Policy
Blue Cross and Blue Shield of Kansas City (Blue KC) will provide coverage for postsurgical outpatient use of limb compression devices when it is determined to be medically necessary because the criteria shown below are met.

When Policy Topic is covered
Postsurgical outpatient use of limb compression devices for venous thromboembolism (VTE) prophylaxis may be considered medically necessary in patients with a contraindication to pharmacologic agents (see Considerations), 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 Considerations).

When Policy Topic is not covered
Postsurgical 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 Considerations).

Postsurgical use of limb compression devices for VTE prophylaxis for periods longer than 30 days postsurgery is not medically necessary.
Considerations
For purposes of this policy, “major orthopedic surgery” includes total hip arthroplasty, total knee arthroplasty, or hip fracture surgery.

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 thrombocytosis can develop, precluding further use of heparin products.

Guidance on determining high risk for bleeding
The ACCP guidelines on prevention of VTE in orthopedic surgery patients list the following general risk factors for bleeding:
- 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.”

The 2016 ACCP guidelines addressing antithrombotic therapy for VTE disease outlined risk factors for bleeding with anticoagulant therapy and estimated the risks of major bleeding for patients in various risk categories (see Table PG1) (Kearon et al, 2016).

Risk factors include (1 point per risk factor):
- “Age >65 y
- Age >75y
- Previous bleeding
- Cancer
- Metastatic cancer
- Renal failure
- Liver failure
- Thrombocytopenia
- Previous stroke
- Diabetes
- Anemia
- Antiplatelet therapy
- Poor anticoagulant control
• Comorbidity and reduced functional capacity
• Recent surgery
• Alcohol abuse
• Nonsteroidal anti-inflammatory drug.”

Table PG1: ACCP Guidelines for Risk of Bleeding (Adapted From Kearon et al, 2016)

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Estimated Absolute Risk of Major Bleeding</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low Risk (0 Risk Factors)</td>
</tr>
<tr>
<td>Anticoagulation 0-3 mo, %</td>
<td></td>
</tr>
<tr>
<td>Baseline risk</td>
<td>0.6</td>
</tr>
<tr>
<td>Increased risk</td>
<td>1.0</td>
</tr>
<tr>
<td>Total risk</td>
<td>1.6</td>
</tr>
<tr>
<td>Anticoagulation after first 3 mo, %/y</td>
<td></td>
</tr>
<tr>
<td>Baseline risk</td>
<td>0.3</td>
</tr>
<tr>
<td>Increased risk</td>
<td>0.5</td>
</tr>
<tr>
<td>Total risk</td>
<td>0.8</td>
</tr>
</tbody>
</table>

ACCP: American College of Chest Physicians.

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 (THA, TKA or HFS), the ACCP guidelines are consistent with use of intermittent compression devices for 10-14 days after surgery. The ACCP suggestion on extended prophylaxis (up to 35 days) was a weak recommendation that did not mention compression devices as an option.

In the ACCP guideline on VTE prophylaxis in patients undergoing non-orthopedic surgery, the length of standard duration or "limited duration" prophylaxis was not defined. However, “extended duration” pharmacologic prophylaxis was defined as 4 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 non-orthopedic surgery

The ACCP guidelines on prevention of VTE in non-orthopedic surgery patients included the following discussion of risk levels:

“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, inguinal herniorrhaphy, and unilateral or bilateral mastectomy. 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 at least 60 years, prior VTE, and cancer; age >60 years, prior VTE, anesthesia at least 2 h, and bed rest at least 4 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 2 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 (available online at: http://guidelines.gov/content.aspx?id=11429):

**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 40-60 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 molecular hypercoagulable state.
Antithrombotic prophylaxis is recommended for surgical patients at moderate-to-high risk of postoperative venous thromboembolism (VTE), including deep vein thrombosis (DVT) and pulmonary embolism (PE), 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. 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. Limb compression devices have been used as an adjunct or alternative to anticoagulation in the home setting for patients in the postoperative period as a method to reduce VTEs.

For individuals who have moderate-to-high postsurgical risk of VTE and no contraindication to pharmacologic prophylaxis who receive home use of a limb compression device as an adjunct to anticoagulation, the evidence includes no randomized controlled trials (RCTs) assessing any incremental benefit of 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 have compared medication plus intermittent pneumatic compression to medication alone in surgical patients in hospital. These studies do not permit inferences to the postdischarge home setting. Results of the meta-analyses have suggested 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 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.

For individuals who have moderate-to-high postsurgical risk of VTE and contraindication to pharmacologic prophylaxis who receive home use of a limb
compression device, the evidence includes a meta-analysis of inpatients and a study comparing use of postdischarge limb compression in the home setting 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 showed 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 that the technology results in a meaningful improvement in the net health outcome.

