Continuous Passive Motion for Knees and Lumbar Spine

Based on Medicare National Coverage Determinations (NCD) for Durable Medical Equipment (DME) Reference List (280.1) and Noridian Medicare Website

For any item to be covered by The Health Plan, it must:

1. Be eligible for a defined Medicare or The Health Plan benefit category
2. Be reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member
3. Meet all other applicable Medicare and/or The Health Plan statutory and regulatory requirements

For the items addressed in this medical policy, the criteria for "reasonable and necessary" are defined by the following indications and limitations of coverage and/or medical necessity. *Please refer to individual product lines certificates of coverage for possible exclusions of benefit.*

For an item to be covered by The Health Plan, the supplier must receive a written, signed, and dated order before a claim is submitted to The Health Plan. If the supplier bills for an item addressed in this policy without first receiving the completed order, the item will be denied as not reasonable and necessary.

Suppliers are to follow The Health Plan requirements for precertification, as applicable.

Continuous passive motion (CPM) machines require precertification and physician face-to-face.

National Coverage Determinations	Medicare NCD Manual, Section 280.1 Internet Only Manual (IOM) Publication 100-3
Local Coverage Determination	None
Effective Date	01/01/09
Review/Revision Date	01/2019, 10/18, 05/2018, 04/01/2017, 02/01/16, 05/01/14
The Health Plan	**Medicare:** Follow Medicare NCD DME Reference List (280.1) and Noridian Medicare website **Commercial and West Virginia Medicaid:** Follows The Health Plan guidelines

DESCRIPTION

A CPM device is a machine that is used to move a joint without the patient having to exert any effort. It is most commonly used on the knee joint, although it can be used on other joints.

COVERAGE GUIDELINES

1. CPM devices are covered for patients who have received a total knee replacement.

   To qualify for coverage, use of the device must commence no later than two days following surgery.

   In addition, coverage is limited to that portion of the three-week period following surgery during which the device is used in the patient's home. There is insufficient evidence to justify coverage of these devices for longer periods of time.

2. Following a revision of a major component of a previous total knee replacement (i.e., tibial or femoral component).

3. The member has had a face-to-face that meets the Affordable Care Act guidelines.

   Authorization will be for 21 days. Day 1 will be date discharged from acute hospital.

   ADDITIONAL COVERAGE GUIDELINES FOR COMMERCIAL AND WV MEDICAID:

4. Members who have undergone authorized autologous chondrocyte transplantation of the knee.

   Initial authorization will be for 21 days. Will need update at that time on compliance and potential therapy.

   Use of the CPM machine beyond the 21 days post-procedure is not supported at this time by the medical literature. There is insufficient evidence to justify use of these devices for longer periods of time.

5. Members who have undergone complicated anterior cruciate ligament repair or major joint manipulation of the knee. Coverage remains limited to three weeks following the surgical procedure.

Payment initiated upon member's discharge date from acute hospital.

NONCOVERAGE STATEMENT

At this time the CPM machine is not covered by The Health Plan for the following indications:

1. Any other joint including, but not limited to shoulder, wrist, hand, hip, back, or any other indication not listed above, as is considered experimental and investigational, for example:
   a. Dupuytren's contracture
   b. Low back pain
   c. Rheumatoid arthritis in absence of covered indication
   d. Rotator cuff repair
   e. Temporomandibular joint repair

At this time, E0936, CMD device for other than the knee, is not covered.

NONCOVERAGE STATEMENT LUMBAR CONTINUOUS PASSIVE MOTION (CPM) DEVICE

Lumbar CPM devices were designed to aid the healing process of injuries to the spine. The gentle motion is designed to encourage the damaged soft tissues to heal in a normal striated fashion instead of conglomerated scarring. Soft tissues are postulated to reform to more elastic fibers and the formation of scar tissue is reduced. Lumbar CPM manufacturers state that this device will help decrease scarring, edema, and loss of range of motion. The device is prescribed for use at home following established protocols and physician's orders. There is no scientific evidence in the published peer-reviewed medical literature that these devices, for patient controlled therapy, are safe or effective. Clinical data is only available at the manufacturer's web pages. These are short summaries of case series which have not been published in peer- reviewed journals.

CODING INFORMATION

CPT/HCPCS codes: The appearance of a code in this section does not necessarily indicate coverage. Coverage if selection criteria are met.

HCPCS CODES

E0935	Continuous passive motion exercise device for use on knee only
E0188 – E0189	Synthetic or Lambs wool sheepskin pad, any size, are not separately billable from rental of device

CPT/HCPCS codes: Not covered all lines of business, including MHT.

HCPCS CODES

E0936	Continuous passive motion exercise device for use other than knee
E1399	MISCELLANEOUS DME ITEM

DOCUMENTATION REQUIREMENTS

For the purposes of this policy, it is expected that the medical record will support the need for the care provided. It is generally understood that the medical record includes the physician's office records, hospital records, nursing home records, home health agency records, records from other health care professionals and test reports.

