Medical Coverage Policy

Effective Date.................................08/15/2020
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Coverage Policy Number ......................0135

Stretch Devices for Joint Stiffness and Contractures

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Related Coverage Resources

Chiropractic Care (CPG 278)
Continuous Passive Motion (CPM) Devices
Home Traction Devices - Cervical and Lumbar - (CPG 265)
Mechanical Devices for the Treatment of Back Pain
Physical Therapy - (CPG 135)
Plantar Fasciitis Treatments
Temporomandibular Joint (TMJ) Disorder Surgery

INSTRUCTIONS FOR USE

The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer’s particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer’s benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Overview

This Coverage Policy addresses mechanical stretching devices including:

- low-load prolonged-duration stretch (LLPS) device/dynamic stretch device (HCPCS codes E1800, E1802, E1805, E1810, E1812, E1815, E1820, E1825, E1830, E1840)
- static progressive stretch (SPS) device (HCPCS codes E1801, E1806, E1811, E1816, E1818, E1821, E1831, E1841)
- patient-actuated serial stretch (PASS) device (HCPCS code E1399)
- jaw stretch device (HCPCS codes E1700, E1701, E1702)

See Related Coverage Resources section above for additional policies/guidelines related to stretching/stretch devices.
Coverage Policy

Coverage for Durable Medical Equipment (DME) including mechanical stretching devices varies across plans. Refer to the customer's benefit plan document for coverage details.

The use of a low-load prolonged-duration stretch (LLPS) device/dynamic stretch device (HCPCS code E1825) is considered not medically necessary for treatment of an extensor tendon injury of the finger.

The use of a low-load prolonged-duration stretch (LLPS) device for any other condition or for any joint other than a finger joint (HCPCS codes E1800, E1802, E1805, E1810, E1812, E1815, E1820, E1830, E1840) is considered experimental, investigational or unproven.

The use of EITHER of the following devices for any indication is considered experimental, investigational or unproven:

- static progressive (SP) stretch device (HCPCS codes E1801, E1806, E1811, E1816, E1818, E1821, E1831, E1841)
- patient-actuated serial stretch (PASS) device (HCPCS code E1399)

The use of a jaw stretch device (HCPCS codes E1700, E1701, E1702) is considered not medically necessary.

General Background

Joint stiffness or contracture may be caused by immobilization following surgery, disease, or trauma. Joint contracture is associated with reduced range of motion (ROM) due to structural changes in non-bony tissues, including muscles, tendons, ligaments and skin. Elastic connective tissue is replaced with inelastic fibrous material that is resistant to stretching, resulting in joint dysfunction. Treatments used to prevent and treat joint stiffness and contractures include manual joint mobilization by a physical therapist, application of casts at regular intervals (serial casting), static splinting, and continuous passive motion (CPM). These techniques involve the mechanical elongation of soft tissues for varying time periods. Stretch induces an immediate, transient increase in joint ROM and reduces resistance to passive joint movement, although the lasting effects are less well understood. Various types of mechanical stretch devices have been proposed for use in the rehabilitation of numerous joints, including the shoulder, neck, back, elbow, wrist, finger, knee, ankle and toe.

U.S. Food and Drug Administration (FDA)

Mechanical stretching devices are classified by the FDA as Class I medical devices. Class I devices have the least amount of regulatory control; manufacturers of these devices are exempt from premarket notification procedures and are not required to provide safety and effectiveness data prior to marketing. Numerous mechanical stretch devices have been developed, and are generally categorized as static progressive (SP) stretch devices, low-load, prolonged-duration stretch (LLPS) devices, and actuated serial stretch (PASS) devices. Jaw stretch devices include the Therabite® Jaw Motion Rehabilitation System™ (Atos Medical, West Allis, WI) and the OraStretch™ Press Jaw Motion Rehab System™ (CranioRehab, Inc., Denver, CO)

Types of Devices

Low-Load Prolonged-Duration Stretch (LLPS) Devices/Dynamic Splinting Systems: LLPS devices permit active and passive motion with elastic traction within a limited range. The devices maintain a set level of tension by incorporated springs. Examples of low-load, prolonged-duration stretch (LLPS) devices include:

- Dynasplint System® (Dynasplint Systems, Inc., Severna Park, MD)
- Ultraflex (Ultraflex Systems, Pottstown, PA)
- Pro-glide™ Dynamic ROM devices (DeRoyal®, Powell, TN)
- Advance Dynamic ROM® devices (Empi, St. Paul, MN)
- SaeboStretch® (Saebo, Charlotte, NC)
Static Progressive (SP) Stretch Devices: SP stretch devices hold the joint in a set position, while allowing manual modification of the joint angle, and may allow active motion without resistance. The device does not exert stress on the tissue unless the angle is set to the joint’s limitation. This type of device allows a limited range of passive or active motion, but the motion is free and does not provide elastic traction. Available static progressive (SP) stretch devices include:

- Joint Active Systems (JAS) Static Progressive Stretch devices (finger, wrist, elbow, shoulder, knee, ankle) (Joint Active Systems, Inc., Effington, IL)
- JAS Pronation/Supination device
- Static-Pro® Knee (DeRoyal Industries, Inc.)

Patient-Actuated Serial Stretch (PASS) Devices: PASS devices provide a low-to high-level load to the joint using pneumatic (Extensionators [ERMI}) or hydraulic (Flexionators [ERMI} systems that are adjusted by the patient. PASS devices are custom-fitted and are available for the ankle, elbow, knee, and shoulder. A customized treatment protocol and training in use of the device are provided to the patient. Available patient-actuated serial stretch (PASS) devices include:

- ERMI Knee Extensionator®, ERMI Knee/Ankle Flexionator®, ERMI Shoulder Flexionator®, ERMI MPJ Extensionator®, ERMI Elbow Extensionator® II (ERMI, Inc., Atlanta, GA)

Jaw Stretch Devices: Jaw stretch devices are devices that open the jaw to stretch the oro-facial tissues and mobilize the temporomandibular joint (TMJ). It is used primarily to prevent and treat trismus and scarring or fibrosis from radiation therapy, surgery, and trauma. Brands include:

- TheraBite® Jaw Motion Rehabilitation System™
- OraStretch™ Press Jaw Motion Rehab

Technology Assessments
A Hayes Medical Technology Directory on Mechanical Stretching Devices for Treatment of Joint Contractures of the Extremities (May 9, 2018) notes that for LLPS for finger contractures following extensor injury and repair, published evidence consistently suggests no incremental benefit in clinical outcomes over standard care such as static splinting plus PT. Hayes also noted that evidence is insufficient to draw conclusions about the efficacy of any other type of mechanical stretching devices for treatment of joint contractures of the knee, wrist, elbow, shoulder, or toes, regardless of etiology.

In a Cochrane review, Harvey et al. (2017) asked the question is stretch effective for treating and preventing joint contractures. The stretch was administered in a variety of different ways including through passive stretching (self-administered, therapist-administered and device-administered), positioning, splinting and serial casting. The stretch dosage was highly variable, ranging from five minutes to 24 hours per day for between two days and seven months. The participants had a variety of neurological and non-neurological conditions including stroke, acquired brain injury and spinal cord injury, arthritis, wrist fracture and burns. The short-term (less than one week) and long-term (more than one week) effects were investigated separately. Forty-nine randomized controlled trials and controlled clinical trials with 2135 participants met the inclusion criteria. The primary objective of this systematic review was to determine whether stretch increases joint mobility in people with existing contractures or those at risk of developing contractures. The results provided high-quality evidence that stretch did not have a clinically important short-term effect on joint mobility in people with or without neurological conditions. Similarly, there was no evidence of a long-term effect of stretch. These findings were robust in most sensitivity and sub-group analyses.