**Background**

**Risk of Venous Thromboembolism**

**Orthopedic Surgery**

Antithrombotic prophylaxis is recommended for surgical patients 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, 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 with an increased risk of VTE include abdominal surgery, pelvic surgery, cancer surgery, and surgery for major trauma. For these types of surgeries, the risk varies. 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 used in developing the 2012 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**

Pharmacologic prophylaxis is effective at reducing postoperative VTE, but also has risks. The main risk is bleeding, although other adverse events 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 the 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, are considered to have a contraindication to anticoagulants. There are a few surgeries for which anticoagulants are contraindicated or avoided, most notably some neurosurgical 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 a high risk of DVT due to venous stasis of the lower limbs as a consequence of immobility during and after surgery. Also, 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. PE occurs when a DVT blood clot detaches and migrates to the lungs. Also, 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 recommended the 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.

**Limb Compression Prophylaxis**

The ACCP guidelines have also noted that compliance is a major issue with the home use of limb compression devices for thromboprophylaxis and recommended 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.6

Nonorthopedic Surgery

Pharmacologic and Limb Compression Prophylaxis
ACCP also issued guidelines (2012) on VTE prophylaxis in nonorthopedic surgery patients.2 For patients undergoing general or abdominal-pelvic surgery who have a risk of VTE of 3% or higher, ACCP has recommended prophylaxis with pharmacologic agents or intermittent pneumatic compression rather than no prophylaxis. For patients at low risk for VTE (»1.5%), the guidelines have suggested 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 have, however, defined “extended duration” pharmacologic prophylaxis as lasting 4 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 the use of limb compression devices in the postdischarge home setting. However, given the availability of portable, battery-operated devices, there is interest in the home use of limb compression devices for VTE prevention following discharge from the hospital for major orthopedic and nonorthopedic surgery.

Regulatory Status
A large number of pneumatic and peristaltic limb compression devices have been cleared for marketing by the U.S. Food and Drug Administration through the 510(k) process for indications including prevention of DVT. Portable devices cleared by the Food and Drug Administration include (Food and Drug Administration product code: JOW):

- VenaPro™ Vascular Therapy System (InnovaMed Health): This device is battery-powered.
- Venowave™ VW5 (Venowave): This device is battery-powered and strapped to the leg below the knee.
- ActiveCare®+S.F.T. System (Medical Compression Systems): The device applies sequential pneumatic compression to the lower limb; it has the option of being battery-operated. Foot compression is achieved with the use of a single-celled foot sleeve. Calf and thigh compression requires the use of a 3-celled cuff sleeve.
- Restep® DVT System (Stortford Medical): This lightweight device uses single-chamber pressure cuffs attached to the patient’s lower legs.
- Kendall SCD™ 700 Sequential Compression System (Covidien): This pneumatic compression device can be used in the clinic or at home; it has a battery-powered option.
- PlasmaFlow™ (ManaMed): This system is portable, to be used at home or in a clinical setting.
Rationale

The evidence review was created in December 2012 and has been updated regularly with searches of the MEDLINE database. The most recent literature update was performed through January 8, 2018.

Evidence reviews assess the clinical evidence to determine whether the use of a technology improves the net health outcome. Broadly defined, health outcomes are length of life, quality of life, and ability to function including benefits and harms. Every clinical condition has specific outcomes that are important to patients and to managing the course of that condition. Validated outcome measures are necessary to ascertain whether a condition improves or worsens; and whether the magnitude of that change is clinically significant. The net health outcome is a balance of benefits and harms.

To assess whether the evidence is sufficient to draw conclusions about the net health outcome of a technology, 2 domains are examined: the relevance and the quality and credibility. To be relevant, studies must represent one or more intended clinical use of the technology in the intended population and compare an effective and appropriate alternative at a comparable intensity. For some conditions, the alternative will be supportive care or surveillance. The quality and credibility of the evidence depend on study design and conduct, minimizing bias and confounding that can generate incorrect findings. The randomized controlled trial (RCT) is preferred to assess efficacy; however, in some circumstances, nonrandomized studies may be adequate. RCTs are rarely large enough or long enough to capture less common adverse events and long-term effects. Other types of studies can be used for these purposes and to assess generalizability to broader clinical populations and settings of clinical practice.

Moderate-to-High Postsurgical Risk of Venous Thromboembolism and No Contraindication to Pharmacologic Prophylaxis

This section focuses on evidence that postdischarge use of limb compression devices in addition to pharmacologic agents provide an incremental benefit to the net health outcome compared with pharmacologic agents alone. The ideal study design to address patients with moderate-to-high postsurgical risk of venous thromboembolism (VTE) and no contraindication to pharmacologic prophylaxis is a superiority RCT comparing VTE prophylaxis plus pharmaceutical agents and limb compression devices with pharmacologic agents alone. No RCTs with this study design were identified for patients discharged after major orthopedic surgery or other types of major surgery. There are, however, RCTs and meta-analyses of RCTs comparing medication plus compression devices with medication alone in surgical patients in the hospital setting. These studies may not permit inferences to the postdischarge home setting. Meta-analyses of RCTs are described next.

