Policy: MP155
Section: Medical Benefit Policy
Subject: Cooling Devices for Joint Surgery or Injury

I. Policy: Cooling Devices for Joint Surgery or Injury

II. Purpose/Objective:
To provide a policy of coverage regarding Cooling Devices for Joint Surgery or Injury

III. Responsibility:
A. Medical Directors
B. Medical Management

IV. Required Definitions
1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions
Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
c. in accordance with current standards of good medical treatment practiced by the general medical community.
d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment
Medical Necessity shall mean a service or benefit that is compensable under the Medical Assistance Program and if it meets any one of the following standards:

(i) The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
(ii) The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or development effects of an illness, condition, injury or disability.
(iii) The service or benefit will assist the Member to achieve or maintain maximum functional
capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for members of the same age.

DESCRIPTION:
Cooling devices, both passive and active, for use after joint surgery or injury are devices through which fluid flows into a blanket or cuff, providing cooling to an affected area. Passive devices (e.g.; Cryocuff, Polar Care Cub, etc.) utilize an insulated jug filled with cold water attached to a cuff. The cooled water is circulated by gravity by raising and lowering the jug. Active units (e.g. AutoChill, Game Ready, etc) utilize a motorized pump to circulate the cold water and may also incorporate a heating/refrigeration unit and provide pneumatic compression.

EXCLUSIONS: There is insufficient evidence in the published, peer-reviewed medical literature to support that active or passive cooling devices when used to control swelling, edema, hematoma, hemarthrosis and pain provide any additional benefit over conventional ice packs. These devices are considered convenience items, and therefore are NOT COVERED.

Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven is outlined in MP 15 - Experimental Investigational or Unproven Services or Treatment.

CODING ASSOCIATED WITH: Cooling Devices
The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at [www.cms.gov](http://www.cms.gov) or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements.

HCPCS/CPT Codes
E0218 Water circulating cold pad with pump
E0236 Pump for water circulating pad
E0249 Pad for water circulating heat unit.
E1399 Durable medical Equipment, miscellaneous
A9270 Non-covered item or service


LINE OF BUSINESS:
Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD’s and NCD’s will supersede this policy. For PA Medicaid Business segment, this policy applies as written.

REFERENCES:

DMERC A, LCD L5038, Cold Therapy


ECRI Hotline Response (ONLINE) Gravity-Controlled Cold Therapy Devices for Musculoskeletal, Postoperative and Orthopedic Trauma. ECRI Current as of September 11, 2006.


This policy will be revised as necessary and reviewed no less than annually.

Devised: 4/05
Revised: 4/06 (references); 4/07, 1/13
Reviewed: 4/08, 4/09, 10/10, 10/11, 10/12, 1/14, 1/15, 1/16, 1/17, 12/17, 12/18