVLS provided clinical practice guidelines for the treatment of venous disease. The recommendations state:

- Compression therapy is an effective method for the management of symptoms related to superficial disease, but it does not correct the source of reflux. When patients have a correctable source of reflux, definitive treatment should also be offered, unless it is contraindicated or unwanted (grade 1A).
- The AVLS recommends against compression therapy as a prerequisite therapy for symptomatic venous reflux disease when other definitive treatments such as endovenous ablation are appropriate (grade 1A).
- After interventional treatment, the use of a compression garment is recommended in the postoperative period. There is extra benefit to the patient in the form of reduced pain after use of compression. The compression dosage and duration are at the discretion and clinical judgment of the treating physician (grade 2B).
- Superficial venous insufficiency is a chronic disease, and, as such, recommendations for the patients with this disease should be counseled to wear a compression garment, even after definite treatment has been provided. The compression dosage is at the discretion and clinical judgment of the treating physician (grade 2C).
- Suggestive treatment of some CEAP C2 patients with isolated varices by medical compression hose alone may be an acceptable form of treatment. A short 1- to 2-week trial of a compression hose may be appropriate where an alternative etiology of symptoms is considered, e.g., musculoskeletal pain or neuropathy (spinal stenosis, sciatica, hip or knee arthritis, diabetic neuropathy, etc.) (grade 2C).

Prevention of Deep Venous Thrombosis

An ECRI Clinical Evidence Assessment (2025a) for intermittent pneumatic compression (IPC) for the prevention of deep vein thrombosis (DVT) following surgery was conducted with the authors concluding that evidence is “favorable”. The authors concluded that five systematic reviews (SRs) with meta-analysis and two additional SRs with network meta-analysis enable low-confidence conclusions that IPC use is better than no prophylaxis/placebo to prevent DVT in specific adult postsurgical patient populations (not including total joint arthroplasty or gynecologic surgery); however, whether IPC alone is superior to other VTE prophylaxis methods is unclear due to low statistical precision in the included studies. Evidence also indicates that IPC used together with pharmacologic prophylaxis results in fewer DVTs than pharmacologic prophylaxis alone in adult patients who underwent surgery for different conditions (not including total joint arthroplasty or gynecologic surgery). This assessment has limitations. No studies compared IPC with early ambulation/mobilization. Evidence on pediatric patients is sparce, and one available SR did not perform meta-analysis. The SRs include many studies at high risk of bias or pool patient populations that have different confounders and VTE risk at baseline, somewhat limiting confidence in the findings and generalizability. Studies also varied in IPC duration. No studies compared IPC with early ambulation, and no study stratified patients by their VTE risk; therefore, results may not generalize from high-risk to low-risk populations and vice versa.

An ECRI Clinical Evidence Assessment (2025b) for intermittent pneumatic compression (IPC) devices for the prevention of DVT in critically ill patients was conducted with the authors concluding that evidence is “favorable”. The authors concluded that evidence from one systematic review (SR) with meta-analysis, one SR with network meta-analysis, and one randomized controlled trial (RCT) indicates IPC alone or in combination with anticoagulation medication reduces DVT and venous thromboembolism (VTE) incidence more than no prophylaxis in adult critically ill patients. However, whether IPC used together with pharmacologic prophylaxis is more effective than pharmacologic prophylaxis alone for reducing DVT or VTE rates is unclear because available studies have low statistical precisions. Limitations include the use of SRs which include only RCTs that are at high risk of bias primarily due to lack of blinding. Also, SRs included RCTs that pooled patient populations with different baseline VTE risks, somewhat limiting the findings’ generalizability. Studies also varied in IPC duration.

Kim et al. (2024) conducted a systematic review and meta-analysis to determine the effects of IPC intervention to prevent deep venous thrombosis (DVT) in surgical individuals. Overall, 16 RCTs met the inclusion criteria, with 2,828 individuals

(1,389 in the intervention group and 1,436 in the control group). The results showed that the overall effect size of IPC for DVT prevention was an odds ratio (OR) of 0.81 (95% CI, 0.59-1.11), which was not statistically significant (Z = 1.31; p = 0.190). The heterogeneity was an I^2 of 68% (χ^2 = 50.52; df = 16; p < 0.001). The 16 studies showed no difference in DVT incidence between the experimental and control groups. The authors concluded that IPC did not differ from pharmacotherapy in preventing DVT but was able to reduce the incidence of DVT compared with individuals who did not receive any management of DVT prevention. Further studies should continue to confirm the effect of IPC on DVT incidence in surgical individuals through well-designed RCTs. The limitations of the study include the high heterogeneity of the surgery-related variables, clinical heterogeneity of IPC duration and methodology, and multiple methods of DVT diagnosis.

