Pneumatic Compression

Face-to-Face Documentation Requirements

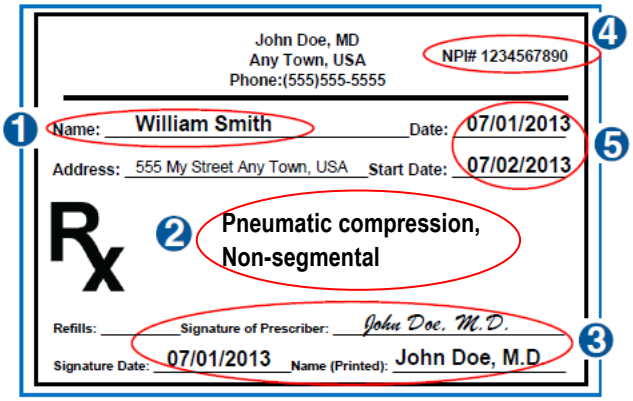
For Any New Order On Or After July 1, 2013

- The patient's medical record must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity of the items ordered.
- A ***Practitioner*** must have a Face-to-Face Evaluation with the beneficiary prior to the written DME order and document the Face-to-Face Evaluation in the patient's medical record. A ***Practitioner*** is:
  - Medical Doctor
  - Doctor of Osteopathic Medicine
  - Doctor of Podiatric Medicine
  - Physician Assistant
  - Nurse Practitioner
  - Clinical Nurse Specialist
- Every item subject to Face-to-Face requirements is also subject to mandatory Specific Written Orders **prior** to delivery. A complete Specific Written Order must be received before the item may be delivered to the patient.
- The Face-to-Face Evaluation must be signed by the Prescribing Practitioner
- Medicare beneficiaries discharged from a hospital do not need to receive a separate Face-to-Face Evaluation, so long as the Prescribing Practitioner who performed the Face-to-Face encounter in the hospital issues the DME order within six months after the patient's discharge from the hospital.
- The Face-to-Face Evaluation must occur during the six months prior to the written order for each item.
- Every item subject to Face-to-Face requirements is also subject to mandatory Specific Written Orders **prior** to delivery. A complete Specific Written Order must be received before the item may be delivered to the patient.

A Written Order for the item must be received before the delivery of the item can take place. A Written Order prior to delivery has five (5) mandatory elements, also referred to as a Five Element Order (5EO).

1. Beneficiary's name
2. Item of DME ordered - this may be general – e.g., "hospital bed"– or may be more specific.
3. Signature of the prescribing practitioner and date signed
4. Prescribing practitioner's National Practitioner Identifier (NPI)
5. The date of the order

A date stamp or equivalent must be used to document the date that the order was received.



Additional requirements, if applicable:

- Dosage or concentration
- Route of administration
- Frequency of use
- Duration of infusion
- Quantity to be dispensed
- Number of refills

Documentation in Medical Records Required by CMS

Documentation Requirements

- ☐ Duration of patient's condition
- ☐ Clinical course
- ☐ Prognosis
- ☐ Nature and extent of functional limitations
- ☐ Other therapeutic interventions and results

Key Items to Address

- ☐ Why does the patient require the item?
- ☐ Do the physical examination findings support the need for the item?
- ☐ Signs and symptoms that indicate the need for the item
- ☐ Diagnoses that are responsible for these signs and symptoms
- ☐ Other diagnoses that may relate to the need for the item

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HCPCS Codes included:

E0650-E0652, E0655-E0657, E0660, E0665-E0669, E0671-E0673, E0675

Coverage Criteria

The determination by the physician of the medical necessity of a pneumatic compression device must be documented in the patient's medical record and must include:

- The patient's diagnosis and prognosis.
- Symptoms and objective findings, including measurements which establish the severity of the condition.
- The reason the device is required, including the treatments which have been tried and failed, **and**
- The clinical response to an initial treatment with the device. This should include change in pre-treatment measurements, ability of the patient to tolerate the session, and ability of the patient or caregiver to apply the device for continued use in the home.

Pneumatic compression devices are only covered for the treatment of lymphedema or chronic venous insufficiency with venous stasis ulcers.

- Lymphedema—The patient has undergone a four-week trial of conservative therapy and the treating physician determines that there has been no significant improvement, or significant improvement, or 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.
- Chronic venous insufficiency with venous stasis ulcers—The patient has one or more venous stasis ulcers which have failed to heal after a six-month trial of conservative therapy directed by the treating physician. The trial of conservative therapy must include a compression bandage system or compression garment, appropriate dressing for the wound, exercise, and elevation of the limb.

Specific Documentation Requirements

If the patient has chronic venous insufficiency with stasis ulcers and it is so noted on the CMN, documentation in the patient's medical record must reflect all of the following:

- The location of the venous stasis ulcers.
- How long each ulcer has been continuously present.
- Previous treatment with a compression bandage system or compression garment, appropriate dressings for the ulcers, exercise and limb elevation for at least the past six months.
- Evidence of regular physician visits for treatment of venous stasis ulcers during the past six months.

Should a pneumatic compressor segmental home model with calibrated gradient pressure be ordered, the following additional documentation supporting the medical necessity for this device must be substantiated by information in the patient's medical record:

- The treatment plan including the pressure in each chamber, and the frequency and duration of each treatment episode.
- Whether a segmented compressor without calibrated gradient pressure or a non-segmented compressor with a segmented appliance had been tried and the results.
- Why the features of the device that was provided are needed for the patient.
- The name, model number, and manufacturer of the device.