Post-surgical Home Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis

(Formerly Post-surgical Outpatient Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis)

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<th>Medical Benefit</th>
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<td>Preauthorization</td>
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Preauthorization is not required.

The following Protocol contains medical necessity criteria that apply for this service. The criteria are also applicable to services provided in the local Medicare Advantage operating area for those members, unless separate Medicare Advantage criteria are indicated. If the criteria are not met, reimbursement will be denied and the patient cannot be billed. Please note that payment for covered services is subject to eligibility and the limitations noted in the patient’s contract at the time the services are rendered.

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<td>Interventions of interest are: • Home use of a limb compression device</td>
<td>Comparators of interest are: • No outpatient venous prophylaxis or other methods of mechanical prophylaxis</td>
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Description

Antithrombotic prophylaxis is recommended for surgical patients who are at moderate-to-high risk of postoperative venous thromboembolism (VTE), including deep vein thrombosis (DVT) and pulmonary embolism (PE). Patients may be classified as moderate-to-high risk of VTE based on the surgical procedure and/or patient characteristics. For some types of surgery (e.g., major orthopedic surgery), there is a particularly high risk of VTE due to the nature of the procedure and the prolonged immobility during and after surgery. All patients undergoing total knee arthroplasty, total hip arthroplasty, or hip fracture surgery are considered at high risk for VTE. Other surgeries with increased risk of VTE include abdominal surgery, pelvic surgery, cancer surgery, and major trauma surgery. Risk is variable and patient-related factors are considered in conjunction with the surgical procedure. Common patient risk factors include increasing age, prior VTE, malignancy, pregnancy, and significant comorbidities. Increased risk of bleeding is a contraindication to anticoagulation as are adverse effects and allergic reactions. There are procedures, notably some neurologic surgeries, for which pharmacologic prophylaxis (i.e., anticoagulation) is avoided.
Summary of Evidence

The evidence for home use of a limb compression device as an adjunct to anticoagulation in individuals who have moderate-to-high postsurgical risk of VTE and no contraindication to pharmacologic prophylaxis includes no randomized controlled trials (RCTs) that assess whether there is incremental benefit to home use of a limb compression device plus pharmacologic agents. Relevant outcomes are overall survival, symptoms, morbid events, and treatment-related morbidity. Four meta-analyses of RCTs compared medication plus intermittent pneumatic compression versus medication alone in surgical patients in hospital. These studies do not permit inference to the postdischarge home setting. Results of the meta-analyses suggest that in-hospital addition of limb compression devices to pharmacologic management improves DVT prophylaxis. Limitations are: not distinguishing between asymptomatic and symptomatic DVT; sparse data on pulmonary embolism PE; and results generally not stratified by patient risk or specific intervention. Moreover, the postdischarge setting differs in important respects from the hospital setting. Discharged patients tend to be healthier than those in hospital. Factors such as treatment consistency, duration, and application errors in use differ in the home. The evidence is insufficient to determine the effects of the technology on health outcomes.

The evidence for home use of a limb compression device in individuals who have moderate-to-high postsurgical risk of VTE and contraindication to pharmacologic prophylaxis includes a meta-analysis of inpatients and a study assessing whether use of postdischarge limb compression in the home setting improves the net health outcome compared to no prophylaxis. Relevant outcomes are overall survival, symptoms, morbid events, and treatment-related morbidity. The meta-analysis showed significantly less incidence of DVT (40 RCTs) and PE (26 RCTs) with limb compression. Despite limitations related to stratification of patient risk and pharmacologic prophylaxis, the meta-analysis shows that limb compression is superior to no prophylaxis. A study of postdischarge use of a limb compression device combined with home visits showed that home use is feasible. With postdischarge planning and support, home use of limb compression devices in moderate-to-high risk patients who have contraindication to pharmacologic prophylaxis is likely to improve VTE prevention. The evidence is sufficient to determine qualitatively that the technology results in a meaningful improvement in the net health outcome.

Policy

Postsurgical home use of limb compression devices for venous thromboembolism (VTE) prophylaxis may be considered medically necessary in patients with a contraindication to pharmacologic agents, (see Policy Guidelines), in the following situations:

- After major orthopedic surgery (total hip arthroplasty, total knee arthroplasty, hip fracture surgery); OR
- After major nonorthopedic surgery or other orthopedic procedures in patients who are at moderate or high risk of VTE (see Policy Guidelines).