Herring et al. (2023) conducted a systematic review comparing the safety and efficacy of IPC and graduated compression stockings used singularly and in combination for surgical individuals. The review included 14 studies articles (12 RCTs and two retrospective studies); seven studies compared IPC and graduated compression stockings directly, and the remaining seven compared a combination of IPC and graduated compression stockings vs graduated compression stockings alone. No studies were found comparing a combination against IPC alone. The results suggested that combination mechanical prophylaxis may be superior to graduated compression stockings alone in high-risk individuals. IPC appeared to have a superior safety profile, although it had a worse adherence rate, and the quality of evidence was poor. The addition of pharmacological prophylaxis may make mechanical prophylaxis unnecessary in the postoperative setting. The authors concluded that IPC may be superior to graduated compression stockings when used as a single prophylactic device. A combination of IPC and graduated compression stockings may be more efficacious than graduated compression stockings alone for high-risk individuals. Further high-quality research is needed that focuses on clinical relevance and safety and compares combination prophylaxis. The limitations of the study include a small sample size, heterogeneity of the literature, and risk of bias.

In 2023, Zhang et al. conducted a systematic review on the incidence of venous thromboembolism (VTE) in neurosurgical interventions to establish an optimum prevention strategy because these individuals usually have longer immobilization time after surgery and possible neurological deficits, which can negatively influence mobility. This is an update to a 2012 review of thromboembolic events in individuals undergoing spinal or intracranial neurosurgical procedures. In 2012, it was concluded that intracranial surgical individuals were more at risk to develop a VTE than spinal surgery individuals. Also, the use of antithrombotic prophylaxis in neurosurgical interventions lowers the VTE incidence from 30 to approximately 1.5 to 6%; a two-fold higher VTE rate was demonstrated in individuals systematically screened for DVT compared with those clinically screened, and subclinical DVT was described to be associated with the incidence of pulmonary embolism (PE). However, large heterogeneity with respect to diagnostic methods for VTE events and variable antithrombotic prophylaxis prevented the authors from drawing firm conclusions on optimal treatment strategy. The current study now, 10 years later, used the Newcastle-Ottawa Quality Assessment Scale and Cochrane Risk of Bias to select 25 studies (21 case series, three comparative studies, and one RCT) within the inclusion criteria. The results demonstrated that VTE was substantially higher if the evaluation was done by duplex ultrasound (DUS) or another systematic screening method compared with clinical evaluation (clin). Without prophylaxis, DVT incidence varied from 4% (clin) to 10% (DUS); studies providing low-molecular-weight heparin (LMWH) reported an incidence of 2% (clin) to 31% (DUS), studies providing LMWH and compression stockings reported an incidence of 6.4% (clin) to 29.8% (DUS), and studies providing LMWH and IPC devices reported an incidence of 3% (clin) to 22.3% (DUS). Due to a lack of data, VTE incidence could not meaningfully be compared between individuals with intracranial and spine surgery. The authors concluded that LMWH, compression stockings, and IPC devices were all evaluated to give reduction in VTE, but with the currently available data, no conclusion can be drawn on generalizing the optimum treatment strategy to lower the incidence of thromboembolic complications. Limitations of the study include the selection bias and heterogeneity of the surgical intervention types.

In 2022, a Cochrane review (Kakkos et al., 2022) assessed the efficacy of combined IPC and pharmacological prophylaxis compared with single modalities in preventing VTE. Overall, 34 studies (n = 14,931), including 25 RCTs mainly undergoing surgery or admitted trauma, were evaluated for PE, DVT, bleeding, and major bleeding outcomes. The use of combined IPC and pharmacological prophylaxis modalities compared with pharmacological prophylaxis alone reduced the incidence of PE from 1.84% (61/3,318) in the pharmacological prophylaxis group to 0.91% (31/3,419) in the combined group (OR, 0.46; 95% CI, 0.30-0.71; 15 studies; 6,737 individuals; low-certainty evidence). The authors concluded that combining IPC with pharmacological prophylaxis compared with pharmacological prophylaxis alone reduces the incidence of both PE (low certainty of evidence) and DVT (high certainty of evidence). The limitations of the study include publication bias, individuals' demographics, intervention, and modality restriction.

