Local Coverage Determination (LCD): Heating Pads and Heat Lamps (L33784)

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Contractor Information

Contractor Name	Contract Type	Contract Number Jurisdiction	State(s)
CGS Administrators, LLC	DME MAC	17013 - DME MAC J-B	Illinois Indiana Kentucky Michigan Minnesota Ohio Wisconsin
CGS Administrators, LLC	DME MAC	18003 - DME MAC J-C	Alabama Arkansas Colorado Florida Georgia Louisiana Mississippi North Carolina New Mexico Oklahoma Puerto Rico South Carolina Tennessee Texas Virginia Virgin Islands West Virginia
Noridian Healthcare Solutions, LLC	DME MAC	16013 - DME MAC J-A	Connecticut District of Columbia Delaware Massachusetts Maryland Maine New Hampshire New Jersey New York - Entire State Pennsylvania Rhode Island Vermont
Noridian Healthcare Solutions, LLC	DME MAC	19003 - DME MAC J-D	Alaska American Samoa Arizona California - Entire State Guam Hawaii Iowa Idaho Kansas Missouri - Entire State Montana North Dakota Nebraska Nevada Oregon South Dakota

Contractor Name	Contract Type	Contract Number	Jurisdiction	State(s)
				Utah Washington Wyoming Northern Mariana Islands

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LCD Information

Document Information

LCD ID
L33784

Original ICD-9 LCD ID
L28399
L28614
L28480
L28484

LCD Title
Heating Pads and Heat Lamps

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Original Effective Date
For services performed on or after 10/01/2015

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For services performed on or after 07/01/2016

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N/A

Retirement Date
N/A

Notice Period Start Date
N/A

Notice Period End Date
N/A

CMS National Coverage Policy CMS Manual System, Pub. 100-3, Medicare National Coverage Determinations Manual, Chapter 1, Section 280.1

Coverage Guidance
Coverage Indications, Limitations, and/or Medical Necessity

For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a

malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements. For the items addressed in this local coverage determination, the criteria for "reasonable and necessary", based on Social Security Act §1862(a)(1)(A) provisions, are defined by the following coverage indications, limitations, and/or medical necessity.

Medicare does not automatically assume payment for a durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) item that was covered prior to a beneficiary becoming eligible for the Medicare Fee For Service (FFS) program. When a beneficiary receiving a DMEPOS item from another payer (including Medicare Advantage plans) becomes eligible for the Medicare FFS program, Medicare will pay for continued use of the DMEPOS item only if all Medicare coverage, coding and documentation requirements are met. Additional documentation to support that the item is reasonable and necessary, may be required upon request of the DME MAC.

For an item to be covered by Medicare, a detailed written order (DWO) must be received by the supplier before a claim is submitted. If the supplier bills for an item addressed in this policy without first receiving the completed DWO, the item will be denied as not reasonable and necessary.

A standard electric heating pad (E0210) is covered to relieve certain types of pain, decrease joint and soft tissue stiffness, relax muscles, or reduce inflammation.

A heating pad is not reasonable and necessary to treat pain due to peripheral neuropathy, including but not limited to diabetic neuropathy.

It has not been established that a moist electric heating pad (E0215) or water circulating heat pad with pump (E0217) is reasonable and necessary compared to a standard electric heating pad (E0210); therefore, if code E0215 or E0217 is provided it will be denied as not reasonable and necessary.

Heating pads that do not meet the definitions listed in the Coding Guidelines section of the related Policy Article and that are billed with code E1399 will be denied as not reasonable and necessary.

Because a water circulating heating pad system is not medically necessary, a replacement pump (E0236) or pad (E0249, A9999) will be denied as not reasonable and necessary.

The safety and effectiveness of using a heat lamp (E0200, E0205) in the home setting is not established. Claims for these items will be denied as not reasonable and necessary.

