Sentara® Health Plans

Medicaid

Electric Stimulation, Medical 349

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All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual *.

Description & Definitions:

Bone Growth Stimulators are used to treat fractures and improve healing after injury or surgery.

Deep brain stimulation (DBS) is the use high-frequency electrical stimulation of electrodes implanted to regulate involuntary tremors or movements in an individual.

Electrical-electromagnetic stimulation for wound healing is composed of electrical stimulation and electromagnetic therapy. Electrical stimulation uses low electrical current through electrode attached to the skin to encourage wound healing. Electromagnetic therapy uses magnetic fields to stimulate wound healing.

External Upper Limb Tremor Stimulator Therapy, is a wrist-worn external upper limb device designed to aid in essential tremor symptom relief by applying Transcutaneous Afferent Patterned Stimulation (TAPS) to the nerves in the wrist.

Dorsal root ganglion (DRG) stimulator implanted to target the cell bodies of the nerves directly by electrical impulses sent to interrupt pain signals.

Functional Electrical Stimulators (FES) are surgically implanted and use electrical impulses during a task to stimulate nerves and muscles, causing them to contract and potentially restore function.

Neuromuscular and Muscular Electrical Stimulation (NMES) uses electrodes placed on the skin over or near the muscle group using electrical impulses to the motor nerves.

Percutaneous electrical stimulation places fine needle-like electrodes around indicated painful areas and small doses of electrical current are delivered to the sites.

Peripheral Nerve Stimulator is a minimally-invasive implanted receiver with electrodes that are placed around a peripheral nerve and an external transmitter is connected for transmitting the low frequency electrical pulses.

Spinal Cord Stimulator (SCS) also known as a **Dorsal column stimulator (DCS)** is an implanted device which electrodes are placed between the spinal cord and the vertebrae to send electrical pulses to block or modify pain signals to the brain.

Transcutaneous Electrical Nerve Stimulator (TENS unit) is a small device that delivers small doses of electrical current through electrodes on the skin to promote pain relief.

Criteria:

Electric Stimulators (FDA approved devices only) are considered medically necessary for **ALL** of the following:

- Implantation type for **1 or more** of the following:
    - Trial Placement
    - Permanent placement
    - Durable Medical equipment
- Type of device is **1 or more** of the following:
    - **Bone Growth/Osteogenic Stimulation (Electric/ Electromagnetic or Ultrasonic)** considered medically necessary for **1 or more** of the following:
        - **Electrical bone growth stimulator** (non-invasive or invasive), (20974, 20975, E0747 – E0749) for **1 or more** of the following:
            - **Spinal (bone growth) stimulator** for occipital-cervical, cervical, cervicothoracic, thoracic, thoracolumbar, lumbar and lumbosacral spinal regions with **1 or more** of the following:
                - Undergoing spinal fusion of two or more motion segments (3 vertebrae)
                - Undergoing a revision spinal fusion (eg, repeat surgery for a previously unhealed fusion attempt)
                - Smokers who cannot stop smoking in preparation for fusion due to the nature of the underlying condition(eg, acute traumatic fracture)
                - Undergoing primary lumbar fusion with **1 or more** of the following comorbidities:
                    - Diabetes
                    - Immunocompromised (eg, undergoing chemotherapy and radiation therapy to the spine, hypogammaglobulinemia, granulocytopenia, acquired immune deficiency syndrome, chronic granulomatous disease)
                    - Inflammatory arthritis (eg, rheumatoid arthritis) that has required long-term corticosteroid therapy
                    - Osteopenia or osteoporosis
                    - Systemic vascular disease
            - **Non-spinal (bone growth) Stimulator** is used for the treatment of **1 or more** of the following:
                - Non-union fracture with **ALL** of the following:
                    - Non-union is located in a long bone (i.e., clavicle, humerus, radius, ulna, femur, tibia, fibula, metacarpal or metatarsal bone) or the carpal and tarsal bones
                    - Fracture gap is ≤ 1 cm
                    - Documented by at least two sets of appropriate imaging studies separated by a minimum of 90 days confirming that clinically significant fracture healing has not occurred
                - Delayed unions of fractures or failed arthrodesis with minimum of 2 sets of radiographs, obtained prior to starting treatment with the osteogenic stimulator, separated by a minimum of 90 days
                - Non-unions, failed fusions, and congenital pseudarthrosis with no X-ray evidence of progression of healing for 3 or more months (90 Days) despite appropriate fracture care
                - Joint fusion secondary to failed surgical arthrodesis (e.g. knee, ankle, subtalar, foot fusion) when performed immediately following revision surgery with **1 or more** of the following:
                    - Active metabolic bone disease that cannot be corrected
                    - Active smoker or habitual smoker within the prior 6 months
                    - Diabetes mellitus
                    - Immunosuppressed individuals whose immunosuppression cannot be corrected