Literature Review
The majority of published mechanical stretching device evidence evaluates the use of low-load prolonged-duration stretch (LLPS) in the rehabilitation of finger injuries. The use of LLPS devices does not improve long-term joint mobility beyond what can be achieved through a standard rehabilitation program including static splinting and/or exercise. There is insufficient evidence to determine whether the use of static progressive stretch (SPS) devices and patient-actuated serial stretch (PASS) devices results in improved outcomes for any joints. One small randomized trial suggests the four week use of a static progressive stretch device in combination with
traditional therapy has beneficial long-term effects on shoulder pain and functional outcomes in patients with adhesive capsulitis of the shoulder (Ibrahim, et al., 2014). Trials with larger study populations are needed to validate these preliminary findings.

<table>
<thead>
<tr>
<th>Study information</th>
<th>Comparator</th>
<th>Study Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finger extensor injury and repair</td>
<td>Khandwala et al. (2000)</td>
<td>N=50 LLPS N=50 static splint</td>
</tr>
<tr>
<td></td>
<td>RCT</td>
<td>six week follow up</td>
</tr>
<tr>
<td></td>
<td>N=100/70</td>
<td>30% attrition</td>
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<td></td>
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<td>Miller system and Total Active Motion (TAM) classification</td>
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<td></td>
<td></td>
<td>There was no significant difference in the results of the two treatment groups.</td>
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<tr>
<td></td>
<td>Chester et al. (2002)</td>
<td>N=30 static splint N=24 LLPS</td>
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<tr>
<td></td>
<td>RCT</td>
<td>three month follow up</td>
</tr>
<tr>
<td></td>
<td>N=54/36</td>
<td>30 - 37% attrition</td>
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<tr>
<td></td>
<td></td>
<td>extension lag, flexion deficit and TAM were measured.</td>
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<tr>
<td></td>
<td></td>
<td>There were no significant differences in the results of the two groups.</td>
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<td></td>
<td>Mowlavi et al. (2005)</td>
<td>N=17 LLPS N=17 static splint</td>
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<tr>
<td></td>
<td>RCT</td>
<td>six month follow up</td>
</tr>
<tr>
<td></td>
<td>N=34</td>
<td>TAM and grip strength</td>
</tr>
<tr>
<td></td>
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<td>LLPS had no significant improvement at 6 months when compared with static splinting.</td>
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<tr>
<td></td>
<td>Hall et al. (2010)</td>
<td>N=4 Immobilization N=5 early passive motion / LLPS N=9 Early active motion/ static splint</td>
</tr>
<tr>
<td></td>
<td>RCT</td>
<td>three month follow up</td>
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<tr>
<td></td>
<td>N=27/18</td>
<td>33% attrition</td>
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<tr>
<td></td>
<td></td>
<td>TAM, VAS score, grip strength</td>
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<td>Significant increasing trends over time were identified in the three comparison groups, suggesting that all patients showed steady improvement during the study period (p &lt; .001).</td>
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<tr>
<td></td>
<td></td>
<td>Differences among the three groups were not significant for extension lag, VAS scores, and grip strength.</td>
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<tr>
<td></td>
<td>Giessler et al. (2008)</td>
<td>N=10 LLPS N=11 early active motion protocol</td>
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<tr>
<td></td>
<td>RCT</td>
<td>two month follow up</td>
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<tr>
<td></td>
<td>N=21</td>
<td>active range of motion (ROM)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No significant difference was found during further course of study (eight weeks).</td>
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<td></td>
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<td>The mean grip strength and tip-pinich strength did not differ significantly after eight weeks.</td>
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<tr>
<td></td>
<td>Kitis et al. (2009)</td>
<td>N=98 LLPS N=94 static splint</td>
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<tr>
<td></td>
<td>Retrospective review</td>
<td>three months follow up</td>
</tr>
<tr>
<td></td>
<td>N=192</td>
<td>TAM, grip strength, and Disabilities of Arm, Shoulder, and Hand (DASH) questionnaire</td>
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<td>TAM - there was no significant difference between the two groups (p=0.09).</td>
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<td></td>
<td>Grip strength - difference was not significant (p=0.08).</td>
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<td>The mean DASH score was 29.6 (4.4) and 41.7 (5.1) in the two groups, respectively. This difference was significant (p=0.01). Authors indicate that a lower DASH score in the LLPS group indicates a better functional state than in the other group.</td>
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<tr>
<td></td>
<td>RCT</td>
<td>four weeks</td>
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<tr>
<td></td>
<td>N=40</td>
<td>wrist extension and the Patient Rated Hand Wrist Evaluation (PRHWE).</td>
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</tbody>
</table>
The results indicate uncertainty about whether eight weeks of wearing a dynamic splint increases passive wrist extension at eight or twelve weeks. The results are similar for the PRHWE at twelve weeks. In contrast, the results conclusively show no effect of dynamic splints on PRHWE at eight weeks.