Arabi et al. (2019), included in the 2022 Cochrane review above, conducted a multisite RCT that evaluated whether adjunctive IPC in critically ill individuals receiving pharmacological thromboprophylaxis with unfractionated heparin or LMWH would result in a lower incidence of proximal lower limb DVT than pharmacological thromboprophylaxis alone. Individuals who were considered adults, according to the local standards at the participating sites (≥ 14, ≥ 16, or ≥ 18

years of age), were randomly assigned within 48 hours after admission to an intensive care unit to receive either IPC for at least 18 hours each day, in addition to pharmacological thromboprophylaxis with unfractionated or LMWH (pneumatic compression group), or pharmacological thromboprophylaxis alone (control group). The primary outcome was an episode of proximal lower limb DVT, as detected on twice-weekly lower limb ultrasound after the third calendar day since randomization until intensive care unit discharge, death, achievement of full mobility, or trial day 28, whichever occurred first. A total of 2,003 individuals underwent randomization; 991 were assigned to the pneumatic compression group and 1,012 to the control group. IPC was applied for a median of 22 hours daily for a median of 7 days. The primary outcome occurred in 37 of 957 individuals (3.9%) in the pneumatic compression group and in 41 of 985 individuals (4.2%) in the control group (relative risk, 0.93; 95% CI, 0.60-1.44; p = 0.74). VTE (PE or any lower limb DVT) occurred in 103 of 991 individuals (10.4%) in the pneumatic compression group and in 95 of 1,012 individuals (9.4%) in the control group (relative risk, 1.11; 95% CI, 0.85-1.44), and death from any cause at 90 days occurred in 258 of 990 individuals (26.1%) and 270 of 1,011 individuals (26.7%), respectively (relative risk, 0.98; 95% CI, 0.84-1.13). The authors found no benefit with the use of adjunctive pneumatic compression in the prevention of DVT in critically ill individuals receiving pharmacological prophylaxis.

Zhang et al. (2018), in a systematic review and meta-analysis, examined the effect of IPC on the risk of DVTs, PE, and mortality compared with no IPC prophylaxis after a stroke. Databases were searched, including MEDLINE, Embase, the Cochrane Library, Wanfang, CNKI, and the Chinese Biomedical Database, from inception to June 2, 2017. RCTs comparing IPC with no IPC in individuals with stroke were included. The rates of PE, DVT, and mortality were compared. The results were pooled using a fixed-effects model to evaluate the differences between the IPC and control groups. If there was significant heterogeneity in the pooled result, a random-effects model was used. There were seven RCTs identified that included 3,551 individuals. Overall, IPC significantly reduced the incidence of DVT [risk ratio (RR), 0.50; 95% CI, 0.27-0.94]. These findings were similar among subgroups of individuals in whom IPC was started more than 72 hours after the stroke and in those who did not receive pharmacological anticoagulation. However, IPC increased IPC-related adverse events (RR, 5.71; 95% CI, 3.40-9.58). Although IPC was associated with a significant increase in survival by 4.5 days during 6 months of follow-up (148-152 days; 95% CI, -0.2 to 9.1), there was a mean gain of only 0.9 days (26.7-27.6 days; 95% CI, 2.1-3.9) in quality-adjusted survival during the 6-month follow-up. Sensitivity analyses did not alter these findings. Limitations of the study include the small number of trials, moderate heterogeneity in the DVT prevention outcome, and inclusion of moderate-quality studies. The authors concluded that this study indicates that there is clear evidence that IPC significantly reduces the risk of DVT and significantly improves survival in a wide variety of individuals who are immobile after stroke. However, IPC does not significantly improve quality-adjusted survival.

A 2018 Hayes Health Technology Assessment, updated in 2023, on pneumatic compression for the prevention of DVT following knee arthroplasty assessed 16 RCTs that compared pneumatic compression with alternative methods of VTE or a combination of therapies, including anticoagulants (including aspirin), LMWH, or graduated compression stockings. It was concluded that pneumatic compression may be effective in reducing the incidence of DVT in individuals who have undergone total knee arthroplasty, particularly when used in combination with LMWH, but that pneumatic compression alone is less effective than LMWH alone. The available studies concerning the efficacy of pneumatic compression alone or combined with other methods of prophylaxis for DVT such as aspirin, graduated compression stockings, and other anticoagulants provide limited and somewhat inconsistent evidence, and additional RCTs are needed.

