

1 **Clinical Practice Guideline: Casting and Splinting**

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3 **Date of Implementation: April 19, 2012**

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5 **Program: Specialty**

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8 **GUIDELINES**

- 9 I. Casting or splinting for non-displaced fractures, muscle spasticity, and
10 contracture when performed by an appropriately trained practitioner to properly
11 set and stabilize bone or improve movement patterns is considered medically
12 necessary. Casting should not be utilized for basic contracture management
13 issues.
14
- 15 II. Air Casts are considered medically necessary for treatment of fractures or other
16 injuries (i.e., sprains, torn ligaments). Air Casts (air splints) are used as an
17 alternative to plaster casts to immobilize an elbow, ankle, or knee. Air Casts are
18 considered experimental and investigational for other indications because their
19 effectiveness for indications other than the one listed above has not been
20 established.
21
- 22 III. Casting of a fracture or severe sprain is considered medically necessary.
23
- 24 IV. Casting following surgical procedures is also considered medically necessary.
25
- 26 V. Certain orthopedic problems are routinely treated with splints or splint-like
27 devices. The following are considered medically necessary: acromio-clavicular
28 splint (also called a Zimmer splint), carpal tunnel splints, clavicle figure-8
29 splint, Denis Browne splint for children with clubfoot or metatarsus valgus to
30 maintain and correct abduction, finger splints and shoulder immobilizers.
31
- 32 VI. Dynamic splinting devices (e.g., Dynasplint™) for the knee, elbow, forearm,
33 wrist, ankle, or finger are medically necessary if one of the following is met:
34 a) As an adjunct to physical and occupational therapy when patient has
35 demonstrated and documented signs and symptoms of significant motion
36 loss and stiffness in the sub-acute injury or post-operative period (greater
37 than or equal to 3 weeks but less than or equal to 4 months after injury or
38 operation); or
39 b) For patients with previously demonstrated and documented history of
40 motion loss and stiffness in a joint, has had a surgery or procedure
41 performed to improve motion of that joint, and are in the acute post-

1 procedure/surgical period following a second or subsequent procedure or
2 surgery; or

- 3 c) For patients who are unable to benefit from standard physical and
4 occupational therapy modalities because of inability to exercise. If there is
5 no significant change in range of motion after a 4-month period, use of the
6 device is considered as maintenance and thus, not medically necessary and
7 appropriate.

8
9 Dynamic splinting devices are also considered medically necessary in
10 conjunction with botulinum toxin injections and physical and occupational
11 therapy, for the management of orthopedic conditions with associated joint
12 contractures and neurologic disorders with associated spasticity and
13 contractures (e.g., post-CVA, traumatic brain injury).

14
15 Use of dynamic splinting devices for joints and/or situations other than those
16 indicated above, and in the management of chronic joint stiffness and/or chronic
17 or fixed contractures, is considered unproven.

18
19 **Note:**

20 Although there is inadequate data published in the peer reviewed medical
21 literature regarding the effectiveness of dynamic splinting devices in improving
22 range of motion, this type of device has been widely used in the orthopedic and
23 physical and occupational therapy communities for select patient population. It
24 is on the basis of national community standards that the use of dynamic
25 splinting devices in specific clinical situations (as indicated in the policy
26 statement above) is considered reasonable and medically appropriate.

27
28 The procedures listed are payable when the cast or splint is a replacement procedure which
29 is medically necessary and used during or after the period of follow-up care, or when the
30 cast or splint application is an initial service performed without a restorative treatment or
31 procedure(s) to stabilize or protect a fracture, injury or dislocation and/or to afford comfort
32 to the patient.

33
34 When a surgical procedure on the musculoskeletal system is performed and a cast or splint
35 is applied to the area of the procedure, there is no separate allowance for the initial
36 application of the cast or splint.

37
38 An individual who applies the initial cast or splint and also assumes all of the subsequent
39 fracture, dislocation, or injury care cannot use the application of casting codes as an initial
40 service, since the first cast/splint application is included in the treatment of fracture and/or
41 dislocation codes.

1 If the cast application or splinting is provided as an initial service in which no other
 2 procedure or treatment is performed or is expected to be performed by an individual
 3 rendering the initial care only, (e.g., casting of a sprained ankle or knee), use the casting
 4 and/or cast supply code(s) (Q4001-Q4051) as well as an evaluation and management (E/M)
 5 code as appropriate.