Kakkos et al (2016) reported on a Cochrane review that compared the efficacy of combined intermittent pneumatic compression (IPC) plus pharmacologic prophylaxis with single therapies alone in preventing VTE, updating a review
initially published in 2008. Overall, 22 trials (total N=9137 patients) were included, of which 15 were RCTs (n=7762). For the comparison of IPC plus pharmacologic therapy with pharmacologic therapy alone, 10 studies evaluated the effect of combined therapies on the incidence of symptomatic pulmonary embolism (PE), 11 studies evaluated the effect on the incidence of deep vein thrombosis (DVT), and 5 studies evaluated the effect on the incidence of symptomatic DVT. The primary pooled study results are summarized in Table 1.

Table 1. IPC Plus Pharmacologic Therapy vs Pharmacologic Therapy

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Trials</th>
<th>N</th>
<th>IPC + Pharmacologic Tx</th>
<th>Pharmacologic Tx</th>
<th>Pooled OR</th>
<th>95% CI</th>
<th>I²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulmonary embolus</td>
<td>10</td>
<td>3544</td>
<td>1.20% (22/1833)</td>
<td>2.92% (50/1711)</td>
<td>0.39</td>
<td>0.23 to 0.64</td>
<td>0%</td>
</tr>
<tr>
<td>DVT</td>
<td>11</td>
<td>2866</td>
<td>2.9% (41/1414)</td>
<td>6.2% (90/1452)</td>
<td>0.42</td>
<td>0.18 to 1.03</td>
<td>68%</td>
</tr>
<tr>
<td>Symptomatic DVT</td>
<td>5</td>
<td>2312</td>
<td>0.43% (5/1155)</td>
<td>0.43% (5/1157)</td>
<td>1.02</td>
<td>0.29 to 3.54</td>
<td>0%</td>
</tr>
</tbody>
</table>


a Values are % (n/N).

These findings were similar in subgroup analyses by surgical type, including orthopedic surgeries. The risk of bias in the selected studies was generally unclear or high. Overall, reviewers concluded that combined modalities for VTE prophylaxis were more effective than single modalities. Although the risks for bias were high, the findings of the meta-analysis were consistent with those of previous studies.

A meta-analysis by O’Connell et al (2016) included 9 RCTs (total N=3347 patients) comparing IPC, with or without pharmacologic therapy, to pharmacologic agent alone in orthopedic and neurologic surgical patients. Six studies included patients undergoing major orthopedic surgery. In a pooled analysis of all 9 trials, significantly fewer patients in the IPC group (38/1680 [2.3%]) were diagnosed with DVT than in the control group (89/1667 [5.3%]) (pooled relative risk [RR], 0.49; 95% confidence interval [CI], 0.25 to 0.96; I²=60%). A pooled analysis of 8 studies did not find a significant difference in the rate of PE in the IPC and control groups; however, the total number of events was low (5 [0.6%] in the IPC group vs 7 [0.9%] in the control group), and 5 studies had no PE (pooled RR=0.71; 95% CI, 0.22 to 2.24; I²=2%).

Zareba et al (2014) published a meta-analysis of RCTs comparing compression plus pharmacologic prophylaxis with either intervention alone for postsurgical VTE prevention. Twenty-five studies met inclusion criteria: 13 on orthopedic surgery, 7 on abdominal surgery, 3 on neurosurgery, and 1 on cardiac surgery (the population in the remaining study was not reported). Eleven RCTs (total N=4866 patients) compared pharmacologic prophylaxis plus compression with pharmacologic prophylaxis alone. IPC was used in 5 studies and graduated compression stockings in the other 6. A pooled analysis of 10 studies found that the risk of DVT with pharmacologic prophylaxis plus compression was significantly lower than with pharmacologic prophylaxis alone (5.1% vs 10.4%; RR=0.51; 95% CI, 0.36 to 0.73; I²=11%). In addition, there was a significant between-group difference in the risk of PE (9 studies; RR=0.43; 95% CI, 0.27 to 0.66; I²=0%).
Reviewers noted that the PE analysis was heavily weighted by a large (N=2786 patients) study of patients undergoing cardiac surgery, which provided 69 of 89 total PE events. Four studies reported on symptomatic DVT. A pooled analysis did not find a significant difference between groups in risk of symptomatic DVT (4 studies; pooled RR=0.39; 95% CI, 0.05 to 2.90; \( I^2=0\% \)).