O'Connell et al. (2016) conducted a systematic review and meta-analysis as an up-to-date evaluation on the use of compression devices (with or without pharmacological anticoagulation) as DVT prophylaxis methods in orthopedic and neurological individuals compared with pharmacological anticoagulation alone. There were nine RCTs that were included in the review and meta-analysis, for a total of 3,347 individuals. The IPC group had a combined total of 1,667 individuals, and the pharmacological anticoagulation alone group had 1,667 individuals. The main outcome measures were the development of DVT and/or PE. In all nine studies, the rate of DVT significantly occurred in the pharmacological anticoagulation group (89/1,667) compared with the IPC group (38/1,680) (p = 0.04). Sensitivity testing did not change this finding. A sensitivity test that looked at IPC alone, without additional chemoprophylaxis, showed no significant difference in the rate of DVT between IPC and the control group. A further test to assess if differences were related to the protocol differences and not necessarily related to IPC by using data from seven studies using only LMWH showed the differences between the group to slightly favor the IPC group, although this was not significant. The main limitation is the lack of blinding in all studies and heterogeneity of both the intervention and control group in the meta-analysis. Some intervention groups included IPC alone, while others included IPC and pharmacological treatment. The authors concluded that the use of an IPC device alone is neither superior nor inferior to chemoprophylaxis.

Pavon et al. (2016), in a systematic review, examined the results of 14 eligible RCTs and three eligible observational studies evaluating the effectiveness of IPC devices for VTE prophylaxis in postoperative surgical individuals. The authors looked at the comparative effectiveness of IPC devices for selected outcomes (mortality, VTE, symptomatic or asymptomatic DVT, major bleeding, ease of use, and adherence) in postoperative surgical individuals. IPC devices were

comparable to anticoagulation for major clinical outcomes (VTE: RR, 1.39; 95% CI, 0.73-2.64). Limited data suggest that concurrent use of anticoagulation with IPC devices may lower VTE risk compared with anticoagulation alone and that IPC devices compared with anticoagulation may lower major bleeding risk. Subgroup analyses did not show significant differences by device location, mode of inflation, or risk-of-bias elements. The authors concluded that IPC devices do not show clear differences in clinical outcomes, although they may decrease the risk of VTE and should be used in accordance with current clinical guidelines. The current evidence base to guide selection of a specific device or type of device is limited, and comparative studies are needed.

Dennis et al. (2015), in a Health Technology Assessment based on the CLOTS 3 trial (2013), looked at whether or not the application of IPC to the legs of immobile individuals after stroke reduced their risk of DVT. CLOTS 3 was a multicenter parallel-group RCT that allocated participants via a central randomization system to IPC or no IPC. A technician who was blinded to treatment allocation performed compression DUS of both legs at 7 to 10 days and 25 to 30 days after enrollment. Participants were followed up for 6 months to determine survival and later symptomatic VTE. There were 2,876 participants enrolled in 94 UK hospitals between December 8, 2008, and September 6, 2012. Inclusion criteria included participants admitted to the hospital within 3 days of acute stroke and who were immobile (not able to get up from a chair/out of bed and walk to the toilet without the help of another person) on the day of admission (day 0) to day 3. Participants were excluded for any of the following: age < 16 years; subarachnoid hemorrhage; and contraindications to IPC, including dermatitis, leg ulcers, severe edema, severe peripheral vascular disease, and congestive cardiac failure. Participants were allocated to routine care or routine care plus IPC for 30 days until earlier discharge from the hospital or participation in a rehabilitation unit or until walking independently, whichever happened first. The mean duration of IPC use was approximately 11 days, with approximately one in four participants using IPC for 3 weeks or more. Most participants also received antiplatelet therapy, and approximately half received pharmacological anticoagulation. The primary outcome occurred in 122 of 1,438 participants (8.5%) allocated to IPC and 174 of 1,438 participants (12.1%) allocated to no IPC, giving an absolute reduction in risk of 3.6% (95% CI, 1.4%-5.8%) and a relative risk reduction of 0.69 (95% CI, 0.55-0.86). After excluding 323 participants who died prior to any primary outcome and 41 who had no screening compression DUS, the primary outcome occurred in 122 of 1,267 IPC participants compared with 174 of 1,245 no-IPC participants, giving an adjusted OR of 0.65 (95% CI, 0.51-0.84; p = 0.001). The secondary outcomes in IPC compared with no-IPC participants were death in the treatment period in 156 (10.8%) vs 189 (13.1%) (p = 0.058); skin breaks in 44 (3.1%) vs 20 (1.4%) (p = 0.002); and falls with injury in 33 (2.3%) vs 24 (1.7%) (p = 0.221). Among participants treated with IPC, there was a statistically significant improvement in survival to 6 months (HR, 0.86; 95% CI, 0.73-0.99; p = 0.042) but no improvement in disability. The authors determined that IPC is an effective method of reducing the risk of DVT and improving survival in immobile individuals after a stroke.