6
 7 An E/M service, including emergency department E/M, may be reported with a
 8 casting/splinting/strapping CPT code if and only if the E/M service is significant and
 9 separately identifiable. ~~Casting/splinting/strapping CPT codes are minor surgical
 10 procedures with a “000” global day period. Global surgery rules for minor surgical
 11 procedures do not allow a provider/supplier to report an E/M service related to deciding
 12 whether to perform a minor surgical procedure.~~

13
 14 When the cast or splint is a replacement for the first cast or splint within or after the follow-
 15 up period, the appropriate code for the cast or splint application is reported. An E/M service
 16 rendered with the reapplication of a cast or splint is not reported separately. However, an
 17 E/M code on the day of reapplication could be separately billed and paid only if a
 18 significant and separately identifiable service (e.g., unrelated problem) was also addressed.
 19 In that situation, the CPT –25 modifier should be added to the E/M code and the diagnosis
 20 code should identify the unrelated condition(s). When reporting reapplication of a cast or
 21 splint, removal of the old cast or splint is included.

22
 23 CPT codes for closed, percutaneous, or open treatment of fractures or dislocations include
 24 the application of casts, splints, or strapping. CPT codes for casting/splinting/strapping
 25 shall not be reported separately.

26
 27 If a physician treats a fracture, dislocation, or injury with an initial cast, strap, or splint and
 28 also assumes the follow-up care, the provider/supplier cannot report the
 29 casting/splinting/strapping CPT codes since these services are included in the fracture
 30 and/or dislocation CPT codes.

31
 32 Supplies for casting or splinting are only considered medically necessary if the need for
 33 casting or splinting meets the criteria for medical necessity.

34
 35 **CPT CODES AND DESCRIPTIONS**

CPT® Code	CPT® Code Description
29010	Application of Risser jacket, localizer, body; only
29015	Application of Risser jacket, localizer, body; including head
29035	Application of body cast, shoulder to hips;

CPT® Code	CPT® Code Description
29040	Application of body cast, shoulder to hips; including head, Minerva type
29044	Application of body cast, shoulder to hips; including 1 thigh
29046	Application of body cast, shoulder to hips; including both thighs
29049	Application, cast; figure-of-eight
29055	Application, cast; shoulder spica
29058	Application, cast; plaster Velpeau
29065	Application, cast; shoulder to hand (long-arm)
29075	Application, cast; elbow to finger (short arm)
29085	Application, cast; hand and lower forearm (gauntlet)
29086	Application, cast; finger (e.g., contracture)
29105	Application of long arm splint (shoulder to hand)
29125	Application of short arm splint (forearm to hand); static
29126	Application of short arm splint (forearm to hand); dynamic
29130	Application of finger splint; static
29131	Application of finger splint; dynamic
29305	Application of hip spica cast; 1 leg
29325	Application of hip spica cast; 1 and 1/2 spica or both legs
29345	Application of long leg cast (thigh to toes)
29355	Application of Long leg cast (thigh to toes); walker or ambulatory type
29358	Application of long leg cast brace
29365	Application of cylinder cast (thigh to ankle)

CPT® Code	CPT® Code Description
29405	Application of short leg cast (below knee to toes)
29425	Application of short leg cast (below knee to toes); walking or ambulatory type
29435	Application of patellar tendon bearing (PTB) cast
29440	Adding walker to previously applied cast
29450	Application of clubfoot cast with molding or manipulation, long or short leg
29505	Application of long leg splint (thigh to ankle or toes)
29515	Application of short leg splint (calf to foot)
29700	Removal or bivalving; gauntlet, boot or body cast
29705	Removal or bivalving; full arm or full leg cast
29710	Removal or bivalving; shoulder or hip spica, Minerva, or Risser jacket, etc.
29720	Repair of spica, body cast or jacket
29730	Windowing of cast
29740	Wedging of cast (except clubfoot casts)
29750	Wedging of clubfoot cast

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HCPCS CODES AND DESCRIPTIONS*