A systematic review and meta-analysis by Sobieraj et al (2013) included RCTs comparing pharmacologic and mechanical prophylaxis with either treatment alone in patients undergoing major orthopedic surgery.\(^{10}\) Six trials (total N=961 patients) were identified, five of which compared combination prophylaxis with pharmacologic prophylaxis alone. Mechanical prophylaxis included IPCs, venous foot pumps, and graduated compression stockings. A pooled analysis of 4 RCTs found a significantly lower risk of DVT with combination prophylaxis than with pharmacologic prophylaxis alone (RR=0.48; 95% CI, 0.32 to 0.72). In other pooled analyses, there were no significant differences between groups in risk of PE (2 studies), proximal DVT (3 studies), or distal DVT (2 studies).

A meta-analysis by Kakkos et al (2012) focused on patients undergoing hip and knee replacement.\(^{11}\) Six RCTs (total N=1399 patients) were included; four of them compared pharmacologic plus mechanical prophylaxis with pharmacologic prophylaxis alone. Three studies included both hip and knee replacement patients and the fourth included only hip replacement patients. A pooled analysis of 3 trials on total knee replacement found a significantly lower rate of DVT in the combined prophylaxis group (3.7%) than in the pharmacologic prophylaxis only group (18.7%; RR=0.27; 95% CI, 0.08 to 0.89; \( I^2=42\% \)). Similarly, there was a significantly lower risk of DVT with combined prophylaxis when pooling findings of 4 studies on hip replacement (0.9% vs 9.7%; RR=0.17; 95% CI, 0.06 to 0.46; \( I^2=0\% \)).

**Section Summary: Moderate-to-High Postsurgical Risk of Venous Thromboembolism and No Contraindication to Pharmacologic Prophylaxis**

Findings from meta-analyses have suggested that the in-hospital addition of limb compression devices to pharmacologic management improves VTE prophylaxis, especially for prevention of DVTs. Findings related to the risk of PE are more limited because analyses might have been underpowered due to the small number of PE events. RCTs varied regarding patient populations (eg, orthopedic surgery, nonorthopedic surgery, medical patients), compression devices (IPCs, foot pumps, sequential compression devices), cointerventions (eg, compression stockings), duration of follow-up, and outcomes reported. The meta-analyses reported on the risk of DVT, but some did not distinguish between symptomatic DVT, which is more clinically relevant, and asymptomatic (imaging-detected) DVT.

The available evidence also does not address the question of interest to this review: Is there an incremental benefit in the postdischarge setting by adding limb compression devices to pharmacologic prophylaxis? The postdischarge setting has important characteristics that preclude making inferences from the inpatient setting. Patient characteristics vary because discharged patients tend to be healthier than those in the hospital. Characteristics of home use also vary (eg,
treatment consistency, duration, application errors in use). RCTs evaluating the addition of limb compression devices to pharmacologic management postdischarge in the home setting are needed to permit conclusions about the incremental benefit of this technology on VTE prophylaxis.

**Moderate-to-High Postsurgical Risk of VTE and a Contraindication to Pharmacologic Prophylaxis**

This section addresses whether postdischarge limb compression device use in moderate-to-high risk patients with a contraindication to pharmacologic prophylaxis improves the net health outcome compared with no postdischarge VTE prophylaxis. The ideal study design is an RCT comparing limb compression devices with no prophylaxis after hospital discharge. However, there may be ethical and practical barriers to conducting such a study, especially in higher risk patients. Alternatively, a network meta-analysis could indirectly compare outcomes of limb compression device use with no VTE prophylaxis. No RCTs or network meta-analyses of postdischarge use in patients with contraindication to pharmacologic prophylaxis were identified.

There is, however, a meta-analysis of RCTs comparing IPC use with placebo in the hospital setting. The meta-analysis was published by Ho and Tan (2013).\(^1\) It included RCTs comparing IPC with no prophylaxis or another type of prophylaxis in hospitalized surgical and nonsurgical patients. As with the meta-analyses reviewed above, there was heterogeneity of participants and interventions. Studies using a no prophylaxis control group might have included lower risk patients and some studies involving higher risk patients also included pharmacologic prophylaxis in both groups. A pooled analysis of 40 RCTs found a significantly lower rate of DVT with IPCs (7.3%) than with placebo (16.7%; RR=0.43; 95% CI, 0.36 to 0.52). Similarly, a pooled analysis of 26 trials found a significantly lower rate of PE with IPC (1.2%) than with placebo (2.8%; RR=0.48; 95% CI, 0.33 to 0.69). Results of the Ho and Tan meta-analysis suggested that IPC devices can be beneficial for VTE prophylaxis in patients with a contraindication to medication.