        - Individuals who cannot discontinue non-steroidal anti-inflammatory medications
        - Severe osteoporosis
        - Stable internal fixation of the fusion cannot be achieved
    - **Ultrasonic Bone Growth Stimulators** (20979, E0760) for **1 or more** of the following:
        - Closed fractures at high risk for nonunion due to a comorbidity which makes healing likely to be compromised for **1 or more** of the following:
            - Diabetes
            - Renal disease
            - Other metabolic diseases
            - History of tobacco use
            - History of alcoholism
            - Nutritional deficiency
            - Obese individuals with Body Mass Index (BMI) greater than 30; or greater than 50% over ideal body weight (IBW);
            - Severe anemia
            - Steroid therapy
        - Fresh fractures, fusions, or delayed unions at **1 or more** of the following:
            - 5th metatarsal (Jones fracture)
            - Distal radius (Colles fracture) treated with closed reduction and cast immobilization
            - Scaphoid (carpal navicular)
        - Non-unions, failed arthrodesis, and congenital pseudarthrosis, pseudoarthrosis of the appendicular skeleton for **ALL** of the following:
            - Bone is non-infected
            - Bone is stable on both ends by means of cast or fixation
            - The two portions of the involved bone are separated by less than 1 centimeter (cm)
        - Non-union of a stress fracture for **ALL** of the following:
            - ≥ 3 months from initial identification of the stress fracture
            - Failure of a minimum of 90 days of conventional, nonsurgical management (e.g., rest, bracing)
            - Radiograph imaging studies at least 90 days from the initial identification of the stress fracture demonstrates a fracture line that has not healed
- **Deep Brain Stimulation (DBS) Intracranial Neurostimulation)** (61850, 61860, 61863, 61864, 61867, 61868) is considered medically necessary for **1 or more** of the following:
    - Essential Tremor with **ALL** of the following:
        - Individual has significant disability of one or more limbs from resting, positional, or kinetic tremor that affects safety, functional status, or quality of life
        - Individual has tremor refractory to at least one year of standard medication
        - Individual has no significant cognitive impairment
        - If individual has depression or mood disorders, they are adequately controlled with medicine
        - Individual has no intracranial pathology on imaging studies that would contraindicate or complicate deep brain stimulation
        - Individual does not have coagulopathy
    - Parkinson's Disease with **ALL** of the following:
        - Individual has idiopathic Parkinson's Disease
        - Individual has significant disability affecting safety, functional status or quality of life due to **1 or more** of the following:
            - Bradykinesia
            - Tremor

