MEDICAL COVERAGE POLICY	
SERVICE: Cold Therapy Devices	
Policy Number:	**035**
Effective Date:	**11/01/2020**
Last Review:	**09/24/2020**
Next Review Date:	**09/24/2021**

Important note:
Unless otherwise indicated, this policy will apply to all lines of business.
Even though this policy may indicate that a particular service or supply may be considered medically necessary and thus covered, this conclusion is not based upon the terms of your particular benefit plan. Each benefit plan contains its own specific provisions for coverage and exclusions. Not all benefits that are determined to be medically necessary will be covered benefits under the terms of your benefit plan. You need to consult the Evidence of Coverage (EOC) or Summary Plan Description (SPD) to determine if there are any exclusions or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and your plan of benefits, the provisions of your benefits plan will govern. However, applicable state mandates will take precedence with respect to fully insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, Federal mandates will apply to all plans. With respect to Medicare-linked plan members, this policy will apply unless there are Medicare policies that provide differing coverage rules, in which case Medicare coverage rules supersede guidelines in this policy. Medicare-linked plan policies will only apply to benefits paid for under Medicare rules, and not to any other health benefit plan benefits. CMS's Coverage Issues Manual can be found on the CMS website. Similarly, for Medicaid-linked plans, the Texas Medicaid Provider Procedures Manual (TMPPM) supersedes coverage guidelines in this policy where applicable.

SERVICE: Cold Therapy Devices

PRIOR AUTHORIZATION: Not applicable.

POLICY: Please review the plan's EOC (Evidence of Coverage) or Summary Plan Description (SPD) for coverage details.

For Medicare plans, please refer to appropriate Medicare LCD (Local Coverage Determination). If there is no applicable LCD, use the criteria set forth below.

For Medicaid plans, please confirm coverage as outlined in the Texas Medicaid TMPPM.

SWHP/FirstCare considers the use of cryogenic machines attached to insulated blankets, or water circulating cold pads (i.e., Polar Care Cold Therapy), or Cold packs (ice, gel, chemical, etc.), or vaso-pneumatic cryotherapy devices (e.g., Game Ready™ which delivers active compression and cold therapy and runs on AC power or optional battery pack) to be alternative methods of delivery of cold therapy which provide additional convenience for cold therapy, but have not been shown to improve outcomes beyond traditional cold compresses, and are therefore **NOT** medically necessary.

OVERVIEW:

Cold therapy is used for the following:

- post-operatively (e.g., after total knee replacement or hip arthroplasty or anterior cruciate ligament repair),
- immediately following injury,
- before or after physical therapy sessions, or
- for typical athletic cold therapy sessions in order to lower skin temperature and reduce swelling thus decrease bleeding and possibly reduce pain medication requirements.

Methods of administering cold therapy include:

- Cryogenic Machines attached to insulated blankets, or
- Water circulating cold pads (i.e., Polar Care Cold Therapy), or
- Cold packs (ice, gel, chemical, etc.), or
- Vasopneumatic cryotherapy devices (e.g., Game Ready ™), (delivers active compression

and cold therapy and runs on AC power or optional battery pack).

Cold therapy, particularly post-operative cold therapy, is a standard treatment modality which can be provided by a variety of methods. None has been demonstrated in clinical trials to demonstrate health benefit over others, or over simple compress.

These are items are primarily used for the convenience of the patient:

- Water circulating cold pads (i.e., Polar Care Pads) or a Cryogenic machine attached to an insulated disposable blanket or similar products are considered convenience items since the same outcome can be achieved with over the counter cold packs.
- Cold Packs are not considered DME and can be purchased over the counter without a prescription.

MANDATES: None

CODES:

Important note:
CODES: Due to the wide range of applicable diagnosis codes and potential changes to codes, an inclusive list may not be presented, but the following codes may apply. Inclusion of a code in this section does not guarantee that it will be reimbursed, and patient must meet the criteria set forth in the policy language.

CPT Codes:	
CPT Not Covered:	
ICD-10 codes:	
ICD-10 Not covered:	
HCPCS Codes Not covered:	E0218

CMS: No NCDs or LCDs have been issued.

POLICY HISTORY:

Status	Date	Action
New	12/6/2010	New policy
Reviewed	12/6/2011	Reviewed.
Reviewed	10/5/2012	Reviewed with minor revisions.
Reviewed	10/3/2013	No changes
Reviewed	07/24/2014	No changes
Reviewed	08/11/2015	No changes
Reviewed	08/18/2016	No changes
Reviewed	08/08/2017	Updated HCPCS codes and references
Reviewed	05/29/2018	No changes
Reviewed	08/22/2019	No changes
Reviewed	09/24/2020	Re-formatted for SWHP/FirstCare

REFERENCES:

The following scientific references were utilized in the formulation of this medical policy. SWHP/FirstCare will continue to review clinical evidence related to this policy and may modify it at a later date based upon the evolution of the published clinical evidence. Should additional scientific studies become available and they are not included in the list, please forward the reference(s) to SWHP/FirstCare so the information can be reviewed by the Medical

Coverage Policy Committee (MCPC) and the Quality Improvement Committee (QIC) to determine if a modification of the policy is in order.

2. Daniel, D.M., Stone, M.L., et al. The effect of cold therapy on pain, swelling, and range of motion after anterior cruciate ligament reconstructive surgery. Arthroscopy (1994 October) 10(5): 530-3.
3. Leutz, D.W., H. Harris. Continuous cold therapy in total knee arthroplasty. American Journal of Knee Surgery (1995 Fall) 8(4): 121-3.
5. American Journal of Orthopedics (1995 November) 24(11): 847-52.
6. Konrath, G.A., T. Lock.: The use of cold therapy after anterior cruciate ligament reconstruction. The American Journal of Sports Medicine (1996 September-October) 24(5): 629-33.
7. Konrath, G.A.,T. Lock. The use of cold therapy in the post-operative management of patients undergoing arthroscopic anterior cruciate ligament reconstruction The American Journal of Sports Medicine (1996 March-April) 24(2): 193-5.
8. Barber, F.A., McGuire, D.A., et al. Continuous flow cold therapy for outpatient anterior cruciate ligament reconstruction. Arthroscopy (1998 March) 14(2): 130-5.
9. Palmetto GBA, DMERC, Medical Policy: Cold Therapy. (2003 Spring) Revision, 1-6.
10. Airaksinen, O.V., Kyeklund, N., et al. Efficacy of cold gel for soft tissue injuries: a prospective randomized double-blinded trial. American Journal of Sports Medicine (2003 September-October) 31(5): 680-4.
11. Block, Jon E.: Cold and compression in the management of musculoskeletal injuries and orthopedic operative procedures: a narrative review. Open Access J Sports Med. 2010: 1: 105-113. Published online 2010 Jul 7.
12. Kuyucu, Ersin et al. “Is Cold Therapy Really Efficient after Knee Arthroplasty?” Annals of Medicine and Surgery 4.4 (2015): 475–478. PMC. Web. 21 July 2017.