HCPCS Code	HCPCS Code Description
A4570	Splint
A4580	Cast supplies (e.g., plaster)
A4590	Special casting material (e.g., fiberglass)
E1800	Dynamic adjustable elbow extension/flexion device, includes soft interface material
E1801	Static progressive stretch elbow device, extension and/or flexion, with or without range of motion adjustment, includes all components and accessories

E1802	Dynamic adjustable forearm pronation/supination device, includes soft interface material
E1805	Dynamic adjustable wrist extension / flexion device, includes soft interface material
E1806	Static progressive stretch wrist device, flexion and/or extension, with or without range of motion adjustment, includes all components and accessories
E1810	Dynamic adjustable knee extension / flexion device, includes soft interface material
E1811	Static progressive stretch knee device, extension and/or flexion, with or without range of motion adjustment, includes all components and accessories
E1812	Dynamic knee, extension/flexion device with active resistance control
E1815	Dynamic adjustable ankle extension/flexion device, includes soft interface material
E1816	Static progressive stretch ankle device, flexion and/or extension, with or without range of motion adjustment, includes all components and accessories
E1818	Static progressive stretch forearm pronation / supination device, with or without range of motion adjustment, includes all components and accessories
E1820	Replacement soft interface material, dynamic adjustable extension/flexion device
E1821	Replacement soft interface material/cuffs for bi-directional static progressive stretch device
E1825	Dynamic adjustable finger extension/flexion device, includes soft interface material
E1830	Dynamic adjustable toe extension/flexion device, includes soft interface material
E1831	Static progressive stretch toe device, extension and/or flexion, with or without range of motion adjustment, includes all components and accessories
E1840	Dynamic adjustable shoulder flexion / abduction / rotation device, includes soft interface material
E1841	Static progressive stretch shoulder device, with or without range of motion adjustment, includes all components and accessories
L0700	Cervical-thoracic-lumbar-sacral-orthoses (CTLSO), anterior-posterior-lateral control, molded to patient model, (minerva type)

L0710	CTLISO, anterior-posterior-lateral-control, molded to patient model, with interface material, (minerva type)
L4370	Pneumatic full leg splint, prefabricated, off-the-shelf
Q4049	Finger splint, static
Q4051	Splint supplies, miscellaneous (includes thermoplastics, strapping, fasteners, padding and other supplies)
S8450	Splint, prefabricated, digit (specify digit by use of modifier)
S8451	Splint, prefabricated, wrist or ankle
S8452	Splint, prefabricated, elbow

1
2 *This list includes common examples of related HCPCS codes and is not meant to be all-
3 inclusive. This list may include HCPCS not applicable to Medicare. Medicare guidelines
4 should be followed when applicable.

5
6 Casting may include other applications as medically necessary (e.g., CPT code 29445).
7 Refer to ASH clinical policy guideline *Rigid Total Contact Leg Cast (CPG 227 - S)* for
8 CPT code 29445.

9
10 For information on strapping and taping, see the *Strapping and Taping (CPG 143 – S)*
11 clinical practice guideline.

12 INTRODUCTION

13 A cast is a “rigid dressing, molded to the body while pliable and hardening as it dries,” that
14 provides firm support; it does not allow movement. A splint is any stiff device attached to
15 a limb in order to discourage movement. There are two types of splints: static or dynamic.
16 Static splints provide full immobilization, while dynamic splints allow some movement.
17 Casting or splinting of non-displaced fracture(s) to properly set and stabilize bone for
18 healing is indicated when performed by an appropriately trained health care practitioner.
19 Medical necessity must be established via confirmatory radiological findings. The casting
20 material used in fracture care can be either fiberglass or plaster. The choice of material is
21 dictated by the individual situation and is left to the discretion of the treating doctor.
22

23
24 Casting and splinting techniques used by practitioners for positioning and stretching are
25 medically necessary when an improvement can be noted in an individual’s movement
26 patterns and skills or when increasing available range of motion is necessary. For example,
27 a spastic hand can be casted or splinted to facilitate relaxation of the fingers. Serial casting
28 or splinting can be essential for individuals with traumatic brain injury-induced spasticity,

1 cerebrovascular accident (CVA), contractures, and other conditions. Casting or splinting
2 goals should objectively indicate expectation of progress.

