Medical Policy:
Mechanical Stretching Devices
(Commercial)

POLICY NUMBER | EFFECTIVE DATE | APPROVED BY
----------------|----------------|---------------------
MG.MM.DM.14d    | 02/01/2020     | MPC (Medical Policy Committee)

IMPORTANT NOTE ABOUT THIS MEDICAL POLICY:

Property of ConnectiCare, Inc. All rights reserved. The treating physician or primary care provider must submit to ConnectiCare, Inc. the clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, ConnectiCare will not be able to properly review the request for prior authorization. This clinical policy is not intended to pre-empt the judgment of the reviewing medical director or dictate to health care providers how to practice medicine. Health care providers are expected to exercise their medical judgment in rendering appropriate care. The clinical review criteria expressed below reflects how ConnectiCare determines whether certain services or supplies are medically necessary. ConnectiCare established the clinical review criteria based upon a review of currently available clinical information (including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). ConnectiCare, Inc. expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test or procedure over another. Each benefit plan defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by ConnectiCare, as some plans exclude coverage for services or supplies that ConnectiCare considers medically necessary. If there is a discrepancy between this guideline and a member's benefits plan, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of the State of CT and/or the Federal Government. Coverage may also differ for our Medicare members based on any applicable Centers for Medicare & Medicaid Services (CMS) coverage statements including including National Coverage Determinations (NCD), Local Coverage Determinations (LCD) and/or Local Medical Review Policies(LMRP). All coding and web site links are accurate at time of publication.

Definitions

| Dynamic splinting devices | A bilateral spring loaded tensioning device that helps to increase joint range of motion by applying a low-load prolonged-duration stretch. 
When used in combination with traditional physical therapy, the dynamic splint can reduce recovery time and maximize the overall range of motion for a joint. 
These may also be referred to as (low-load prolonged-duration stretch [LLPS]) devices.

| Static progressive stretching (SPS) devices | The incremental, periodic application of stress relaxation (SR) loading. |
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<th>(aka bi-directional static progressive stretch)</th>
<th>In SR loading, tissue is stretched and held at a constant length and the amount of force is reduced over time.</th>
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<td>Patient-actuated serial stretch (PASS) devices (aka extensionators or flexionators)</td>
<td>Custom-fitted devices that supply a low–high level load to the joint using pneumatic or hydraulic systems that can be adjusted by the patient.</td>
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**Guideline**

Members with the DME benefit are eligible for coverage of mechanical stretching devices for the ankle, finger, knee, toe, wrist, forearm, elbow, and adhesive capsulitis of the shoulder.

Splinting must be applied within the adaptive phase of wound healing or within 100 days from the date of injury or trauma.

Application is most appropriate under any of the following circumstances:

1. Adjunct to physical therapy when persistent joint stiffness is present; either:
   a. Post-operative phase
   b. Sub-acute injury
   (Initiation must be ≥ 3 weeks post the event, but not ≥ 4 months after the event)

2. Acute post operative period when surgery is performed to enhance range of motion in a previously affected joint.

For members unable to benefit and/or perform physical therapy (improvement must be evident within 4 months; see Limitations/Exclusions below).

**Limitations/Exclusions**

Mechanical stretching devices are not considered medically necessary for any indication other than those listed above or when any of the following are applicable:

1. ≥ 100 days post initial injury or trauma.
2. Pediatric use.
3. Prophylactic use for any of the following conditions (except in cases when the device is for post-surgical use of a chronic condition and whereby the appropriateness criteria put forth in the Guideline section are met):
   a. Chronic contractures
   b. Joint stiffness secondary to any of the following:
      i. Burns
      ii. Cerebral palsy
      iii. Fractures
      iv. Head and spinal chord injuries
      v. Multiple sclerosis
      vi. Muscular dystrophy
      vii. Rheumatoid arthritis
      viii. Trauma
Applicable Coding

To access the codes, please download the policy to your computer, and click on the paperclip icon within the policy

| Applicable CPT and Diagnosis Codes |

References


Specialty-matched clinical peer review.

Washington State Department of Labor and Industries, Office of the Medical Director. ERMI Flexionators and Extensionators. Health Technology Assessment Brief. Olympia, WA: Washington State Department
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Revision history

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<tr>
<td>02/01/2020</td>
<td>• Connecticare has adopted the clinical criteria of its parent corporation, EmblemHealth</td>
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<td></td>
<td>• Reformatted and reorganized policy, transferred content to new template</td>
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