Cold Therapy Durable Medical Equipment

Origination: 03/18/03	**Revised:** 7/23/20	**Annual Review:** 11/12/24
Line of Business: Commercial Only ☐ QHP/Exchange Only ☐ Medicare Only ☐ Commercial & QHP/Exchange ☐ Commercial, QHP/Exchange, & Medicare ☒		

Purpose:

To provide Cold Therapy Durable Medical Equipment (DME) guidelines specific for Members with chronic and disabling conditions for Population Health and Provider Alliances associates to reference when making benefit determinations.

Background Information:

Definitions

- Cooling devices use chilled water to decrease the local temperature of tissue.
- There are a variety of cooling devices available, ranging from gravity-fed devices that are manually filled with iced water, to motorized units that both cool and circulate the chilled water.
- These devices are typically used when ice packs would normally be applied (e.g., after orthopedic surgical procedures).

Exclusions

- Passive cold compression therapy units (e.g., AirCast Cryo Cuff, AirCast Cryo Strap, the Polar Care Cub unit, and the Polar Pack) are considered investigational and not covered because their effectiveness has not been established. They are considered personal convenience items.
- Active cold compression therapy units with mechanical pumps and portable refrigerators (e.g., AutoChill, Game Ready, IceMan, NanoTherm, Prothermo, and Vascutherm) are considered investigational and not covered because they have not been proven to offer clinically significant benefits over passive cold compression therapy units.
- The Hot/Ice Machine and similar devices (e.g., the Hot/Ice Thermal Blanket, the TEC Thermoelectric Cooling System, the VitalWear Cold/Hot Wrap, and the VitalWrap) are considered investigational and not covered for reducing pain and swelling after surgery or injury as studies have failed to show that the Hot/Ice Machine offers any benefit over standard cryotherapy with ice bags/packs.
- Codes affected: E0218, E0236

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References:

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Disclaimer Information:

Coverage Issues Guidelines and Medical Technology Assessment Recommendations are developed to determine coverage for AvMed's benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. AvMed makes coverage decisions using these guidelines, along with the Member's benefit document. The use of this guideline is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated.

Coverage Issues Guidelines and Medical Technology Assessment Recommendations are developed for selected therapeutic or diagnostic services found to be safe, but proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the AvMed service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations.

Treating providers are solely responsible for the medical advice and treatment of Members. This guideline may be updated and therefore is subject to change.