Postsurgical home use of limb compression devices for VTE prophylaxis is considered investigational in all other situations, including but not limited to:

- After major orthopedic surgery (total hip arthroplasty, total knee arthroplasty, hip fracture surgery) in patients without a contraindication for anticoagulation; OR
- After major nonorthopedic surgery or other orthopedic procedures in patients without a contraindication for anticoagulation who are at moderate or high risk of VTE (see Policy Guidelines).

Postsurgical home use of limb compression devices for VTE prophylaxis for periods longer than 30 days postsurgery is not medically necessary.
Policy Guidelines

This section reviews guidance on contraindications to use of anticoagulants, determining risk for bleeding, determining risk for VTE, and duration of treatment postoperatively.

Contraindications to Anticoagulants

The main contraindication to anticoagulants is a high risk of bleeding. However, there is no absolute threshold at which anticoagulants cannot be used. Rather, there is a risk-benefit continuum that takes into account benefits of treatment and risks of bleeding. There may also be intolerance to specific agents, although this is uncommon. Intolerance may result from allergic reactions or adverse effects. Finally, when heparin preparations are used, serum antibodies and heparin-induced thrombocytopenia can develop, precluding further use of heparin products.

Guidance on Determining High Risk for Bleeding

American College of Chest Physicians (ACCP) guidelines on prevention of VTE in orthopedic surgery patients list the following general risk factors for bleeding (Falck-Ytter et al, 2012):

- “Previous major bleeding (and previous bleeding risk similar to current risk)
- Severe renal failure
- Concomitant antiplatelet agent
- Surgical factors: history of or difficult-to-control surgical bleeding during the current operative procedure, extensive surgical dissection, and revision surgery”

The guidelines note, however, that “…specific thresholds for using mechanical compression devices or no prophylaxis instead of anticoagulant thromboprophylaxis have not been established.”

A clinical guideline from the American Academy of Orthopaedic Surgeons (2011) states:

“Patients undergoing elective hip or knee arthroplasty are at risk for bleeding and bleeding-associated complications. In the absence of reliable evidence, it is the opinion of this work group that patients be assessed for known bleeding disorders like hemophilia and for the presence of active liver disease which further increase the risk for bleeding and bleeding-associated complications. (Grade of Recommendation: Consensus) Current evidence is not clear about whether factors other than the presence of a known bleeding disorder or active liver disease increase the chance of bleeding in these patients, and therefore, the work group is unable to recommend for or against using them to assess a patient’s risk of bleeding. (Grade of Recommendation: Inconclusive).”

Guidance on Duration of Use

In patients with contraindications to pharmacologic prophylaxis who are undergoing major orthopedic surgery (total hip arthroplasty, total knee arthroplasty, hip fracture surgery), the ACCP guidelines are consistent with use of intermittent limb compression devices for 10 to 14 days after surgery (Falck-Ytter et al, 2012). The ACCP suggestion on extended prophylaxis (up to 35 days) was a weak recommendation that did not mention limb compression devices as an option.

In the ACCP guideline on VTE prophylaxis in patients undergoing nonorthopedic surgery, the length of standard duration or “limited duration” prophylaxis was not defined. However, “extended duration” pharmacologic prophylaxis was defined as four weeks; this was recommended only for patients at high risk for VTE undergoing abdominal or pelvic surgery for cancer and not otherwise at high risk for major bleeding complications.

Guidance on Risk Level for Patients Undergoing Nonorthopedic Surgery

The ACCP guidelines on prevention of VTE in nonorthopedic surgery patients included the following discussion of risk levels (Gould et al, 2012):
“In patients undergoing general and abdominal-pelvic surgery, the risk of VTE varies depending on both patient-specific and procedure-specific factors. Examples of relatively low-risk procedures include laparoscopic cholecystectomy, appendectomy, transurethral prostatectomy, and inguinal herniorrhaphy. Open abdominal and open-pelvic procedures are associated with a higher risk of VTE. VTE risk appears to be highest for patients undergoing abdominal or pelvic surgery for cancer...