Domeij-Arverud et al. (2015), in an RCT, investigated the use of IPC therapy and the prevention of DVT in outpatients who had undergone surgical repair of acute ruptures of the Achilles tendon, were immobilized, and did not receive pharmacological anticoagulation. A total of 150 participants who had undergone surgical repair of the Achilles tendon were randomized to either treatment with IPC for 6 hours per day for 2 weeks (n = 74) under an orthosis or treatment as usual (n = 74) in a plaster cast without IPC. At 2 weeks post operation, the incidence of DVT was assessed using blinded, double-reported compression DUS. At this point, IPC was discontinued, and all participants were immobilized in an orthosis for a further 4 weeks. At 6 weeks post operation, a second compression DUS scan was performed. At 2 weeks, the incidence of DVT was 21% in the treated group and 37% in the control group (p = 0.042). An age of over 39 years was found to be a strong risk factor for DVT (OR, 4.84; 95% CI, 2.14-10.96). Treatment with IPC, corrected for age differences between groups, reduced the risk of DVT at the 2-week point (OR, 2.60; 95% CI, 1.15-5.91; p = 0.022). At 6 weeks, which is 4 weeks after the end of the IPC intervention, the incidence of DVT was 52% in the treated group and 48% in the control group (OR, 0.94; 95% CI, 0.49-1.83). The authors concluded that IPC appears to be an effective method of reducing the risk of DVT in the early stages of postoperative immobile outpatients. Additional research is necessary to clarify whether it could result in similar benefits over longer periods of immobilization and in a more heterogeneous group of individuals.

Clinical Practice Guidelines

American Society of Hematology (ASH)

In the 2019 evidence-based guidelines for the prevention of VTE in surgical hospitalized patients undergoing major surgery, ASH (Anderson et al.) makes the following conditional recommendations regarding mechanical prophylaxis, based on very low certainty in the evidence:

- The use of pharmacological or mechanical prophylaxis:
  - For patients considered at a high risk for bleeding, the balance of effects may favor mechanical methods over pharmacological prophylaxis.
  - For patients who do not receive pharmacological prophylaxis, the panel suggests using mechanical prophylaxis over no mechanical prophylaxis.

    - For patients who receive mechanical prophylaxis, the panel suggests using intermittent compression devices over graduated compression stockings.
- For patients who receive pharmacological prophylaxis, the panel suggests using combined prophylaxis with mechanical and pharmacological methods over prophylaxis with pharmacological agents alone.
    - For patients considered at a high risk for VTE, combined prophylaxis is particularly favored over mechanical or pharmacological prophylaxis alone. (Further high-quality research studies using clinically important outcomes to identify patients with a high baseline risk for VTE, in whom combined pharmacological and mechanical prophylaxis would be of value, particularly outside the orthopedic setting, are needed.)

In the 2018 (updated 2022) ASH guidelines for the management of VTE, which discuss prophylaxis for hospitalized and nonhospitalized medical patients (Schünemann et al.), the following statement is noted:

- In acutely or critically ill medical patients who do not receive pharmacological VTE prophylaxis, the ASH guideline panel suggests using mechanical VTE prophylaxis over no VTE prophylaxis (conditional recommendation, moderate certainty in the evidence of effects).

National Institute for Health and Care Excellence (NICE)

A 2018 (updated 2019) NICE guideline on reducing the risks of hospital-acquired DVT or PE states that all patients should be assessed for risk on admission and if their clinical condition changes. NICE states that the indications for antiembolism stockings and pneumatic compression devices are both considered “mechanical prophylaxis” and states that mechanical prophylaxis should not be used in patients with the following:

- Suspected or proven PAD.
- Peripheral arterial bypass grafting.
- Peripheral neuropathy or other causes of sensory impairment.
- Any local conditions in which mechanical prophylaxis may cause damage (e.g., fragile “tissue paper” skin, dermatitis, gangrene, recent skin graft).
- Severe leg edema.
- Major limb deformity or unusual leg size or shape that prevents a correct fit.