Berner and Willis (2010) retrospective
N=133

No comparator. There was a significant improvement in maximal active range of motion (AROM) for all patients (p< 0.0001) after a mean duration of 3.9 weeks of dynamic splinting.

Elbow – post-traumatic elbow stiffness

Lindenhovius et al. (2012) RCT
N=66

N=31 LLPS
N=35 Static progressive stretch (SPS)
dee months
motion and DASH scores
There were no significant differences in flexion arc at any time point.
The average DASH score (dynamic versus static) was 28 versus 26 points at twelve months after enrollment (p = 0.61).

Shoulder – adhesive capsulitis

Ibrahim et al. (2014) RCT
N=60

N=30 SPS + PT
N=30 PT only
(4 weeks tx for both groups)
dee months
range of motion, DASH scores
At 12-month follow-up, significant differences (p < 0.001) were found between the groups for all outcome measures, all in favor of the SPS group.
Authors state ‘Further studies are needed for direct comparison of static progressive stretch and dynamic splinting as treatment methods in order to characterize their relative ability to provide functional improvements for patients with adhesive capsulitis of the shoulder.’

Knee – post-operative total knee arthroplasty

Hewitt and Shakespeare (2001) Prospective
N=160

N=86 SPS (dynamic extension)
N=74 static flexion regime
dsix weeks
range of movement
Patients subjected to the static flexion regime had a better maximum flexion and range of movement at six weeks and were also discharged earlier. These results were statistically significant (p<0.05).

Multi-joint (shoulder elbow, forearm, wrist, knee and ankle)

Sodhi et al. (2019) Medical records review.
N= 600 (patients treated with a JAS Brace) per year were randomly and prospectively selected to complete the survey (for 10 years).

Unknown number of patients completed survey.
only Static Progressive Stretch Brace (Joint Active Systems Inc.,)
In 2008, 59% of patients reported no pain, 45% no stiffness, and 79% no swelling after device use. Those numbers increased by 2013, to 70% of patients reporting no pain, 79% reporting no stiffness, and 84% reporting no swelling after brace use. A consistent positive trend was also seen for mobility, with at least 90% of patients reporting improved mobility after orthosis use.

**Jaw Stretch Devices**

Preventing trismus (e.g., lockjaw, limited jaw range of motion) and maintaining a maximum interincisal opening (MIO) in patients undergoing treatment for head and neck cancers is important as once trismus has developed, it is difficult to reverse. The most common treatment for trismus is physical therapy consisting of active range of
motion (ROM) exercises, hold and relax techniques, and manual stretching. Studies demonstrate that adding a mechanical jaw stretching device to a jaw stretching regimen does not provide any additional long-term health benefit.

Forty head and neck cancer patients at high risk for trismus who were planned for either primary or adjuvant radiation with or without chemotherapy were randomized to a jaw stretching regimen or jaw stretching regimen plus the Jaw Dynasplint. At six months after initiation of the preventative regimen, 50% of patients in the Dynasplint arm and 75% in the conventional stretching arm remained on their assigned therapy. Trismus was diagnosed in two patients in the control arm and in four patients in the Dynasplint arm. The authors concluded that use of the Jaw Dynasplint for 30 minutes, 3 times a day, during primary or adjuvant radiation in head and neck cancer patients is not feasible as a preventive intervention. Compliance decreased over the course of radiation to the point that only 50% of patients used the Dynasplint for any length of time at the end of treatment (Zatarain, et al., 2018).

