HAP CareSource™

MEDICAL POLICY STATEMENT
Michigan Health Link

Policy Name & Number	Date Effective
Mechanical Stretching Devices-MI MCD-MM-1547	06/01/2025
Policy Type	
MEDICAL	

Medical Policy Statements are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased, or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage or Certificate of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other plan policies and procedures.

Medical Policy Statements do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage or Certificate of Coverage) for the service(s) referenced in the Medical Policy Statement. Except as otherwise required by law, if there is a conflict between the Administrative Policy Statement and the plan contract, then the plan contract will be the controlling document used to make the determination.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject

Mechanical Stretching Devices

B. Background

Mechanical stretching devices are intended to restore range of motion (ROM) for joint stiffness or contracture by stretching joints. These devices provide passive stretching to an adjustable degree for a selected duration for multiple sessions. A variety of mechanical stretching devices are available for extension or flexion of the shoulder, elbow, wrist, fingers, knee, ankle, and toes. These devices can provide stretching for longer periods than a physical therapist and are generally used as adjunct treatment to physical therapy and/or exercise. Mechanical stretching devices (also known as dynamic splinting systems) include:

- Low-load prolonged duration stretch devices (LLPS)
- Static progressive stretch (SPS) splint devices
- Patient actuated serial stretch (PASS) devices

C. Definitions

- **Low-load Prolonged Duration Stretch Devices (LLPS)** – These devices permit resisted active and passive motion (elastic traction) within a limited range and maintain a set level of tension by means of incorporated rubber bands or springs.
- **Patient Actuated Serial Stretch (PASS) Devices** – These devices hold the joint in a set position but allow for manual modification of the joint angle and may allow for active motion without resistance (inelastic traction). This type of device itself does not exert a stress on the tissue unless the joint angle is set at the maximum ROM.
- **Static Progressive Stretch Devices (SPS)** – These devices hold the joint in a set position but allow for manual modification of the joint angle and may allow for active motion without resistance (inelastic traction).

D. Policy

I. HAP CareSource considers dynamic splinting devices medically necessary durable medical equipment (DME) as an adjunct treatment to physical therapy, massage, and/or exercise for an existing joint contracture when the following clinical criteria is met:
   A. Medically necessary only for the following joints: knee, elbow, wrist, finger, ankle and toe.
   B. After three weeks of exercise and skilled therapy in the initial subacute injury or post-operative period in members with:
      1. signs and symptoms of persistent joint stiffness or contracture
      2. limited range of motion that poses a meaningful functional limitation as judged by a physician
   C. May be used for an initial period of 4 weeks, a subsequent 4-week period with reevaluation, and then up to 4 months based on continued improvement.

II. In the acute post-operative period for members who have undergone additional surgery to improve the range of motion of a previously affected joint, HAP CareSource considers use of an LLPS device medically necessary for
   A. An initial four-week period.
   B. An additional four-week period, if improvement was noted after the initial four weeks, for up to 4 months.

III. Non-Covered Services
   A. HAP CareSource considers the use of dynamic splinting experimental and investigational for the following indications, including but not limited to:
      1. adhesive capsulitis
      2. carpal tunnel syndrome
      3. cerebral palsy
      4. foot drop associated with neuromuscular diseases,
      5. hallux valgus
      6. head and spinal cord injuries
      7. Improvement of outcomes following botulinum toxin injection for treatment of limb spasticity
      8. injuries of the ankle and shoulder
      9. multiple sclerosis
      10. muscular dystrophy
      11. plantar fasciitis
      12. rheumatoid arthritis
      13. stroke
      14. trismus
   B. HAP CareSource considers the following devices experimental and investigational due to insufficient scientific evidence of efficacy:
      1. patient actuated serial stretch (PASS) devices (eg, ERMI Knee Extensionater®, ERMI Shoulder Extensionater®)
      2. static progressive stretch devices (SPS) (eg, Joint Active Systems (JAS) splints (eg, JAS Elbow, JAS Shoulder, JAS Ankle, JAS Knee, JAS Wrist, JAS Pronation-Supination)

E. Conditions of Coverage

All claims for LLPS are subject to post-payment review by HAP CareSource.

F. Related Policies/Rules

NA

G. Review/Revision History

	DATE	ACTION
Date Issued	11/09/2023	New Policy
Date Revised	02/15/2023	e-voted addition of ankle and toe to policy to match fee schedule and MCG.

The MEDICAL Policy Statement detailed above has received due consideration as defined in the MEDICAL Policy Statement Policy and is approved.

	06/07/2023 03/27/2024 03/12/2025	Annual review. Added examples of PASS and SPS devices. Annual review. Updated references. Approved at Committee. Annual review. Updated references. Approved at Committee.
Date Effective	06/01/2025	
Date Archived		

H. References

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Independent medical review –12/21