3
4 Dynamic splinting devices are spring-loaded, adjustable devices designed to provide low-
5 load prolonged stretch while patients are asleep or at rest. Dynamic splinting devices are
6 available for elbow, wrist, fingers, knee, ankle and toes. These units are being marketed
7 for the treatment of joint stiffness due to immobilization or limited range of motion (ROM)
8 as a result of fractures, dislocations, tendon and ligament repairs, joint arthroplasties, total
9 knee replacements, burns, rheumatoid arthritis, tendon releases, brain and spinal cord
10 injuries, cerebral palsy (CP), multiple sclerosis, and other traumatic and non-traumatic
11 disorders. Dynamic splinting is often used post-operatively for the treatment of motion loss
12 and stiffness/ in the knee, elbow, wrist or finger. It is not generally used in other joints such
13 as the hip, ankle or foot. There are several types of mechanical stretching devices that have
14 been developed to restore range of motion to a joint.

- 15 1. Dynamic Splinting Devices – these are spring-loaded low load prolonged stretch
16 devices that apply continuous stretch to the affected joint. The patient may adjust
17 the tension of the spring but otherwise no patient intervention is required. Examples
18 include the Dynasplint, Ultraflex, LMB Pro-Glide and EMPI Advance.
- 19 2. Flexionators and Extensionators – these are patient-controlled bi-directional static
20 progressive stretch devices intended to provide alternating stretching and relaxation
21 of the affected joint. Examples include the ERMI Shoulder Flexionater, ERMI
22 Elbow Extensionater, and ERMI Knee/Ankle Flexionater. Also included in this
23 category are the pronator/supinator devices.
- 24 3. Joint Active System (JAS) Splints – these devices apply static progressive stretch
25 in which the patient manually increases the angle to which the device applies to the
26 affected joint. Examples include the JAS Shoulder, JAS Elbow, and JAS Knee.

27 28 **DOCUMENTATION REQUIREMENTS TO SUBSTANTIATE MEDICAL** 29 **NECESSITY**

30 “Medically necessary” or “medical necessity” shall mean health care services that a
31 Healthcare Provider, exercising prudent clinical judgment, would provide to a patient for
32 the purpose of evaluating, diagnosing, or treating an illness, injury, disease or its
33 symptoms, and that are (a) in accordance with generally accepted standards of medical
34 practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration;
35 and considered effective for the patient’s illness, injury, or disease; and (c) not primarily
36 for the convenience of the patient or healthcare provider, and not more costly than an
37 alternative service or sequence of services at least as likely to produce equivalent
38 therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness,
39 injury, or disease.

1 More than 8-10 visits for evaluation, treatment, modification and caregiver education for
 2 contracture casting would generally not be considered medically necessary without
 3 significant documentation.

5 **PRACTITIONER SCOPE AND TRAINING**

6 Practitioners should practice only in the areas in which they are competent based on their
 7 education, training and experience. Levels of education, experience, and proficiency may
 8 vary among individual practitioners. It is ethically and legally incumbent on a practitioner
 9 to determine where they have the knowledge and skills necessary to perform such services
 10 and whether the services are within their scope of practice.

11
 12 It is best practice for the practitioner to appropriately render services to a patient only if
 13 they are trained to competency, equally skilled, and adequately competent to deliver a
 14 service compared to others trained to perform the same procedure. If the service would be
 15 most competently delivered by another health care practitioner who has more skill and
 16 training, it would be best practice to refer the patient to the more expert practitioner.

17
 18 *Best practice* can be defined as a clinical, scientific, or professional technique, method, or
 19 process that is typically evidence-based and consensus driven and is recognized by a
 20 majority of professionals in a particular field as more effective at delivering a particular
 21 outcome than any other practice (Joint Commission International Accreditation Standards
 22 for Hospitals, 2020).

23
 24 Depending on the practitioner’s scope of practice, training, and experience, a patient’s
 25 condition and/or symptoms during examination or the course of treatment may indicate the
 26 need for referral to another practitioner or even emergency care. In such cases it is essential
 27 for the practitioner to refer the patient for appropriate co-management (e.g., to their primary
 28 care physician) or if immediate emergency care is warranted, to contact 911 as appropriate.
 29 See the *Managing Medical Emergencies (CPG 159 – S)* policy for information.

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