Lee et al. (2018) conducted a randomized trial in 71 patients who have had radiotherapy for stage three and four oral and oropharyngeal cancer (37 patients in the Therabite group and 34 in the wooden spatula group). Mean mouth opening after six months increased in both groups, but the difference between the groups was not significant (p = 0.39). It should be noted that the power of the study was low because we failed to achieve the target recruitment and the attrition rate was higher than anticipated.

Kamstra et al. (2016) prospectively studied 18 consecutive patients with trismus (mouth opening of 35 mm or less) who were instructed to use the Dynasplint Trismus System (DTS) for 16 weeks. Five patients had undergone a different exercise therapy for their trismus prior to enrolment in the DTS exercise program. Complete data up to follow-up was available for 12 patients. After the patients completed the DTS exercise program, mouth opening increased (7.1 mm) and perceived difficulty of opening the mouth improved significantly (p < 0.05). However, for the subgroup of patients who were treated for their cancer longer than 36 months previously, no significant increase in mouth opening was achieved. The authors noted that early detection of trismus and the start of exercise therapy are important for better outcome of mouth opening. About one third of the gained increase was lost in the follow-up period.

In a randomized controlled trial, Kraaijenga et al. (2014) compared standard physical therapy to a mechanical stretching device (TheraBite) in 79 patients with myogenic temporomandibular disorder (TMD). This was a short-term RCT with a small study population. A limitation of this study was it was underpowered due to a high drop-out rate. Initially, there were 41 standard PT participants and 38 device participants. By three months, there were 16 standard PT participants and 14 device participants. After six-week follow-up, patients using the device reported a significantly greater functional improvement (MFIQ score) than the patients receiving regular PT exercises (p=0.0050). This advantage was not maintained over time. At six weeks, no significant differences in pain, and active or passive MIO were found between the two groups. At three months (12 weeks), results were the same. Patients in both treatment groups did equally well, and showed a significant improvement in all parameters assessed.

Maloney et al. (2002) conducted a randomized controlled trial that included 46 patients with TMJ disease. This study evaluated the use of Therabite and an intraoral appliance (n=17), the use of tongue depressors in conjunction with an intraoral appliance (n=12), and an intraoral appliance only (n=17). The Therabite group showed increased jaw mobility and decreased pain compared to the group using intraoral appliances alone. The use of tongue depressors had little effect. This trial was also very small, with unblinded evaluations and a follow-up period of only four weeks.

Cohen et al. (2005) evaluated the use of Therabite in the early postoperative management of trismus in seven patients who underwent resection and reconstruction for head and neck cancer. Patients were given a Therabite device, instructed in its proper use, and began using the device within six weeks following surgery. All patients were instructed to perform six repetitions holding the mouth open for six seconds each time, six times daily. Maximum interincisor opening was measured by a gauge provided with the device at the start of use and at the most recent postoperative visit. Follow-up ranged from 12 to 48 weeks after surgery. The average maximum interincisor opening was 30 mm (range 21–38 mm) at the last visit, with an average gain of 10 mm (range 1–21 mm). Two patients were lost to follow-up. Four of five patients reported minimal or no limitation on overall quality
of life relative to jaw opening. The authors concluded that the Therabite mechanical stretching device is effective and safe for the management of trismus in a select group of patients. These results cannot be generalized, however, due to the study design and small number of patients.

A systematic review of the effectiveness of physical therapy interventions for TMJ disorders concluded that the results of the review support the use of active and passive oral exercises as effective interventions to reduce symptoms, but more information on the exercise prescription is necessary to allow for replication in clinical settings. The authors advised that findings must be interpreted with caution, since most studies were of poor methodological quality. The Therabite system is described in the review as a mechanical aid that provides passive stretch to the TMJ, but no recommendation for use of the device is made (McNeely, et al., 2006).

Published studies evaluating the use of the OraStretch System are lacking.

Professional Societies/Organizations
No relevant information found.

The American Board of Internal Medicine’s (ABIM) Foundation Choosing Wisely® Initiative: No relevant information found.