        - Rigidity
        - Levodopa-induced dyskinesia
    - Individual has had a favorable response in the past to administration of levodopa
    - Individual has current signs or symptoms refractory to standard medication for Parkinson's disease
    - Individual has no significant cognitive impairment
    - If individual has depression or mood disorders, they are adequately controlled with medicine
    - Individual has no intracranial pathology
  - Partial onset seizures with **ALL** of the following:
    - 18 years of age or older
    - Individual has undergone diagnostic testing that localized no more than two (2) epileptogenic foci
    - Individual is refractory to 2 or more antiepileptic medications
  - Primary Dystonia with **ALL** of the following:
    - 7 years of age or older
    - Individual has severe impairment in daily activities despite optimal medical management
    - Individual has no intracranial pathology on imaging studies that would contraindicate or complicate deep brain stimulation
    - Individual does not have coagulopathy
  - Replacement/revision of a cranial neurostimulator pulse generator or receiver or electrodes (61880, 61885, 61886, 61888)
- **Dorsal Column (Spinal Cord) Stimulation (DCS or SCS)** and **Dorsal Root Ganglion Stimulator (DRG) (**63650, 63655, 63685) are considered medically necessary for **1 or more** of the following:
  - Indications of **1 or more** of the following:
    - Failed back surgery syndrome (FBSS) with low back pain and significant radicular pain
    - Intractable pain caused by complex regional pain syndrome (CRPS)
    - Intractable pain caused by phantom limb syndrome that has not responded to medical management
    - Intractable pain caused by plexopathy
    - Intractable pain caused by cauda equina injury
    - Intractable pain caused by incomplete spinal cord injury
    - Inoperable chronic ischemic limb pain from peripheral vascular disease
    - Neuropathic pain due to Diabetes or inoperable critical limb ischemia
    - Chronic back pain or neck pain with **ALL** of the following:
      - Individual with chronic back or neck pain who are considered inoperable
      - Documentation of at least 12 months of trial and failure of standard therapy (including non-steroidal anti-inflammatory drugs, tricyclic antidepressants, and anticonvulsants)
    - Individual with intractable angina has angiographically documented significant coronary artery disease with **ALL** of the following:
      - Individual not suitable for revascularization procedures such as coronary artery bypass grafting or percutaneous transluminal coronary angioplasty
      - Individual has had optimal pharmacotherapy for at least one month including maximal tolerated dosages of **1 or more** of the following:
        - Anti-anginal medications
        - Long-acting nitrates
        - Beta-adrenergic blockers
        - Calcium channel antagonists

- Individual's angina pectoris is New York Heart Association Functional Class III or Class IV
- Reversible ischemia is documented by symptom-limited treadmill exercise test

- Documentation of successful completion of a trial with percutaneous spinal stimulator, after meeting criteria for trial
- Individual has the ability to understand and operate the device
- No cardiac pacemaker or implantable defibrillator
- No coagulopathy, anticoagulant or antiplatelet therapy, or thrombocytopenia (ie, platelet count of less than75,000/mm3 (75 x109/L))
- No current or chronic infection
- Individuals have undergone careful screening, evaluation and diagnosis by a multidisciplinary team prior to implantation. (Such screening must include psychological, as well as physical evaluation

- **Electric Stimulation and Electromagnetic Therapy and Treatment of Wounds** (E0769, G0281, G0282, G0329) is considered medically necessary for **ALL** of the following:
  - Used as adjunctive therapy
  - Appropriate condition, as indicated by **1 or more** of the following:
    - Arterial ulcer
    - Chronic Stage III or Stage IV pressure ulcer (defined as ulcer that has not healed within 30 days of occurrence)
    - Diabetic ulcer
    - Venous stasis ulcer
  - Appropriate standard wound therapy has been tried for at least 30 days (which may begin while wound is acute), as indicated by **ALL** of the following:
    - Optimization of nutritional status
    - Debridement by any means to remove devitalized tissue
    - Maintenance of clean moist bed of granulation tissue with appropriate moist dressings
    - Necessary treatment to resolve any infection, if present
    - Standard wound care, based on specific type of wound, including **1 or more** of the following:
      - Pressure ulcer: frequent repositioning of patient (usually every 2 hours)
      - Diabetic ulcer: offloading of pressure and good glucose control
      - Arterial ulcer: establishment of adequate circulation
      - Venous ulcer: use of compression system
  - Absence of measurable signs of improved healing, as indicated by **1 or more** of the following:
    - No decrease in wound size (either surface area or volume)
    - No decrease in amount of exudates
    - No decrease in amount of necrotic tissue
  - Services performed by physician, physical therapist, or incident to physician service and **ALL** of the following:
    - Evaluation of wound occurs as integral part of wound therapy, and provider performing services contacts treating physician if wound worsens
    - Wound evaluation done at least monthly by treating physician
- **External Upper Limb Tremor Stimulator Therapy (i.e Cala Trio)** (E0734, A4542) is considered medically necessary for **1 or more** of the following:
  - Initial usage (first 3 months) stimulator therapy of peripheral nerves of wrist and supplies and accessories, as indicated by **ALL** of the following:
    - 18 years of age or older
    - Device prescribed to treat individual's **dominant** upper limb **only**
    - Diagnosis of essential tremor (ET)