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Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

N/A
Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the policy, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

N/A
CPT/HCPCS Codes
Group 1 Paragraph:

The appearance of a code in this section does not necessarily indicate coverage.

HCPCS MODIFIERS:

EY - No physician or other licensed health care provider order for this item or service

HCPCS CODES:

Group 1 Codes:
A9273 HOT WATER BOTTLE, ICE CAP OR COLLAR, HEAT AND/OR COLD WRAP, ANY TYPE
A9999 MISCELLANEOUS DME SUPPLY OR ACCESSORY, NOT OTHERWISE SPECIFIED
E0200 HEAT LAMP, WITHOUT STAND (TABLE MODEL), INCLUDES BULB, OR INFRARED ELEMENT
E0205 HEAT LAMP, WITH STAND, INCLUDES BULB, OR INFRARED ELEMENT
E0210 ELECTRIC HEAT PAD, STANDARD
E0215 ELECTRIC HEAT PAD, MOIST
E0217 WATER CIRCULATING HEAT PAD WITH PUMP
E0225 HYDROCOLLATOR UNIT, INCLUDES PADS
E0236 PUMP FOR WATER CIRCULATING PAD
E0239 HYDROCOLLATOR UNIT, PORTABLE
E0249 PAD FOR WATER CIRCULATING HEAT UNIT, FOR REPLACEMENT ONLY
E1399 DURABLE MEDICAL EQUIPMENT, MISCELLANEOUS

ICD-10 Codes that Support Medical Necessity
Group 1 Paragraph: Not specified

Group 1 Codes: N/A

ICD-10 Codes that DO NOT Support Medical Necessity
Group 1 Paragraph: Not specified

Group 1 Codes: N/A

ICD-10 Additional Information

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General Information

Associated Information
DOCUMENTATION REQUIREMENTS

Section 1833(e) of the Social Security Act precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider." It is expected that the beneficiary's medical records will reflect the need for the care provided. The beneficiary's medical records include the treating practitioner's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be available upon request.

PRESCRIPTION (ORDER) REQUIREMENTS

GENERAL (PIM 5.2.1)

All items billed to Medicare require a prescription. An order for each item billed must be signed and dated by the prescribing practitioner, kept on file by the supplier, and made available upon request. Items dispensed and/or billed that do not meet these prescription requirements and those below must be submitted with an EY modifier added to each affected HCPCS code.

DISPENSING ORDERS (PIM 5.2.2)

Equipment and supplies that are NOT on the ACA 6407 list or that require a written order prior to delivery (WOPD) may be delivered upon receipt of a dispensing order (prescription). A dispensing order may be verbal or written. The supplier must keep a record of the dispensing order on file. It must contain:

- Description of the item
- Beneficiary's name
- Prescribing practitioner's name
- Date of the order
- Prescribing practitioner's signature (if a written order) or supplier signature (if verbal order)

For the “Date of the order” described above, use the date the supplier is contacted by the prescribing practitioner (for verbal orders) or the date entered by the prescribing practitioner (for written dispensing orders).

In some cases, the prescribing practitioner may specify a future start date for therapy that is different from the date of the order. This start date does not impact the date of the order, date of service (DOS) entered on the claim, Medicare-required forms (e.g., CMN, DIF) or refill/delivery timelines. As long as the supplier has a properly completed dispensing order with a correctly determined prescription date, an item may be shipped or delivered on or after the date of the dispensing order (except for items that require written orders prior to delivery).

Signature and date stamps are not allowed. Signatures must comply with the CMS signature requirements outlined in PIM 3.3.2.4.

The dispensing order must be available upon request.

For items that are provided based on a dispensing order, the supplier must obtain a detailed written order before submitting a claim.