European Guidelines on Perioperative Venous Thromboembolism Prophylaxis

In 2024, Fenger-Eriksen et al. updated the 2018 (Afshari et al.) European guidelines on perioperative VTE prophylaxis; the authors note that the use of graduated compression stockings and IPC strongly differs between institutions. Most evidence does not support the use of mechanical prophylaxis alone. In patients at a very high risk of VTE, a combination of mechanical and pharmacological prophylaxis may further reduce DVT, and IPC appears to be more effective than graduated compression stockings. They made the following recommendations and suggestions in regard to mechanical prophylaxis:

- An institution-wide protocol for the prevention of VTE that integrates early ambulation, pharmacological thromboprophylaxis with anticoagulants, and mechanical thromboprophylaxis (grade IB).
- For each patient before surgery, an assessment of the risk of postoperative VTE and the bleeding related to both the surgical procedure and the patient’s characteristics (grade 1B).
- In patients with a low thrombosis risk, such as day surgery and/or immediate mobilization, general measures of thromboprophylaxis (including early ambulation and optimal hydration) over mechanical or pharmacological prophylaxis are recommended (grade 1B).
- In patients with a low thrombosis risk, such as hospitalized patients and/or postoperative immobilization, pharmacological prophylaxis is recommended over no prophylaxis (grade 1C). Additional IPC is optional (grade 2C).
- In hospitalized patients with a high thrombosis risk, prophylaxis with IPC is suggested if there is a high bleeding risk or contraindication to pharmacological prophylaxis (grade 2C).
- In patients with a high thrombosis risk and low bleeding risk, pharmacological prophylaxis plus optional IPC or graduated compression stockings are suggested (grade 2B).
- In patients with a high thrombosis risk and high bleeding risk, IPC over no prophylaxis is recommended (grade 1C).
- In patients with a very high thrombosis risk, IPC plus pharmacological prophylaxis is suggested (grade 1C).

American Association of Plastic Surgeons (AAPS)

Pannucci et al. (2016) authored a clinical practice guideline based on a systematic review and meta-analysis sponsored by the AAPS that examined both the benefits and risks of VTE prophylaxis in plastic surgery patients. The authors found that meta-analyses in surgical patients (but not necessarily plastic surgery patients) have shown significant DVT risk reduction with IPC compared with placebo. Meta-analysis has also shown that IPC is superior to elastic compression stockings for DVT risk reduction (OR, 0.61; 95% CI, 0.39-0.93). The following statements were made:

- Recommend using IPC to prevent perioperative VTE events in plastic surgery patients. In the absence of rigorous publications in plastic surgery, this recommendation was derived largely from meta-analyses in other specialties (grade 1B).
- Elastic compression stockings are associated with a decreased risk for perioperative VTE in other surgical specialties. In the absence of rigorous publications in plastic surgery, this recommendation was derived largely from meta-analysis in other specialties (grade 1B).
- IPC is superior to elastic compression stockings for VTE prevention in other surgical specialties. In the absence of rigorous publications in plastic surgery, this recommendation was derived largely from meta-analysis in other specialties (grade 1B).

U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

The Flexitouch Plus System (Tactile Systems Technology, Inc) received FDA clearance on December 20, 2020. The Flexitouch System and garments for the head and neck are intended for use by medical professionals and patients who are under medical supervision for the treatment of head and neck lymphedema: https://www.accessdata.fda.gov/cdrh_docs/pdf20/K203178.pdf. (Accessed January 13, 2026)

Devices and systems to perform pneumatic compression are regulated by the FDA as Class II devices. Refer to the following website for more information (use product code JOW): http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm. (Accessed January 13, 2026)

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Policy History/Revision Information

Date	Summary of Changes
06/01/2026	**Coverage Rationale** • Revised language pertaining to medical necessity clinical coverage criteria; replaced reference to the "InterQual® CP: Durable Medical Equipment, Pneumatic *and other Powered* Compression Devices" with "InterQual® CP: Durable Medical Equipment, Pneumatic Compression Devices" **Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information • Archived previous policy version 2026T0563W

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

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UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.