- Treating practitioner has performed clinical evaluation (in-person or via approved telehealth service).
- Severe symptoms significantly impair beneficiary's ability to perform dominant hand, upper-limb-related ADLs as demonstrated by Bain & Findley Tremor ADL Scale (BF-ADL) score of 3 or more for **1 or more** of the following eating, drinking, self-care, or writing assessment items:
    - Cut food with knife and fork
    - Use spoon to drink soup
    - Hold cup of tea
    - Pour milk from bottle or carton
    - Wash and dry dishes
    - Brush teeth
    - Use handkerchief to blow nose
    - Use bath
    - Use lavatory
    - Wash face and hands
    - Tie up shoelaces
    - Do up buttons
    - Do up zip
    - Write letter
    - Put letter in envelope
    - Get up out of armchair
- Tremor exacerbating medication (eg, stimulants, beta agonists) has been reduced or eliminated, or reduction or elimination of medication is not medically appropriate.
- At least 2 pharmacologic treatment options for management of ET symptoms have been either tried and failed at maximal tolerable treatment dosages (ie, no or limited effect, intolerable side effects) or considered and ruled out (eg, not appropriate in context of beneficiary's medical history).
- Stimulator therapy prescribed as alternative to invasive and/or permanent surgical treatment option (eg, deep brain stimulation, magnetic resonance guided focused ultrasound, radiosurgery)

▪ Continued treatment - after initial 3 months, as indicated by **ALL** of the following:
- Treating practitioner has performed clinical re-evaluation (in-person or via approved telehealth service) and documents **ALL** of the following:
    - Individual receiving benefits from therapy as indicated by one-point improvement in BF-ADL score in any eating, drinking, self-care, or writing task scored as 3 or more prior to initiation of therapy
    - Individual adhering to therapy as defined as use of external upper limb tremor stimulator therapy on 70% of days during consecutive 30-day period anytime during the first 3 months of initial use

o **Functional Electrical Stimulators (FES)** (i.e. Parastep I System) (E0764, E0770) or **Neuromuscular and Muscular Electrical Stimulation** (i.e. ReActiv8) (NMES) (E0745, A4595) is considered medically necessary for **1 or more** of the following:

▪ Disuse atrophy with intact nerve supply to the muscle (including the brain, spinal cord, and peripheral nerves) with **1 or more** of the following:
- Previous casting or splinting of a limb when unable to participate in physical therapy
- Contractures due to scarring of soft tissue (e.g. burn scarring)
- Hip replacement prior to initiation of physical therapy.
- Major knee surgery (e.g., total knee replacement) when there is failure to respond to physical therapy

▪ Hemiplegia or hemiparesis with foot drop after chronic stroke, as indicated by **ALL** of the following:

- Ankle range of motion within limits required for normal gait
- Cognitively able to understand and comply with rehabilitation protocol
- Stroke onset greater than 3 months prior

- Spinal cord injury where restoration of walking is the goal, and the individual has the **ALL** of the following:
  - Intact lower motor units (L1 and below) (both muscle and peripheral nerve).
  - Muscle and joint stability for weight bearing at upper and lower extremities that can demonstrate balance and control to maintain an upright support posture independently.
  - Brisk muscle contraction to NMES and sensory perception of electrical stimulation sufficient for muscle contraction.
  - High motivation, commitment and cognitive ability to use such devices for walking.
  - Ability to transfer independently and independent standing tolerance for at least 3 minutes.
  - Hand and finger function to manipulate controls.
  - At least 6-month post recovery spinal cord injury and restorative surgery.
  - No evidence of hip and knee degenerative disease and no history of long bone fracture secondary to osteoporosis.
  - Willingness to use the device long-term.