DETAILED WRITTEN ORDERS (PIM 5.2.3)

A detailed written order (DWO) is required before billing. Someone other than the prescribing practitioner may produce the DWO. However, the prescribing practitioner must review the content and sign and date the document. It must contain:

- Beneficiary's name
- Prescribing practitioner’s name
- Date of the order
- Detailed description of the item(s) (see below for specific requirements for selected items)
- Prescribing practitioner’s signature and signature date

For the “Date of the order” described above, use the dispensing order date i.e., the date the supplier was contacted by the prescribing practitioner (for verbal orders) or the date entered by the prescribing practitioner (for written dispensing orders).

Additional order date instructions:

- If the prescriber creates a complete and compliant DWO, only a single date - the "order date" - is required. This order date may be the date that the prescriber signs the document (either wet signature or electronic signature).
- If someone other than the prescriber (e.g., DME supplier) creates the DWO then the prescription must be reviewed and, "…personally signed and dated…" by the prescriber. In this scenario, two (2) dates are required: an "order date" and a prescriber-entered "signature date".

In some cases, the prescribing practitioner may specify a future start date for therapy that is different from the date of the order. This start date does not impact the date of the order, date of service (DOS) entered on the claim, Medicare-required forms (e.g., CMN, DIF) or refill/delivery timelines. As long as the supplier has a properly completed dispensing order with a correctly determined prescription date, an item may be shipped or delivered on or after the date of the dispensing order (except for items that require written orders prior to delivery).

The detailed description in the written order may be either a narrative description or a brand name/model number.

Signature and date stamps are not allowed. Signatures must comply with the CMS signature requirements outlined in PIM 3.3.2.4.

The DWO must be available upon request.

A prescription is not considered as part of the medical record. Medical information intended to demonstrate compliance with coverage criteria may be included on the prescription but must be corroborated by information contained in the medical record. (PIM 5.7)

NEW ORDER REQUIREMENTS (PIM 5.2.7)

A new prescription is required when:

- There is a change in the order for the accessory, supply, drug, etc.;
- On a regular basis (even if there is no change in the order) only if it so specified in the documentation section of a particular medical policy;
- When an item is replaced; and
- When there is a change in the supplier.

MEDICAL RECORD INFORMATION

GENERAL (PIM 5.7 - 5.9)

The COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY section of this LCD contains numerous reasonable and necessary (R&N) requirements. The NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES section of the related Policy Article contains numerous non-reasonable and necessary, benefit category and statutory requirements that must be met in order for payment to be justified. Suppliers are reminded that:

- Supplier-produced records, even if signed by the prescribing practitioner, and attestation letters (e.g. letters of medical necessity) are deemed not to be part of a medical record for Medicare payment purposes.

- Templates and forms, including CMS Certificates of Medical Necessity, are subject to corroboration with information in the medical record.

Information contained directly in the contemporaneous medical record is the source required to justify payment except as noted elsewhere for prescriptions and CMNs. The medical record is not limited to treating practitioner's office records but may include records from hospitals, nursing facilities, home health agencies, other healthcare professionals, etc. (not all-inclusive). Records from suppliers or healthcare professionals with a financial interest in the claim outcome are not considered sufficient by themselves for the purpose of determining that an item is reasonable and necessary.

CONTINUED MEDICAL NEED

For all Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items, the initial justification

for medical need is established at the time the item(s) is first ordered; therefore, beneficiary medical records demonstrating that the item is reasonable and necessary are created just prior to, or at the time of, the creation of the initial prescription. For purchased items, initial months of a rental item or for initial months of ongoing supplies or drugs, information justifying reimbursement will come from this initial time period. Entries in the beneficiary's medical record must have been created prior to, or at the time of, the initial DOS to establish whether the initial reimbursement was justified based upon the applicable coverage policy.

For ongoing supplies and rental DME items, in addition to information described above that justifies the initial provision of the item(s) and/or supplies, there must be information in the beneficiary's medical record to support that the item continues to be used by the beneficiary and remains reasonable and necessary. Information used to justify continued medical need must be timely for the DOS under review. Any of the following may serve as documentation justifying continued medical need:

- A recent change in prescription
- Timely documentation in the beneficiary's medical record showing usage of the item

Timely documentation is defined as a record in the preceding 12 months unless otherwise specified elsewhere in the policy.

