

Medicare Medical Policy

Cold Therapy and Cooling Devices

MEDICARE MEDICAL POLICY NUMBER: 513

Effective Date: 12/1/2025

Last Review Date: 11/2025

Next Annual Review: 11/2026

MEDICARE COVERAGE CRITERIA	2
POLICY CROSS REFERENCES.....	2
POLICY GUIDELINES.....	2
REGULATORY STATUS.....	3
BILLING GUIDELINES AND CODING	3
REFERENCES.....	4
POLICY REVISION HISTORY.....	4

INSTRUCTIONS FOR USE: Company Medicare Medical Policies serve as guidance for the administration of plan benefits and do not constitute medical advice nor a guarantee of coverage. Company Medicare Medical Policies are reviewed annually to guide the coverage or non-coverage decision-making process for services or procedures in accordance with member benefit contracts (otherwise known as Evidence of Coverage or EOCs) and Centers of Medicare and Medicaid Services (CMS) policies, manuals, and other CMS rules and regulations. In the absence of a CMS coverage determination or specific regulation for a requested service, item or procedure, Company policy criteria or applicable utilization management vendor criteria may be applied. These are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

The Company reserves the right to determine the application of Medicare Medical Policies and make revisions to these policies at any time. Any conflict or variance between the EOC and Company Medical Policy will be resolved in favor of the EOC.

SCOPE: Providence Health Plan, Providence Health Assurance, and Providence Plan Partners as applicable (referred to individually as “Company” and collectively as “Companies”).

PRODUCT AND BENEFIT APPLICATION

☒ Medicare Only

MEDICARE COVERAGE CRITERIA

IMPORTANT NOTE: More than one Centers for Medicare and Medicaid Services (CMS) reference may apply to the same health care service, such as when more than one coverage policy is available (e.g., both an NCD and LCD exist). All references listed should be considered for coverage decision-making. The Company uses the most current version of a Medicare reference available at the time of publication; however, these websites are not maintained by the Company, so Medicare references and their corresponding hyperlinks may change at any time. If there is a conflict between the Company Medicare Medical Policy and CMS guidance, the CMS guidance will govern.

Note: This medical policy does not address in-facility use of passive or active cooling devices or cold therapy. Use of passive or active cooling devices or cold therapy in a facility setting, such as a hospital or ambulatory care center, is not separately reimbursable.

Service	Medicare Guidelines
Cold Therapy/Cooling Devices	<ul style="list-style-type: none">• For E0218: Local Coverage Determination (LCD): Cold Therapy (L33735)• For A9273 and E0236: LCD: Heating Pads and Heat Lamps (L33784) (While this LCD is specific to heating devices, relevant codes may be used for either heat or cold and the noted non-coverage found in this LCD applies to both uses.)

IMPORTANT NOTICE: While some services or items may appear medically indicated for an individual, they may also be a direct exclusion of Medicare or the member's benefit plan. Such excluded services or items by Medicare and member EOCs include, but are not limited to, services or procedures considered to be cosmetic, not medical in nature, or those considered not medically reasonable or necessary under *Title XVIII of the Social Security Act, §1862(a)(1)(A)*. If there is uncertainty regarding coverage of a service or item, please review the member EOC or submit a pre-service organization determination request. Note that the Medicare Advance Beneficiary Notice of Noncoverage (ABN) form **cannot** be used for Medicare Advantage members. (Medicare Advance Written Notices of Non-coverage. MLN006266 May 2021)

POLICY CROSS REFERENCES

None

The full Company portfolio of Medicare Medical Policies is available online and can be [accessed here](#).

POLICY GUIDELINES

BACKGROUND

Cold therapy includes items such as cold packs, cool jackets, ice packs, ice collars, ice/cooling wraps, and water circulating cold pad with pump (e.g., Polar Units).

In addition to being reasonable and necessary to treat or diagnosis a medical condition (*Social Security Act §1862(a)(1)(A)*), Medicare defines durable medical equipment (DME) as equipment which:^{1,2}

- Can withstand repeated use; and
- Is primarily and customarily used to serve a medical purpose; and
- Generally is not useful to a person in the absence of an illness or injury; and
- Is appropriate for use in the home; and
- Has an expected life of at least 3 years (for items classified as DME after January 1, 2012).

