5101:3-10-04 **Pneumatic Compression Devices and Accessories.**

(A) Definitions

(1) Lymphedema is the swelling of subcutaneous tissues due to the accumulation of excessive lymph fluid. The accumulation of lymph fluid results from impairment to the normal clearing function of the lymphatic system and/or from an excessive production of lymph. Lymphedema is divided into two broad classes according to etiology. Primary lymphedema is a relatively uncommon, chronic condition which may be due to such causes as Milroy's disease or congenital anomalies. Secondary lymphedema, which is much more common, results from the destruction of or damage to formerly functioning lymphatic channels, such as radical surgical procedures with removal of regional groups of lymph nodes (for example, after radical mastectomy), post-radiation fibrosis, and spread of malignant tumors to regional lymph nodes with lymphatic obstruction, among other causes.

(2) Chronic venous insufficiency (CVI) of the lower extremities is a condition caused by abnormalities of the venous wall and valves, leading to obstruction or reflux of blood flow in veins. Signs of CVI include hyperpigmentation, status dermatitis, chronic edema, and venous ulcers.

(B) Coverage determination

(1) Pneumatic compression devices and accessories are only covered in a private residence for the treatment of lymphedema or the treatment of chronic venous insufficiency with venous stasis ulcers.

(2) Pneumatic compression devices and accessories are covered in a private residence for the treatment of lymphedema if the consumer has undergone a four-week trial of conservative therapy and the prescriber determines that there has been no significant improvement or if significant symptoms remain after the trial. The trial of conservative therapy must include use of an appropriate compression bandage system or compression garment, exercise, and elevation of the limb. The compression garment may be prefabricated or custom-fabricated but must provide adequate graduated compression.

(3) Pneumatic compression devices and accessories are covered in a private residence for the treatment of CVI of the lower extremities only if the consumer has one or more venous stasis ulcer(s) which have failed to heal after a six month trial of conservative therapy directed by the treating prescriber. 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.

(4) For either lymphedema or CVI with venous stasis ulcers, pneumatic compression devices are covered only when prescribed by a prescriber and

when they are used with appropriate prescriber oversight, i.e., prescriber evaluation of the consumer's condition to determine medical necessity of the device, assuring suitable instruction in the operation of the machine, a treatment plan defining the pressure to be used and the frequency and duration of use, and ongoing monitoring of use and response to treatment.

(5) Any prescription for a pneumatic compression device and accessories must be prescribed by a prescriber actively involved in managing the consumer's medical condition as defined in paragraph (A)(2) of rule 5101:3-10-05 of the Administrative Code and who should be treating the consumer under a comprehensive plan of care which addresses the underlying medical need for any equipment and accessories referenced in this rule.

(C) Non-coverage determination

(1) Pneumatic compression devices and accessories are not separately reimbursable for consumers in long term care facilities (LTCFs) as this equipment and supplies are included in the facility's per diem payment.

(2) Accessories used for pneumatic compression of the chest or trunk will be denied as non-covered.

(D) Authorization

(1) In addition to a fully completed prior authorization form JFS 03142 (rev. 2/2003), a fully completed "Certificate of Medical Necessity/Prescription Pneumatic Compression Devices" form JFS 02929 3/2009 (appendix A to this rule) signed and dated by the treating prescriber must be obtained by the provider no more than thirty days prior to the first date of service in order to request authorization for any pneumatic compression device and/or accessories and must specify:

(a) The consumer's diagnosis and prognosis;

(b) The symptoms and objective findings, including measurements which establish the severity of the condition;

(c) The reason the device is required, including the treatments which have been tried and failed; and

(d) The clinical response to an initial treatment with the device via rental which includes the change in pre-treatment measurements, ability to tolerate the treatment session and prescribed parameters, and the ability of the consumer (or caregiver) to apply the device for continued use in the home. The initial rental period of this device cannot be less than thirty days or more than ninety days before request for purchase is made by the provider.

(2) When a pneumatic compression device is covered, a non-segmented device or segmented device without manual control of the pressure in each chamber is generally sufficient to meet the clinical needs of the consumer.

(3) A non-segmented compressor with a segmented appliance/sleeve is considered functionally equivalent to a compressor with a segmented appliance/sleeve.

(E) Dispensing

(1) The following components are considered "inclusive" with any pneumatic compression device payment made by medicaid on behalf of a consumer and cannot be submitted to medicaid for separate payment:

(a) Any supporting wires, cables, or attachment kits;

(b) Education, training, monitoring, or counseling in support of the consumer's ordered treatment plan;

(c) Maintenance, repair, or cleaning charges incurred by the provider during a rental period; and

(d) Delivery, set up, or pick up charges associated with the equipment or supplies.

(2) The provider of a pneumatic compression device must assure that the consumer (or the consumer's caregiver) is properly instructed on how to use the device and is aware of and understands any emergency procedures regarding the use of the device. The provider must maintain written documentation regarding the consumer's instruction on the use of the device in the consumer's medical record.

(3) Upon the dispensing of a pneumatic compression device, the consumer (or the consumer's caregiver) must be supplied by the provider with a twenty-four hour, seven-day-a-week telephone number to be utilized in case of an emergency during the rental period. This telephone number must meet all requirements of the Americans with Disabilities Act of 1990.

(F) Reimbursement

(1) Pneumatic compression devices and accessories are reimbursed according to the department fee schedule contained in appendix DD to rule 5101:3-1-60 of the Administrative Code or the provider's usual and customary charge, whichever is less.

(2) The department does not purchase previously utilized, refurbished or loaner pneumatic compression devices.

Effective: 01/07/2010

R.C. 119.032 review dates: 01/01/2015

CERTIFIED ELECTRONICALLY

Certification

12/28/2009

Date

Promulgated Under: 119.03
Statutory Authority: 5111.02
Rule Amplifies: 5111.01, 5111.02, 5111.021