CONTINUED USE

Continued use describes the ongoing utilization of supplies or a rental item by a beneficiary.

Suppliers are responsible for monitoring utilization of DMEPOS rental items and supplies. No monitoring of purchased items or capped rental items that have converted to a purchase is required. Suppliers must discontinue billing Medicare when rental items or ongoing supply items are no longer being used by the beneficiary.

Beneficiary medical records or supplier records may be used to confirm that a DMEPOS item continues to be used by the beneficiary. Any of the following may serve as documentation that an item submitted for reimbursement continues to be used by the beneficiary:

- Timely documentation in the beneficiary’s medical record showing usage of the item, related option/accessories and supplies
- Supplier records documenting beneficiary confirmation of continued use of a rental item

Timely documentation is defined as a record in the preceding 12 months unless otherwise specified elsewhere in this policy.

PROOF OF DELIVERY (PIM 4.26, 5.8)

Proof of delivery (POD) is a Supplier Standard and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers are required to maintain POD documentation in their files. Regardless of the method of delivery, the contractor must be able to determine that the item(s) delivered are the same item(s) submitted for Medicare reimbursement and that the item(s) are received by a specific Medicare beneficiary.

Suppliers, their employees, or anyone else having a financial interest in the delivery of the item are prohibited from signing and accepting an item on behalf of a beneficiary (i.e., acting as a designee on behalf of the beneficiary). The signature and date the beneficiary or designee accepted delivery must be legible.

For the purpose of the delivery methods noted below, designee is defined as any person who can sign and accept the delivery of DMEPOS on behalf of the beneficiary.

Proof of delivery documentation must be available to the Medicare contractor on request. All services that do not have appropriate proof of delivery from the supplier will be denied and overpayments will be requested. Suppliers who consistently fail to provide documentation to support their services may be referred to the Office of Inspector General for imposition of Civil Monetary Penalties or other administrative sanctions.

Suppliers are required to maintain POD documentation in their files. There are two methods of delivery:

1. Delivery directly to the beneficiary or authorized representative

2. Delivery via shipping or delivery service

Method 1—Direct Delivery to the Beneficiary by the Supplier

Suppliers may deliver directly to the beneficiary or the designee. In this case, POD to a beneficiary must be a signed and dated delivery document. The POD document must include:

- Beneficiary's name
- Delivery address
- Sufficiently detailed description to identify the item(s) being delivered (e.g., brand name, serial number, narrative description)
- Quantity delivered
- Date delivered
- Beneficiary (or designee) signature

The date delivered on the POD must be the date that the DMEPOS item was received by the beneficiary or designee. The date of delivery may be entered by the beneficiary, designee, or the supplier. When the supplier's delivery documents have both a supplier-entered date and a beneficiary or beneficiary's designee signature date on the POD document, the beneficiary or beneficiary's designee-entered date is the date of service.

In instances where the supplies are delivered directly by the supplier, the date the beneficiary received the DMEPOS supply must be the date of service on the claim.

Method 2—Delivery via Shipping or Delivery Service Directly to a Beneficiary

If the supplier utilizes a shipping service or mail order, the POD documentation must be a complete record tracking the item(s) from the DMEPOS supplier to the beneficiary. An example of acceptable proof of delivery would include both the supplier's own detailed shipping invoice and the delivery service's tracking information. The supplier's record must be linked to the delivery service record by some clear method like the delivery service's package identification number or supplier's invoice number for the package sent to the beneficiary. The POD document must include:

- Beneficiary's name
- Delivery address
- Delivery service's package identification number, supplier invoice number or alternative method that links the supplier's delivery documents with the delivery service's records
- Sufficiently detailed description to identify the item(s) being delivered (e.g., brand name, serial number, narrative description)
- Quantity delivered
- Date delivered
- Evidence of delivery

If a supplier utilizes a shipping service or mail order, suppliers must use the shipping date as the date of service on the claim.