Cold therapy devices do not meet the definition of DME under Medicare and therefore, are not covered. Use of these devices is considered **not** medically reasonable or necessary.

REGULATORY STATUS

U.S. FOOD & DRUG ADMINISTRATION (FDA)

While clearance by the Food and Drug Administration (FDA) is a prerequisite for Medicare coverage, the 510(k) premarket clearance process does not in itself establish medical necessity. Medicare payment policy is determined by the interaction of numerous requirements, including but not limited to, the availability of a Medicare benefit category and other statutory requirements, coding and pricing guidelines, as well as national and local coverage determinations and clinical evidence.

BILLING GUIDELINES AND CODING

GENERAL

See the associated local coverage article (LCA) for additional billing and coding guidance, including direction regarding what types of devices may be reported with specific HCPCS codes:

- LCA: Cold Therapy - Policy Article ([A52460](#))
- LCA: Heating Pads and Heat Lamps - Policy Article ([A52502](#))

The *National Physician Fee Schedule Relative Value File (NPFSRVF)*, which is published by the Centers for Medicare and Medicaid Services (CMS)³, indicates HCPCS code A9273 has been assigned a Status Indicator of “N,” which is defined as “Non-covered Services.” This is a statutorily excluded service based on Medicare’s definition of durable medical equipment or DME.

CODES*		
CPT	None	
HCPCS	A9273	Cold or hot fluid bottle, ice cap or collar, heat and/or cold wrap, any type (<i>CMS-assigned Status “N” code – See “Billing Guidelines”</i>)
	E0218	Water circulating cold pad with pump, any type
	E0236	Pump for water circulating pad
	E1399	Durable medical equipment, miscellaneous

***Coding Notes:**

- The code list above is provided as a courtesy and may not be all-inclusive. Inclusion or omission of a code from this policy neither implies nor guarantees reimbursement or coverage. Some codes may not require routine review for medical necessity, but they are subject to provider contracts, as well as member benefits, eligibility and potential utilization audit. According to Medicare, “presence of a payment amount in the MPFS and the Medicare physician fee schedule database (MPFSDB) does not imply that CMS has determined that the service may be covered by Medicare.” The issuance of a CPT or HCPCS code or the provision of a payment or fee amount by Medicare does **not** make a procedure medically reasonable or necessary or a covered benefit by Medicare. (*Medicare Claims Processing Manual, Chapter 23 - Fee Schedule Administration and Coding Requirements, §30 - Services Paid Under the Medicare Physician’s Fee Schedule, A. Physician’s Services*)
- All unlisted codes are reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is submitted for non-covered services addressed in this policy then it will be **denied as not covered**. If an unlisted code is submitted for potentially covered services addressed in this policy, to avoid post-service denial, **prior authorization is recommended**.
- See the non-covered and prior authorization lists on the Company [Medical Policy, Reimbursement Policy, Pharmacy Policy and Provider Information website](#) for additional information.
- HCPCS/CPT code(s) may be subject to National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) bundling edits and daily maximum edits known as “medically unlikely edits” (MUEs) published by the Centers for Medicare and Medicaid Services (CMS). This policy does not take precedence over NCCI edits or MUEs. Please refer to the CMS website for coding guidelines and applicable code combinations.

REFERENCES

1. National Coverage Determination (NCD): Durable Medical Equipment Reference List (280.1). <https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=190>. Accessed 9/24/2025.
2. Medicare Benefit Policy Manual, Chapter 15 - Covered Medical and Other Health Services, §110.1 - Definition of Durable Medical Equipment. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf>. Accessed 9/24/2025.
3. Medicare Physician Fee Schedule (PFS) Relative Value Files. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files>. Accessed 9/24/2025.

POLICY REVISION HISTORY

DATE	REVISION SUMMARY
2/2022	New Medicare Advantage medical policy (converted to new format 2/2023)
3/2023	Annual review
12/2023	Annual review
12/2024	Annual review, no changes
12/2025	Annual review, title revision