To draw inferences about the benefit of limb compression devices postdischarge in these patients, the feasibility of home use should be considered. An unblinded RCT by Sobieraj-Teague et al (2012) compared the use of a portable battery-operated IPC device with usual care alone in patients undergoing cranial or spinal neurosurgery.\(^1\) All patients were also prescribed graduated compression stockings and 20% to 25% used anticoagulants. Patients were evaluated at 9 days postsurgery, and those discharged earlier were permitted to use an IPC at home (median duration of hospitalization, 4 days). Patients who used the IPC device postdischarge received home visits at least daily to optimize compliance. Three (4%) of 75 patients in the IPC group and 14 (19%) of 75 patients in the usual care group developed VTE; the difference between groups was statistically significant (p=0.008). Among evaluable patients in the IPC group, 23.3% were continuous users, 53.4% were intermittent users, and 23.3% discontinued use (this includes both inpatient and outpatient use). The mean duration of IPC use was 6.6 days. Findings would suggest that in-home use of IPC devices is feasible with adequate postdischarge planning and support.
**Section Summary: Moderate-to-High Postsurgical Risk of VTE and a Contraindication to Pharmacologic Prophylaxis**

A meta-analysis has supported the conclusion that the use of limb compression devices is superior to placebo for VTE prevention in hospitalized patients. Notably, the incidences of both DVT and PE were significantly lower among patients receiving limb compression. A limitation of the meta-analysis is that it did not stratify patients by risk level, nor was pharmacologic prophylaxis absent in all cases. Nonetheless, the inference is supported that in patients with a contraindication to pharmacologic prophylaxis, postdischarge use of limb compression devices is superior for VTE prophylaxis compared with no prophylaxis.

Results of an unblinded RCT, which only enrolled 150 patients and evaluated a single approach to patient support in the home (ie, daily visits by care provider), were consistent with the feasibility of postdischarge home use of limb compression devices. In the U.S. health care system, appropriate postdischarge planning and transition are recognized as critical to reducing readmissions.\(^{14,15}\) When appropriate postdischarge planning and support are in place, the use of limb compression devices in the home in moderate-to-high risk patients with a contraindication to pharmacologic prophylaxis is likely to improve VTE prevention.

**Summary of Evidence**

For individuals who have a moderate-to-high postsurgical risk of VTE and no contraindication to pharmacologic prophylaxis who receive home use of a limb compression device as an adjunct to anticoagulation, the evidence includes no RCTs assessing any incremental benefit of 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 have compared medication plus intermittent pneumatic compression with medication alone in surgical patients in the hospital setting. These trials do not permit inferences to the postdischarge home setting. Results of the meta-analyses have suggested 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; 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 the 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.

For individuals who have a moderate-to-high postsurgical risk of VTE and a contraindication to pharmacologic prophylaxis who receive home use of a limb compression device, the evidence includes a meta-analysis of inpatients and a study comparing the use of postdischarge limb compression in the home setting to no prophylaxis. Relevant outcomes are overall survival, symptoms, morbid events, and treatment-related morbidity. The meta-analysis showed significantly fewer incidence of DVT (40 RCTs) and pulmonary embolism (26 RCTs) with limb
compression. Despite limitations related to stratification of patient risk and pharmacologic prophylaxis, the meta-analysis showed that limb compression is superior to no prophylaxis. A study of the 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 a contraindication to pharmacologic prophylaxis is likely to improve VTE prevention. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

SUPPLEMENTAL INFORMATION

Practice Guidelines and Position Statements

American College of Chest Physicians
In 2016, the American College of Chest Physicians (ACCP) updated its 2012 evidence-based guideline, on antithrombotic therapy and prevention of thrombosis. The 2016 update, which addressed antithrombotic therapy for venous thromboembolism (VTE), outlined risk factors for bleeding with anticoagulant therapy and estimated the risks of major bleeding for patients in various risk categories (see Table 2).

Risk factors include (1 point per factor):

- “Age >65 y”
- Age>75y
- Previous bleeding
- Cancer
- Metastatic cancer
- Renal failure
- Liver failure
- Thrombocytopenia
- Previous stroke
- Diabetes
- Anemia
- Antiplatelet therapy
- Poor anticoagulant control
- Comorbidity and reduced functional capacity
- Recent surgery
- Alcohol abuse
- Nonsteroidal anti-inflammatory drug.”
Table 2. Guidelines for Risk of Bleeding

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Estimated Absolute Risk of Major Bleeding</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low Risk (0 Risk Factors)</td>
</tr>
<tr>
<td>Anticoagulation 0-3 mo, %</td>
<td></td>
</tr>
<tr>
<td>Baseline risk</td>
<td>0.6</td>
</tr>
<tr>
<td>Increased risk</td>
<td>1.0</td>
</tr>
<tr>
<td>Total risk</td>
<td>1.6</td>
</tr>
<tr>
<td>Anticoagulation after first 3 mo, %/y</td>
<td></td>
</tr>
<tr>
<td>Baseline risk</td>
<td>0.3</td>
</tr>
<tr>
<td>Increased risk</td>
<td>0.5</td>
</tr>
<tr>
<td>Total risk</td>
<td>0.8</td>
</tr>
</tbody>
</table>

Adapted from Kearon et al (2016).17

In its updated 2012 guidelines on antithrombotic therapy and prevention of VTE in patients undergoing orthopedic and nonorthopedic surgery, ACCP recommended use of limb compression devices in orthopedic surgical patients:

2.1.1 “In patients undergoing total hip arthroplasty (THA) or total knee arthroplasty (TKA), we recommend use of one of the following for a minimum of 10 to 14 days rather than no antithrombotic prophylaxis: low-molecular-weight heparin (LMWH), fondaparinux, apixaban, dabigatran, rivaroxaban, low-dose unfractionated heparin (LDUH), adjusted-dose vitamin K antagonist (VKA), aspirin (all Grade 1B), or an intermittent pneumatic compression device (IPCD) (Grade 1C).”