Suppliers may also utilize a return postage-paid delivery invoice from the beneficiary or designee as a POD. This type of POD document must contain the information specified above.

CORRECT CODING (PIM 3.3)

Correct coding is a determination that the item(s) provided to the beneficiary are billed using the appropriate HCPCS code for the item. Suppliers are required to correctly code for the items billed. An item/service is correctly coded when it meets all the coding guidelines listed in CMS HCPCS guidelines, LCDs, or MAC articles. Information that is sufficiently detailed to unambiguously identify the specific product delivered to the beneficiary and the HCPCS code used to bill for that item must be maintained by the supplier and be available upon request.

For LCDs that use ICD-10 diagnosis codes, correct coding of the ICD-10 code is required. A diagnosis is correctly coded when it meets all the coding guidelines listed in International Classification of Diseases Guidelines (ICD), CMS ICD policy or guideline requirements, LCDs, or MAC articles. Information that is sufficiently detailed to unambiguously justify the ICD-10 code used to bill for DMEPOS items must be contained in the beneficiary's medical record and be available upon request.

EQUIPMENT RETAINED FROM A PRIOR PAYER

When a beneficiary receiving a DMEPOS item from another payer (including a Medicare Advantage plan) becomes eligible for the Medicare FFS program, the first Medicare claim for that item or service is considered a new initial Medicare claim for the item. Even if there is no change in the beneficiary's medical condition, the beneficiary must meet all coverage, coding and documentation requirements for the DMEPOS item in effect on the date of service of the initial Medicare claim.

A POD is required for all items, even those in the beneficiary's possession provided by another insurer prior to Medicare eligibility. To meet the POD requirements for a beneficiary transitioning to Medicare, the supplier:

1. Must obtain a new POD as described above under "Methods of Delivery" (whichever method is applicable); or,

2. Must obtain a statement, signed and dated by the beneficiary (or beneficiary's designee), attesting that the supplier has examined the DMEPOS item, it is in good working order and that it meets Medicare requirements.

For the purposes of reasonable useful lifetime and calculation of continuous use, the first day of the first rental month in which Medicare payments are made for the item (i.e., date of service) serves as the start date of the reasonable useful lifetime and period of continuous use. In these cases, the proof of delivery documentation serves as evidence that the beneficiary is already in possession of the item.

REPAIR/REPLACEMENT (100-02, Chapter 15, §110.2)

A treating practitioner's order is not needed for repairs.

In the case of repairs to a beneficiary-owned DMEPOS item, if Medicare paid for the base equipment initially, medical necessity for the base equipment has been established. With respect to Medicare reimbursement for the repair, there are two documentation requirements:

1. The treating practitioner must document that that the DMEPOS item being repaired continues to be reasonable and necessary (see Continued Medical Need section above); and

2. Either the treating practitioner or the supplier must document that the repair itself is reasonable and necessary.

The supplier must maintain detailed records describing the need for and nature of all repairs including a detailed explanation of the justification for any component or part replaced as well as the labor time to restore the item to its functionality.

A treating practitioner's order is needed to reaffirm the medical necessity of the item for replacement of an item.

Miscellaneous

Refer to the Supplier Manual for additional information on documentation requirements.

Appendices

PIM citations above denote references to CMS Program Integrity Manual, Internet Only Manual 100-08

Utilization Guidelines
Refer to Coverage Indications, Limitations, and/or Medical Necessity

Sources of Information and Basis for Decision
N/A
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Revision History Information

Please note: Most Revision History entries effective on or before 01/24/2013 display with a Revision History Number of "R1" at the bottom of this table. However, there may be LCDs where these entries will display as a separate and distinct row.