- **Percutaneous electrical nerve stimulation (PENS)** (64555, 64596, 64597, 64999) is considered medically necessary for **1 or more** of the following:
  - Treatment of chronic low back pain secondary to degenerative disc disease for up to a thirty (30) day period as part of a multi-modality rehabilitation program that includes exercise
  - Diabetic neuropathy pain when used to stimulate the anatomical source of pain
- **Peripheral Neuromuscular Stimulator (PNS)** (64590 64595, 64598, 64575) is considered medically necessary for **1 or more** of the following:
  - Placement with **ALL** of the following:
    - Individual has chronic, severe neurogenic pain including but not limited to complex regional pain syndrome, neuropathic pain, neuralgias, post-surgical pain for at least three to six months in the region of the nerve being targeted
    - Individual has failed conservative, less invasive treatment including but not limited to medications, physical therapy, braces, local injections, TENS, psychological therapy, attempts to cure the underlying condition causing the pain for at least six months
    - Individual does not have contraindications to the procedure including but not limited to local infections, surgical/medical /psychological conditions that can adversely impact the procedure
    - Individual does not have any substance abuse issues
    - Individual has been educated and psychologically prepared following discussion of risks and benefits by the treating physician
    - Request is for **1 or more** of the following:
      - Criteria must be met for implantation in order to perform a trial
      - Individual had undergone a successful stimulation trial with greater than or equal to 50% reduction in pain intensity before implantation
  - Removal with or without replacement is considered medically necessary when **1 or more** the following are met:
    - The device malfunctions or breaks and individual continues to meet placement criteria
    - Becomes infected
    - No longer warranted with a documented reason
- **Transcutaneous Electrical Nerve Stimulator (TENS unit)** (E0720, E0730, E0733) is considered medically necessary for **1 or more** of the following:
  - Acute post-operative pain with **1 or more** of the following:

- Initial trial period with **ALL** of the following:
    - Used as an adjunct or alternative to pharmacotherapy
    - Used in the first 30 days after surgery
    - Monitored by the physician to determine the effectiveness of the transcutaneous electrical nerve stimulator in managing the pain
- Continued treatment with **ALL** of the following:
    - Individual has completed an initial trial period within the first 30 days after surgery
    - Documentation from the physician indicates how often the individual used the transcutaneous electrical unit, the duration of use, and the results
    - Documentation from the physician proving the treatment has significantly alleviated pain and continued treatment would be beneficial over a long period of time
    - The ordering physician must be the attending physician or a consulting physician for the disease or condition
- Chronic, intractable pain other than low back pain with **ALL** of the following:
    - The presumed etiology of the pain must be a type that is accepted as responding to TENS therapy
    - The pain must have been present for at least three months
    - Other appropriate treatments treatment modalities must have been tried and failed
- Dysmenorrhea as indicated with **ALL** of the following:
    - Disabling dysmenorrhea
    - Secondary causes of dysmenorrhea have been ruled out (e.g. endometriosis)
    - No response to treatment with non-steroidal anti-inflammatory medications (NSAIDs)
- Replacement supplies for use with Transcutaneous Electrical Nerve Stimulator (TENS) requested