2.1.2 “In patients undergoing hip fracture surgery (HFS), we recommend use of one of the following rather than no antithrombotic prophylaxis for a minimum of 10 to 14 days: LMWH, fondaparinux, LDUH, adjusted-dose VKA, aspirin (all Grade 1B), or an IPCD (Grade 1C).”

2.5 “In patients undergoing major orthopedic surgery, we suggest using dual prophylaxis with an antithrombotic agent and an IPCD during the hospital stay (Grade 2C).”

2.6 “In patients undergoing major orthopedic surgery and increased risk of bleeding, we suggest using an IPCD or no prophylaxis rather than pharmacologic treatment (Grade 2C).”

For all above recommendations related to pneumatic compression pumps, ACCP recommended only portable, battery-powered devices be used and stated that efforts should be made to ensure devices are worn for 18 hours a day. Guidelines
noted that compliance is the biggest challenge with the use of pneumatic compression devices.

ACCP recommendations on the use of limb compression devices in nonorthopedic general and abdominal-pelvic surgical patients, stratified by patient risk of VTE and risk of bleeding are listed in Table 3.2.

Table 3. Recommendations on Limb Compression Device Use in Nonorthopedic General and Abdominal-Pelvic Surgical Patients

<table>
<thead>
<tr>
<th>Patient Risk Group</th>
<th>Recommendation</th>
<th>GOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very low risk (&lt;0.5%)</td>
<td>“[W]e recommend that no specific pharmacologic or mechanical prophylaxis be used other than early ambulation.”</td>
<td>1B</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2C</td>
</tr>
<tr>
<td>Low risk for VTE (≥1.5%)</td>
<td>“[W]e suggest mechanical prophylaxis, preferably with intermittent pneumatic compression (IPC), over no prophylaxis.”</td>
<td>2C</td>
</tr>
<tr>
<td>Moderate risk for VTE (≥3%) and not at high risk of bleeding</td>
<td>“[W]e suggest low-molecular-weight heparin (LMWH), low-dose unfractionated heparin, or mechanical prophylaxis with IPC over no prophylaxis.”</td>
<td>2B</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2B</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2C</td>
</tr>
<tr>
<td>Moderate risk for VTE (≥3%) and high risk for major bleeding complications or in whom bleeding consequences would be particularly severe</td>
<td>“We suggest mechanical prophylaxis, preferably with IPC, over no prophylaxis.”</td>
<td>2C</td>
</tr>
<tr>
<td>High risk for VTE (≥6.0%) and not at high risk of bleeding</td>
<td>“[W]e recommend pharmacologic prophylaxis with LMWH or low-dose unfractionated heparin over no prophylaxis. In these patients, we suggest adding mechanical prophylaxis with elastic stockings or IPC to pharmacologic prophylaxis.”</td>
<td>1B</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1B</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2C</td>
</tr>
<tr>
<td>High risk for VTE (≥6.0%) and high risk for major bleeding complications or in whom bleeding consequences would be particularly severe</td>
<td>“[W]e suggest use of mechanical prophylaxis, preferably with IPC, over no prophylaxis until the risk of bleeding diminishes and pharmacologic prophylaxis may be initiated.”</td>
<td>2C</td>
</tr>
<tr>
<td>High risk for VTE, both LMWH and unfractionated heparin contraindicated or unavailable and not at high risk for major bleeding complications:</td>
<td>“[W]e suggest low-dose aspirin, fondaparinux, or mechanical prophylaxis, preferably with IPC, over no prophylaxis.”</td>
<td>2C</td>
</tr>
<tr>
<td>High risk for VTE, undergoing abdominal or pelvic surgery for cancer and not otherwise at high risk for major bleeding complications</td>
<td>“[W]e recommend extended-duration, postoperative, pharmacologic prophylaxis (4 weeks) with LMWH over limited-duration prophylaxis.”</td>
<td>1B</td>
</tr>
</tbody>
</table>

GOR: grade of recommendation VTE: venous thromboembolism.
Note that a standard duration of prophylaxis was not defined. An “extended-duration” prophylaxis was defined as lasting 4 weeks.