Revision History Date	Revision History Number	Revision History Explanation	Reason(s) for Change
07/01/2016	R3	**Revision Effective Date: 07/01/2016** DOCUMENTATION REQUIREMENTS: Revised: Standard Documentation Language for orders, and Proof of delivery instructions, added New order requirements, and Correct coding instructions; (Effective 04/28/2016)	• Provider Education/Guidance
07/01/2016	R2	Effective July 1, 2016 oversight for DME MAC LCDs is the responsibility of CGS Administrators, LLC 18003 and 17013 and Noridian Healthcare Solutions, LLC 19003 and 16013. No other changes have been made to the LCDs.	• Change in Assigned States or Affiliated Contract Numbers
10/01/2015	R1	**Revision Effective Date: 10/31/2014:** INDICATIONS AND LIMITATIONS OF COVERAGE AND MEDICAL NECESSITY: Revised: Standard Documentation Language regarding Medicare coverage DOCUMENTATION REQUIREMENTS: Added: Instructions for Refill Documentation Revised: Standard Documentation Language to add who can enter date of delivery date on the POD Revised: Moved continued need above continued use documentation Added: Equipment Retained from a Prior Payer Added: Instructions for Repair Replacement to beneficiary-owned DMEPOS	• Provider Education/Guidance

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Associated Documents

Attachments N/A

Related Local Coverage Documents Article(s) A52502 - Heating Pads and Heat Lamps - Policy Article

Related National Coverage Documents N/A

Public Version(s) Updated on 08/10/2016 with effective dates 07/01/2016 - N/A Updated on 06/07/2016 with effective dates 07/01/2016 - N/A Updated on 03/17/2015 with effective dates 10/01/2015 - 06/30/2016 Updated on 04/04/2014 with effective dates 10/01/2015 - N/A Back to Top

Keywords

N/A Read the **LCD Disclaimer** Back to Top

END OF LOCAL COVERAGE DETERMINATION

Per the Code of Federal Regulations, 42 C.F.R § 426. 325, only those portions of the currently effective Local Coverage Determination (LCD) that are based on section 1862(a)(1)(A) of the Social Security Act, may be challenged through an acceptable complaint as described in 42 C.F.R § 426.400. Also, per 42 C.F.R § 426.325 items that are not reviewable, and therefore cannot be challenged, include the Policy Article. Please note the distinction of the documents when reviewing the materials.

Local Coverage Article:
Heating Pads and Heat Lamps - Policy Article (A52502)

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Contractor Information

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CGS Administrators, LLC	DME MAC	17013 - DME MAC J-B	J-B	Illinois Indiana Kentucky Michigan Minnesota Ohio Wisconsin
CGS Administrators, LLC	DME MAC	18003 - DME MAC J-C	J-C	Alabama Arkansas Colorado Florida Georgia Louisiana Mississippi North Carolina New Mexico Oklahoma Puerto Rico South Carolina Tennessee Texas Virginia Virgin Islands West Virginia
Noridian Healthcare Solutions, LLC	DME MAC	16013 - DME MAC J-A	J-A	Connecticut District of Columbia Delaware Massachusetts Maryland Maine New Hampshire New Jersey New York - Entire State Pennsylvania Rhode Island Vermont
Noridian Healthcare Solutions, LLC	DME MAC	19003 - DME MAC J-D	J-D	Alaska American Samoa Arizona California - Entire State Guam Hawaii Iowa Idaho Kansas Missouri - Entire State Montana North Dakota Nebraska Nevada Oregon South Dakota

Contractor Name	Contract Type	Contract Number	Jurisdiction	State(s)
				Utah Washington Wyoming Northern Mariana Islands

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Article Information

General Information

Article ID
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A47980
A48140
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Article Guidance

Article Text:

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES

For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements. Information provided in this policy article relates to determinations other than those based on Social Security Act §1862(a)(1)(A) provisions (i.e. "reasonable and necessary").