Use Outside the U.S.
No relevant information found.

Medicare Coverage Determinations

<table>
<thead>
<tr>
<th>Contractor</th>
<th>Policy Name/Number</th>
<th>Revision Effective Date</th>
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<tr>
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<tr>
<td>LCD</td>
<td>No Local Coverage Determination found</td>
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</tbody>
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Note: Please review the current Medicare Policy for the most up-to-date information.

Coding/Billing Information

Note: 1) This list of codes may not be all-inclusive.
   2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Low-load prolonged-duration stretch (LLPS) device/dynamic stretch device

Considered Not Medically Necessary:

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>E1825</td>
<td>Dynamic adjustable finger extension/flexion device, includes soft interface material</td>
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Considered Experimental/Investigational/Unproven:

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<tr>
<th>HCPCS Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>E1800</td>
<td>Dynamic adjustable elbow extension/flexion device, includes soft interface material</td>
</tr>
<tr>
<td>E1802</td>
<td>Dynamic adjustable forearm pronation/supination device, includes soft interface material</td>
</tr>
<tr>
<td>E1805</td>
<td>Dynamic adjustable wrist extension/flexion device, includes soft interface material</td>
</tr>
<tr>
<td>E1810</td>
<td>Dynamic adjustable knee extension/flexion device, includes soft interface material</td>
</tr>
<tr>
<td>E1812</td>
<td>Dynamic knee, extension/flexion device with active resistance control</td>
</tr>
<tr>
<td>E1815</td>
<td>Dynamic adjustable ankle extension/flexion device, includes soft interface material</td>
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### HCPCS Codes

<table>
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<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>E1820</td>
<td>Replacement soft interface material, dynamic adjustable extension/flexion device</td>
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<tr>
<td>E1830</td>
<td>Dynamic adjustable toe extension/flexion device, includes soft interface material</td>
</tr>
<tr>
<td>E1840</td>
<td>Dynamic adjustable shoulder flexion/abduction/rotation device, includes soft interface material</td>
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</table>

#### Static Progressive (SP) Stretch Device

**Considered Experimental/Investigational/Unproven:**

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>E1801</td>
<td>Static progressive stretch elbow device, extension and/or flexion, with or without range of motion adjustment, includes all components and accessories</td>
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<tr>
<td>E1806</td>
<td>Static progressive stretch wrist device, flexion and/or extension, with or without range of motion adjustment, includes all components and accessories</td>
</tr>
<tr>
<td>E1811</td>
<td>Static progressive stretch knee device, extension and/or flexion, with or without range of motion adjustment, includes all components and accessories</td>
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<tr>
<td>E1816</td>
<td>Static progressive stretch ankle device, flexion and/or extension, with or without range of motion adjustment, includes all components and accessories</td>
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<tr>
<td>E1818</td>
<td>Static progressive stretch forearm pronation/supination device, with or without range of motion adjustment, includes all components and accessories</td>
</tr>
<tr>
<td>E1821</td>
<td>Replacement soft interface material/cuffs for bi-directional static progressive stretch device</td>
</tr>
<tr>
<td>E1831</td>
<td>Static progressive stretch toe device, extension and/or flexion, with or without range of motion adjustment, includes all components and accessories</td>
</tr>
<tr>
<td>E1841</td>
<td>Static progressive stretch shoulder device, with or without range of motion adjustment, includes all components and accessories</td>
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#### Patient actuated serial stretch (PASS) device

**Considered Experimental/Investigational/Unproven:**

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
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<tbody>
<tr>
<td>E1399</td>
<td>Durable medical equipment, miscellaneous</td>
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#### Jaw stretch device

**Considered Not Medically Necessary:**

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>E1700</td>
<td>Jaw motion rehabilitation system</td>
</tr>
<tr>
<td>E1701</td>
<td>Replacement cushions for jaw motion rehabilitation system, pkg. of 6</td>
</tr>
<tr>
<td>E1702</td>
<td>Replacement measuring scales for jaw motion rehabilitation system, pkg. of 200</td>
</tr>
</tbody>
</table>


## References