American Academy of Orthopaedic Surgeons
In 2011, the American Academy of Orthopaedic Surgeons updated its guidelines on prevention of VTE in patients undergoing elective hip and knee arthroplasty.18 The guidelines included the following recommendations relevant to this evidence review:

5. “The work group suggests the use of pharmacologic agents and/or mechanical compressive devices for the prevention of venous
thromboembolism in patients undergoing elective hip or knee arthroplasty, and who are not at elevated risk beyond that of the surgery itself for venous thromboembolism or bleeding. (Grade of Recommendation: Moderate) Current evidence is unclear about which prophylactic strategy (or strategies) is/are optimal or suboptimal. Therefore, the work group is unable to recommend for or against specific prophylactics in these patients. (Grade of Recommendation: Inconclusive) In the absence of reliable evidence about how long to employ these prophylactic strategies, it is the opinion of this work group that patients and physicians discuss the duration of prophylaxis. (Grade of Recommendation: Consensus)

6. In the absence of reliable evidence, it is the opinion of this work group that patients undergoing elective hip or knee arthroplasty, and who have also had a previous venous thromboembolism, receive pharmacologic prophylaxis and mechanical compressive devices. (Grade of Recommendation: Consensus)

7. In the absence of reliable evidence, it is the opinion of this work group that patients undergoing elective hip or knee arthroplasty, and who also have a known bleeding disorder (e.g., hemophilia) and/or active liver disease, use mechanical compressive devices for preventing venous thromboembolism. (Grade of Recommendation: Consensus)

American College of Obstetricians and Gynecologists
In 2007 (reaffirmed in 2012), the American College of Obstetricians and Gynecologists updated its practice bulletin on prevention of deep vein thrombosis and pulmonary embolism after gynecologic surgery.5 As with ACCP recommendations discussed above, prophylaxis recommendations varied by patient risk level. For patients at moderate and high risk of deep vein thrombosis, intermittent pneumatic compression was one of the recommended options for deep vein thrombosis prophylaxis. For patients at highest risk (ie, >60 years plus prior VTE, cancer, or molecular hypocoagulable state), intermittent pneumatic compression or graduated compression stockings plus low-dose unfractionated heparin or low-molecular-weight heparin were recommended as prophylactic options. For all but the highest risk patients, the practice bulletin stated that, when intermittent pneumatic compression devices were used, “the devices should be used continuously until ambulation and discontinued only at the time of hospital discharge.” For the highest risk patients, the bulletin stated that continuing prophylaxis for 2 to 4 weeks after discharge should be considered.

American Orthopaedic Foot and Ankle Society
In 2013, the American Orthopaedic Foot and Ankle Society published a position statement on VTE prophylaxis after foot and ankle surgery. It stated that: “There is currently insufficient data for the American Orthopaedic Foot & Ankle Society (AOFAS) to recommend for or against routine VTE prophylaxis for patients undergoing foot and ankle surgery. Further research in this field is necessary and is encouraged.”19.
European Society of Anesthesiology
In 2018, the European Society of Anesthesiology published a series of guidelines on the prevention of VTE, with specific recommendations as listed in Table 4.

Table 4. Recommendations on Prevention of VTE

<table>
<thead>
<tr>
<th>Patient Risk Group</th>
<th>Recommendation</th>
<th>GOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mechanical prophylaxis(^{20})</td>
<td>In patients with contraindications to pharmacologic thromboprophylaxis, IPC is recommended. In patients not at high risk for VTE, IPC is not recommended.</td>
<td>1B</td>
</tr>
<tr>
<td>Elderly patients(^{21})</td>
<td>Multifaceted interventions (pneumatic compression devices and oral anticoagulants) are recommended after knee and hip replacement</td>
<td>1C</td>
</tr>
<tr>
<td>Cardiovascular and thoracic surgery(^{22})</td>
<td>For patients undergoing coronary artery bypass graft and bioprosthetic aortic valve implantation, IPC is recommended. For low-risk patients undergoing thoracic surgery, IPC is recommended. For high-risk patients undergoing thoracic surgery, pharmacologic prophylaxis plus IPC are recommended.</td>
<td>2C</td>
</tr>
<tr>
<td>Neurosurgery(^{23})</td>
<td>Patients undergoing craniotomy or with nontraumatic intracranial hemorrhage, IPC is recommended on admission. In patients with spinal cord injury or significant motor impairment, thromboprophylaxis extended into rehabilitation is suggested.</td>
<td>1C</td>
</tr>
<tr>
<td>Obese patients(^{24})</td>
<td>For patients undergoing bariatric surgery, IPC or anticoagulants recommended for low-risk patients, and IPC plus anticoagulants recommended for high-risk patients.</td>
<td>2C</td>
</tr>
</tbody>
</table>

GOR: grade of recommendation; IPC: intermittent pneumatic compression; VTE: venous thromboembolism.
None of the guidelines specified use of compression devices in the home setting.

U.S. Preventive Services Task Force Recommendations
Not applicable.

Medicare National Coverage
There is no national coverage determination. In the absence of a national coverage determination, coverage decisions are left to the discretion of local Medicare carriers.