Patient-specific factors also determine the risk of VTE, as demonstrated in several relatively large studies of VTE in mixed surgical populations. Independent risk factors in these studies include age greater than 60 years, prior VTE, and cancer; age ≥ 60 years, prior VTE, anesthesia ≥ two hours, and bed rest ≥ four days; older age, male sex, longer length of hospital stay, and higher Charlson comorbidity score; and sepsis, pregnancy or postpartum state, central venous access, malignancy, prior VTE, and inpatient hospital stay more than two days. In another study, most of the moderate to strong independent risk factors for VTE were surgical complications, including urinary tract infection, acute renal insufficiency, postoperative transfusion, perioperative myocardial infarction, and pneumonia.”

The American College of Obstetricians and Gynecologists (ACOG) proposed the following risk classification for VTE in patients undergoing major gynecological surgery:

**Low:** Surgery lasting less than 30 minutes in patients younger than 40 years with no additional risk factors.

**Moderate:** Surgery lasting less than 30 minutes in patients with additional risk factors; surgery lasting less than 30 minutes in patients age 40 to 60 years with no additional risk factors; major surgery in patients younger than 40 years with no additional risk factors.

**High:** Surgery lasting less than 30 minutes in patients older than 60 years or with additional risk factors; major surgery in patients older than 40 years or with additional risk factors.

**Highest:** Major surgery in patients older than 60 years plus prior venous thromboembolism, cancer, or hypercoagulable state.”

**Background**

Antithrombotic prophylaxis is recommended for surgical patients who are at moderate-to-high risk of postoperative VTE, including DVT and PE. Patients may be classified as moderate-to-high risk of VTE based on the surgical procedure and/or patient characteristics. For some types of surgery, such as major orthopedic surgery, there is a particularly high risk of VTE due to the nature of the procedure and the prolonged immobility during and after surgery. The specific orthopedic procedures of concern are total knee arthroplasty, total hip arthroplasty, and hip fracture surgery. For these surgeries, all patients undergoing the procedure are considered at high risk for VTE.

Other surgeries that have increased risk of VTE include abdominal surgery, pelvic surgery, cancer surgery, and surgery for major trauma. For these types of surgeries, the risk is variable. There are numerous patient-related risk factors such as increasing age, prior VTE, malignancy, pregnancy, and significant comorbidities that can be used in conjunction with the type of surgery to determine risk. There are tools for assessing VTE risk in surgical patients, such as the modified Caprini Risk Assessment Model that was used in developing the American College of Chest Physicians (ACCP) guidelines on VTE prevention. However, in clinical practice, this and similar instruments are not regarded as definitive for assessment of individual patient risk. Pharmacologic prophylaxis is indicated for patients at moderate-to-high risk for VTE. As described in the ACCP guidelines, there are preferred antithrombotic prophylaxis regimens according to procedure and patient risk characteristics.\(^1\)\(^2\)

Pharmacologic prophylaxis is effective at reducing postoperative VTE, but also has risks. The main risk is bleeding, although other adverse effects such as allergic reactions and development of heparin antibodies can
occur. Contraindications to pharmacologic prophylaxis include previous intolerance to these agents and increased risk of bleeding. Most patients undergoing major surgery will not have an increased risk of bleeding precluding use of anticoagulants, because these patients would also likely have had a contraindication to the surgery itself and, thus, are likely to avoid the procedure. However, there are some cases in which patients with a high bleeding risk will undergo major surgery, such as patients with severe renal failure who require an essential procedure. Other patients may develop contraindications during the episode of care. For example, patients who have excessive bleeding during or after surgery, or patients who develop bleeding complications such as a gastrointestinal bleed, will subsequently have a contraindication to anticoagulants. There are a few surgeries for which anticoagulants are contraindicated or avoided, most notably some neurosurgery procedures. Assessment and quantitation of bleeding risk can be performed using instruments such as HAS-BLED scoring system, although these tools were not developed specifically for the postoperative period.

