Medical Necessity Guidelines: Continuous Passive Motion (CPM) Device – Extension Beyond 21 Days

Effective: July 25, 2018

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Applies to:</td>
<td></td>
</tr>
<tr>
<td>☒ Tufts Health Plan Commercial Plans products; Fax: 617.972.9409</td>
<td></td>
</tr>
<tr>
<td>☒ Tufts Health Public Plans products</td>
<td></td>
</tr>
<tr>
<td>☐ Tufts Health Direct – Health Connector; Fax: 888.415.9055</td>
<td></td>
</tr>
<tr>
<td>☒ Tufts Health Together – A MassHealth Plan; Fax: 888.415.9055</td>
<td></td>
</tr>
<tr>
<td>☐ Tufts Health Unify – OneCare Plan; Fax: 781.393.2607</td>
<td></td>
</tr>
<tr>
<td>☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404</td>
<td></td>
</tr>
<tr>
<td>☒ Tufts Health Freedom Plan products; Fax: 617.972.9409</td>
<td></td>
</tr>
</tbody>
</table>

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

OVERVIEW
Continuous passive motion (CPM) device is a treatment modality in which joint motion is provided by a device, without causing contraction of muscle groups.

COVERAGE GUIDELINES
Initial use of a CPM device is covered without prior authorization for twenty-one days for each lower extremity within a 365-day period.

For upper extremity coverage, refer to the Medical Necessity Guidelines for Continuous Passive Motion (CPM) Machine–Upper Extremity.

The use of a CPM device beyond the initial twenty-one days requires prior authorization.
Tufts Health Plan may authorize coverage of CPM device beyond the initial coverage period when all of the following criteria are met:

- The Member has undergone one of the following surgical procedures: total joint arthroplasty, revision total joint arthroplasty, joint manipulation under anesthesia or surgical release arthofibrosis; OR the Member is in the non-weight bearing stage following intra-articular cartilage repair (including microfracture, autologous chondrocyte implantation, chondroplasty of focal cartilage deficit, intra-articular fracture, abrasion arthroplasty and osteochondritis dessicans)
- Progressive improvement in the Member’s active and passive range of motion (ROM)
- The Member is using the device for at least 4 hours per day
- Concomitant therapy involvement, such as a concurrent home exercise plan (HEP) or skilled physical therapy
- The CPM Request for Coverage Extension is completed by the treating physical therapist or Physician and submitted for review. The status report is to include the following information:
  - Member’s active and passive ROM, including initial and most current measurements
  - Member’s current functional level
  - Clear documentation as to why standard physical therapy is either contraindicated or not likely to be as effective as continued CPM therapy
  - Documentation of non-weight bearing status, including timeframe, if applicable.

LIMITATIONS
Tufts Health Plan does not cover the use of CAMO®ped. CAMO®ped is a device that may be used as a substitute for traditional CPM. It is considered experimental and investigative.

1 CAMO®ped is a trademark or registered trademark of OPED, Inc.
CODES

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0935</td>
<td>Continuous passive motion exercise device for use on knee only</td>
</tr>
<tr>
<td>E0936</td>
<td>Continuous passive motion exercise device for use other than knee</td>
</tr>
</tbody>
</table>

REFERENCES


APPROVAL HISTORY

October 1999: Reviewed by the Medical Technology Assessment Committee

Subsequent endorsement date(s) and changes made:
- May 2000: Renewed
- October 2001: Renewed
- July 2002: Revised: Additional covered diagnosis added: flexor tendon repair of finger
- October 3, 2003: Revised: Initial authorization period for autologous chondrocyte transplant increased to four weeks.
- February 6, 2004: Requirements for continued authorization clarified
- June 15, 2006: Added coverage for the following diagnoses: Patello-femoral arthroplasty, abrasion arthroplasty, microfracture chondroplasty, and mosaicplasty/osteochondral autograft transfer system (OATS)
- November 13, 2007: Specific criteria for extension of coverage added.
- February 27, 2008: Reviewed and renewed without changes.
- March 16, 2009: Reviewed and renewed without changes.
- January 21, 2010: Wording of “21 day auth period” (per year) clarified.
- May 2010: Reviewed by Medical Affairs and Medical Policy. Administrative changes made Precertification Dept. will now review, specifically a Physical Therapist; all diagnoses will be covered for 21 days per year without prior authorization; treatment beyond 21 days for all diagnoses will require prior authorization. Effective date October 1, 2010.
- April 2011: Reviewed by MSPAC. No changes.
- September 12, 2012: Reviewed by Integrated Medical Policy Advisory Committee (IMPAC), and renewed without changes.
- December 28, 2012: For a January 1, 2013 effective date, reviewed by IMPAC, Continuous Passive Motion Machine (CPM) for the Upper Extremity has a separate medical necessity guideline effective January 1, 2013.
Continuous Passive Motion (CPM) Device - Extension Beyond 21 Days

- November 25, 2013: Reviewed by IMPAC, renewed without changes
- May 14, 2014: Reviewed by IMPAC: Documentation of passive ROM is now required. CPM device extension request form can now also be completed by a Physician. Medical Director review is not required.
- October 8, 2014: Reviewed by IMPAC, renewed without changes
- September 9, 2015: Reviewed by IMPAC, renewed without changes
- September 2015: Branding and template change to distinguish Tufts Health Plan products in "Applies to" section. Added Tufts Health Freedom Plan products, effective January 1, 2016.
- August 10, 2016: Reviewed by IMPAC, renewed without changes
- April 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017
- September 13, 2017: Reviewed by IMPAC, renewed without changes
- July 25, 2018: Reviewed by IMPAC, renewed without changes

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Medical Necessity Guidelines are developed to determine coverage for benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member’s benefit document, and in coordination with the Member’s physician(s) on a case-by-case basis considering the individual Member’s health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and 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 our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

Medical Necessity Guidelines apply to the fully insured Commercial and Medicaid products when Tufts Health Plan conducts utilization review unless otherwise noted in this guideline or in the Member’s benefit document, and may apply to Tufts Health Unify to the same extent as Tufts Health Together. This guideline does not apply to Tufts Medicare Preferred HMO, Tufts Health Plan Senior Care Options or to certain delegated service arrangements. For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern. Applicable state or federal mandates or other requirements will take precedence. For CareLinkSM Members, Cigna conducts utilization review so Cigna’s medical necessity guidelines, rather than these guidelines, will apply.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of these guidelines is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.

Provider Services