Ongoing and Unpublished Clinical Trials
Some currently unpublished trials that might influence this review are listed in Table 5.

Table 5. Summary of Key Trials

<table>
<thead>
<tr>
<th>NCT No.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCT01317160</td>
<td>Compression Treatment Effects on Complications and Healing of Achilles Tendon Rupture</td>
<td>150</td>
<td>Sep 2017 (ongoing)</td>
</tr>
<tr>
<td>NCT02987946(^{a})</td>
<td>Leiden Trial in Prevention of Post-Operative Thromboembolic Events (TIPOTEE)</td>
<td>280</td>
<td>May 2018</td>
</tr>
<tr>
<td>NCT03044574(^{a})</td>
<td>Intermittent Pneumatic Compression in Surgical Patients at Extremely High Risk for Venous Thromboembolism (IPCSUPER)</td>
<td>400</td>
<td>Jul 2018</td>
</tr>
</tbody>
</table>

NCT: national clinical trial.
\(^{a}\) Denotes industry-sponsored or cosponsored trial.
References


Billing Coding/Physician Documentation Information

97016 Application of a modality to 1 or more areas; vasopneumatic devices
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
E0656 Segmental pneumatic appliance for use with pneumatic compressor, trunk
E0657 Segmental pneumatic appliance for use with pneumatic compressor, 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, 2 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
E0676 Intermittent limb compression device (includes all accessories), not otherwise specified
**ICD-10 Codes:**

**M05.051-M05.059; M05.061-M05.069**
- Felty's syndrome, hip and knee code ranges

**M05.151-M05.159; M05.161-M05.169**
- Rheumatoid lung disease with rheumatoid arthritis, hip and knee code ranges

**M05.251-M05.259; M05.261-M05.269**
- Rheumatoid vasculitis with rheumatoid arthritis, hip and knee code ranges

**M05.351-M05.359; M05.361-M05.369**
- Rheumatoid heart disease with rheumatoid arthritis, hip and knee code ranges

**M05.451-M05.459; M05.461-M05.469**
- Rheumatoid myopathy with rheumatoid arthritis, hip and knee code ranges

**M05.551-M05.559; M05.561-M05.569**
- Rheumatoid polyneuropathy with rheumatoid arthritis, hip and knee code ranges

**M05.651-M05.659; M05.661-M05.669**
- Rheumatoid arthritis with involvement of other organs and systems, hip and knee code ranges

**M05.751-M05.759; M05.761-M05.769**
- Rheumatoid arthritis with rheumatoid factor without organ or systems, hip and knee code ranges

**M05.851-M05.859; M05.861-M05.869**
- Other rheumatoid arthritis with rheumatoid factor, hip and knee code ranges

**M06.051-M06.059; M06.061-M06.069**
- Rheumatoid arthritis without rheumatoid factor, hip and knee code ranges

**M06.851-M06.859; M06.861-M06.869**
- Other specified rheumatoid arthritis, hip and knee code ranges

**M08.051-M08.059**
- Unspecified juvenile rheumatoid arthritis, hip and knee code ranges
M08.061-M08.069
M08.251-M08.259; M08.261-M08.269
M08.451-M08.459; M08.461-M08.469
M08.851-M08.859; M08.861-M08.869
M08.951-M08.959; M08.961-M08.969
M12.551-M12.559; M12.559
M12.561-M12.569
M15.0-M15.9
M16.0-M16.9
M17.0-M17.9
M80.051-M80.059
M80.851-M80.859
M84.451-M84.453; M84.459
M84.450-M84.453; M84.459
M84.550-M84.553; M84.559
M84.650-M84.653; M84.659
S72.001A-S72.399S

**Additional Policy Key Words**

N/A
<table>
<thead>
<tr>
<th>Date</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/1/13</td>
<td>New policy; may be considered medically necessary</td>
</tr>
<tr>
<td>4/1/14</td>
<td>“Pneumatic” removed from policy statements and policy title. Major nonorthopedic surgery changed to “major nonorthopedic surgery or nonmajor orthopedic surgery” in 3rd and 4th policy statements. “Postsurgical” added to policy. E0675 removed from code table as it is for arterial insufficiency and this policy is specific to venous thromboembolism</td>
</tr>
<tr>
<td>4/1/15</td>
<td>No policy statement changes.</td>
</tr>
<tr>
<td>4/1/16</td>
<td>No policy statement changes.</td>
</tr>
<tr>
<td>7/1/16</td>
<td>The policy statements and Policy Guidelines section were rewritten for clarity. The intent of the policy statements was unchanged.</td>
</tr>
<tr>
<td>4/1/17</td>
<td>No policy statement changes.</td>
</tr>
<tr>
<td>4/1/18</td>
<td>No policy statement changes.</td>
</tr>
<tr>
<td>4/1/19</td>
<td>No policy statement changes.</td>
</tr>
</tbody>
</table>

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