Major orthopedic surgeries have high risk of DVT due to venous stasis of the lower limbs as a consequence of immobility during and after surgery. In addition, direct venous wall damage associated with the surgical procedure itself may occur. DVTs are frequently asymptomatic and generally resolve when mobility is restored. However, some episodes of acute DVT can be associated with substantial morbidity and mortality. The most serious adverse consequence of acute DVT is PE, which can be fatal; this occurs when the DVT detaches and migrates to the lungs. In addition, DVT may produce long-term vascular damage that leads to chronic venous insufficiency. Without thromboprophylaxis, the incidence of venographically detected DVT is approximately 42% to 57% after total hip replacement, and the risk of PE is approximately 1% to 28%. Other surgical patients may be at increased risk of VTE during and after hospitalization. For example, it is estimated that rates of VTE without prophylaxis after gynecologic surgery are 15% to 40%.

Thus, antithrombotic prophylaxis is recommended for patients undergoing major orthopedic surgery and other surgical procedures who are at increased risk of VTE. For patients undergoing major orthopedic surgery, 2012 clinical practice guidelines published by ACCP recommended that one of several pharmacologic agents or mechanical prophylaxis be provided rather than no thromboprophylaxis. The guidelines further recommend use of pharmacologic prophylaxis during hospitalization, whether or not patients are using a limb compression device. A minimum of 10 to 14 days of prophylaxis is recommended, a portion of which can be postdischarge home use.

The ACCP guidelines noted that compliance is a major issue with home use of limb compression devices for thromboprophylaxis and recommend that, if this prophylactic option is selected, use should be limited to portable, battery-operated devices. Moreover, ACCP recommended that devices be used for 18 hours a day. A 2009 nonrandomized study found that there was better compliance with a portable battery-operated limb compression device than with a nonmobile device when used by patients in the hospital following hip or knee replacement surgery.

ACCP also issued guidelines on VTE prophylaxis in nonorthopedic surgery patients. For patients undergoing general or abdominal-pelvic surgery who have a risk of VTE of 3% or higher, ACCP recommends prophylaxis with pharmacologic agents or intermittent pneumatic compression rather than no prophylaxis. For patients at low risk for VTE (≈ 1.5%), the guidelines suggest mechanical prophylaxis. Unlike the guidelines on major orthopedic surgery, which recommend a minimum of 10 to 14 days of VTE prophylaxis, the guidelines on nonorthopedic surgery patients do not include a general timeframe for prophylaxis. They do, however, define “extended duration” pharmacologic prophylaxis as lasting four weeks; the latter is recommended only for patients at high risk for VTE, undergoing abdominal or pelvic surgery for cancer, and who are not otherwise at high risk for major bleeding complications.

National clinical guidelines have not specifically recommended use of limb compression devices in the postdischarge home setting. However, given the availability of portable, battery-operated devices, there is interest in
home use of limb compression devices for VTE prevention following discharge from the hospital for major orthopedic and nonorthopedic surgery.

**Regulatory Status**

Various pneumatic and peristaltic limb compression devices have been approved by the U.S. Food and Drug Administration (FDA) through the premarket approval process for indications including prevention of DVT. Portable devices cleared by FDA include:

- **Venowave™ VW5** (Venowave, Stouffville, ON): This peristaltic pump is strapped to the leg below the knee. It is powered using a single NiMH AA battery.
- **ActiveCare®+S.F.T. System** (Medical Compression Systems, Or Akiva, Israel): The device applies sequential pneumatic compression to the lower limb; it has the option of being battery-operated. Foot compression is achieved with use of a single-celled foot sleeve. Calf and thigh compression requires use of a three-celled cuff sleeve.
- **Restep® DVT System** (Stortford Medical, West Windsor, NJ): This lightweight device uses single-chamber pressure cuffs attached to the patient’s lower legs.
- **Kendall SCD™ 700 Sequential Compression System** (Covidien, Mansfield, MA): This pneumatic compression device can be used in the clinic or at home. It has a battery-operated option.

**Related Protocol**

Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers

Services that are the subject of a clinical trial do not meet our Technology Assessment Protocol criteria and are considered investigational. *For explanation of experimental and investigational, please refer to the Technology Assessment Protocol.*

It is expected that only appropriate and medically necessary services will be rendered. We reserve the right to conduct prepayment and postpayment reviews to assess the medical appropriateness of the above-referenced procedures. **Some of this Protocol may not pertain to the patients you provide care to, as it may relate to products that are not available in your geographic area.**

**References**

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