This documentation must be available with precertification.

Medicare has made changes to its requirements for dispensing orders, detailed written orders, and proof of delivery. The Health Plan will require the following:

1. Physician detailed written order. Order must include the following:
    a. Member’s name
    b. Date

c. Description of item. The medical record must contain the information that supports the request for each item and must be submitted with the precertification if the item requires precertification, or with the claim, if no precertification was required

d. Order must include diagnosis code

e. Physician signature with date. Date stamps are not appropriate

f. Quantity of items required and duration. A new order is required if there is an increase in the quantity of the supply used per month and/or the type of supply used
The supplier is to contact The Health Plan in this instance to update referral

2. There must be documentation in the supplier's records to support the medical necessity of that item. This information must be available upon request usually with precertification per The Health Plan policy.

3. Proof of delivery to be kept on file by the provider of the item.
Note: If templates or forms are submitted, (i.e., a Medicare Certificate of Medical Necessity, and/or a provider created form), and all of the required information is not included, The Health Plan reserves the right to request the medical record, that may include, but not limited to, the physician office notes, hospital and nursing facility records, and home health records.

Note: Template provider forms, prescriptions, and attestation letters are not considered part of the medical record, even if signed by the ordering physician.

Precertification is required when supplies used are greater than the usual maximum quantity listed in above. There must be adequate, clear documentation in the medical record corroborating the medical necessity of this amount. This documentation is to be submitted with precertification.

CPM MACHINE PROVIDED WHILE MEMBER IN PART A FACILITY STAY

Reimbursement for a CPM provided to a member while the member is covered in a Part A facility is based on specific contract information with the individual facility, and whether or not the device is intended for use while the member is in the facility.

Payment for the CPM is included in the payment to a hospital or inpatient rehab if:

1. The CPM is provided to a patient during an inpatient hospital stay prior to the day of discharge; and

2. The patient uses the CPM for medically necessary inpatient treatment or rehabilitation.

A separate claim must not be submitted in this situation.

Reimbursement for a CPM provided while a member is in a SNF receiving Part A services, will be reimbursed according to individual facility contracts.

BILLING GUIDELINES

Continuous passive motion (CPM) devices are used to exercise joints following injury or surgery.

A payment is made for each day that the device is used in the patient's home. No payment will be made for the device when the device is not used in the patient's home or once the 21-day period has elapsed.

Since it is possible for a member to have CPM therapy on the date of discharge from the hospital this day counts as the first day of the 21-day coverage

Dates used in an inpatient rehabilitation unit will count toward the 21 days, even though payment may be included in the facility fees.

KX, GA, and GZ MODIFIERS

Suppliers may submit a claim with a KX modifier only if all the criteria for that item is met.

If coverage criteria are not met, the GA or GZ modifier must be used. When there is an expectation of a medical denial, suppliers must enter the GA modifier on the claim line if they have obtained a properly executed Advance Beneficiary Notice (ABN) or the GZ modifier, if they have not obtained a valid ABN.

ADVANCED BENEFICIARY NOTICE

The Health Plan expects providers to follow the Medicare policy on ABN across all Medicare, Medicaid, and Commercial plans.

NOTE: Providers may be held financially responsible if they furnish the above items without notifying the member, verbally and in writing, that the specific service being provided is not covered. This must be done prior to the dispensing of the device. The provider must submit the waiver or ABN to The Health Plan with the claim showing the member agreed to pay for the device. Generalized statements on waivers or ABN are not acceptable.

PRICING, DATA ANALYSIS, AND CODING (PDAC)

The Health Plan has implemented use of Medicare's PDAC contractor for review of authorizations. Suppliers should contact the PDAC contractor for guidance on the correct coding of these items. dmepdac.com/

MEDICARE DEFINITIONS AND DESCRIPTION

E0935 - Continuous passive motion exercise device for use on knee only.

E0936 - Continuous passive motion exercise device for use other than knee.

The equipment must be capable of continuous passive motion of the affected limb. The device must have inherent within itself the ability to move the affected limb. It must have the following characteristics:

- In an appropriate plane of motion
- In a continuous fashion
- At the same rate of speed
- For a prescribed length of time
- With adjustable limits of range of motion
- With an identical range of motion in each cycle
- Without any input from the patient by the contralateral or other limbs
- With easily accessible safety or cutoff switches

These characteristics require that the device be electrically powered, either by AC current or battery. Battery powered models must have an AC adapter for long-term use. CPM machines must meet all these characteristics in order to be coded as E0935 or E0936.

AMA CPT/ADA CDT COPYRIGHT STATEMENT

INTERNET LINKS AND SOURCES

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