Heating pads are covered under the Durable Medical Equipment benefit (Social Security Act §1861(s)(6)). In order for a beneficiary's equipment to be eligible for reimbursement the reasonable and necessary (R&N) requirements set out in the related Local Coverage Determination must be met. In addition, there are specific statutory payment policy requirements, discussed below, that also must be met.

A nonelectric heating pad or wrap (A9273) does not meet the definition of durable medical equipment (DME) and will be denied as noncovered.

Hydrocollator units (E0225, E0239) are considered institutional equipment and will be denied as statutorily noncovered.

CODING GUIDELINES

A standard electric heating pad (E0210) is a flexible device containing electric resistive elements producing heat. It must have a fabric cover. It must have a timing device for automatic shut-off. It may include heat-retaining material (e.g., gel, fluid, vegetable matter). If so, the heat retaining materials must be contained in an enclosed pouch or bag in or around the heating elements. The heating pad must be certified by Underwriters Laboratories. A heating pad that includes a cover or other element that utilizes water vapor (humidity) drawn from the air to create moisture when heated is billed using this code.

A moist electric heating pad (E0215) is a flexible device containing electric resistive elements producing heat. It must have a fabric cover. It must have a timing device for automatic shut-off. It must have a component that absorbs and retains liquid water. The water containing element must be protected from contact with the electrical components and the water must be in direct contact with the skin on application. The heating pad must be certified by Underwriters Laboratories. A cover or other element that utilizes water vapor (humidity) drawn from the air to create moisture when heated does not meet the definition of this code. Water must be added to the device to meet the description of this code.

A water circulating heat pad with pump (E0217) is a flexible pad containing a series of channels through which water is circulated by means of an electrical pumping mechanism. The water is heated in an external reservoir. The pump, pad, and all accessories needed for the pad to be functional are included in the code. The device must be certified by Underwriters Laboratories.

A hydrocollator unit (E0225, E0239) is a container which is filled with water and then heated. Bags of silicone dioxide or other material are placed in the heated water. These packs/pads are then applied to the body part over towels. They are used to heat the body part prior to physical therapy.

Code E0249 is a durable replacement pad used with a water circulating heat pump system (E0217). It is made of rubber, heavy plastic, or durable fabric. It can be cleaned and is designed for long term use. A replacement pad made of other material that is designed for shorter term use must be billed using code A9999 (Miscellaneous DME supply or accessory, not otherwise specified).

Heating pads that do not meet the coding criteria described above for E0210, E0215 or E0217 must be billed with code E1399.

Suppliers should contact the Pricing, Data Analysis, and Coding (PDAC) contractor for guidance on the correct coding of these items. Back to Top

Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the article does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the article should be assumed to apply equally to all claims.

N/A

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the article, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the article should be assumed to apply equally to all Revenue Codes.

N/A

CPT/HCPCS Codes N/A
ICD-10 Codes that are Covered N/A
ICD-10 Codes that are Not Covered N/A
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Revision History Information

Please Note: The Revision History information included in this Article prior to 06/20/2013 will now display with a Revision History Number of "R1" at the bottom of this table. All new Revision History information entries completed on or after 06/20/2013 will display as a row in the Revision History section of the Article and numbering will begin with "R2".

Revision History Date	Revision History Number	Revision History Explanation
07/01/2016	R2	**Revision Effective Date: 07/01/2016** Updated: Title to remove effective date
07/01/2016	R1	Effective July 1, 2016 oversight for DME MAC Articles is the responsibility of CGS Administrators, LLC 18003 and 17013 and Noridian Healthcare Solutions, LLC 19003 and 16013. No other changes have been made to the Articles.

Back to Top **Related Local Coverage Document(s)** LCD(s) L33784 - Heating Pads and Heat Lamps

Related National Coverage Document(s) N/A

Statutory Requirements URL(s) N/A

Rules and Regulations URL(s) N/A

CMS Manual Explanations URL(s) N/A

Other URL(s) N/A

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Keywords

N/A Read the **Article Disclaimer** Back to Top