- **Form fitting, conductive garment** (E0731), as indicated by **ALL** of the following:
    - There is a large area or many sites to be stimulated.
    - Stimulation will be delivered so frequently that it is not practical to use conventional items including, but not limited to, wires, electrodes or tapes
    - Individual needs garment for treatment of chronic intractable pain where conventional items would not be accessible.
    - Individual has a medical condition that does not allow for conventional items including, but not limited to, tapes, wires or electrodes.
    - Individual needs to access site under a cast, if applicable (may not have a cast applied)

Electrical Stimulation devices that are considered **non-covered/not medically necessary** for any use other than those indicated in clinical criteria, to include but not limited to:

- Acupuncture for stimulation of auricular points (64999, E1399)
    - NeuroStim system/NSS
    - P-Stim
    - ANSiStim
    - E-Pulse
- Auricular electrical stimulation (E0721)
- Auricular electro-acupuncture (i.e. P-STIM device) (0783T, E0765)
- Bioelectric Nerve Block (Electroceutical Therapy) (E1399)
- Cefaly transcutaneous electrical stimulator headband (A9270)
- Cranial Electrotherapy Stimulation (e.g. Alpha-Stim, Fisher Wallace Stimulator) (A4596, E0732, 64553)
- Dorsal Column Stimulation for:
    - Chronic malignant pain
    - Other chronic non-malignant neuropathic pain (e.g., cephalgia, diabetic neuropathy, headache, inguinal pain occipital neuralgia, phantom limb syndrome, and trigeminal neuralgia) that does not meet the clinical indications
    - Spasticity

    - Critical limb ischemia as a technique to forestall amputation
    - Chronic vegetative state or minimally conscious state
    - Irritable bowel syndrome
- The **combined use of dorsal column stimulation and dorsal root ganglion stimulation** for the treatment of complex regional pain syndromeor any other indications are not medically necessary.
- Electric Cell-Signaling Energy Waves (EcST and ESI)
- Electrical stimulation indications for any of the following:
    - Abdominal pain, including pregnancy
    - Acute and Chronic headaches including Migraine
    - Acute pain (less than three months duration) other than post-operative pain
    - Adhesive capsulitis (frozen shoulder)
    - Blockade of the stellate ganglion
    - Carpal tunnel syndrome pain
    - Chemotherapy-induced peripheral neuropathy
    - Chondromalacia patellae and patellofemoral disorders
    - Dry mouth (xerostomia) (E0755)
    - In individuals with convulsive disorders of the head and neck
    - In individuals with implantable electrical devices such as pacemakers or defibrillators
    - Management of opioid withdrawal
    - Nausea and vomiting
    - Pelvic pain, including labor and delivery
    - Temporomandibular joint (TMJ) pain
- Galvanic stimulation (E1399)
- H-Wave Type Stimulators (E1399)
- Interferential Therapy (IF) Neurostimulator Devices (e.g., RS Medical TENS Plus, Sequential Stimulation with 4 leads or RS-4i) (S8130, S8131)
- Intramuscular stimulation device
- Intravaginal electrical stimulation – **See MCG**
- Microcurrent Electrical Nerve Stimulation Devices aka electro-therapeutic point stimulation (e.g., Algonix, Alpha-Stim 100, Electro-Acuscope Myopulse Therapy System, Electro-Myopulse 75L, electro-Lyoscope 85P, KFH Energy, MENS 2000-D, MICROCURRENT or Myopulse 75C) (E1399)
- Nexwave by Zynex (64590) 3-1 device: Interferential, TENS, and NMES
- Non-Invasive Interactive Neurostimulation (E1399)
- Non-invasive/No-Incision Pain Procedure (NIP) Device (E1399)
- NTX-100 Tonic Motor Activation (TOMAC) System for Restless Leg Syndrome (E0743)
- Neuromuscular and Muscular Electrical Stimulation devices for the following:
    - Autonomic dysreflexia
    - Bell’s palsy
    - Cardiac conditioning
    - Cerebral palsy
    - Chronic Obstructive Pulmonary Disease
    - Congestive Heart Failure
    - Erectile dysfunction
    - Irreversible contracture
    - Masseter muscle oral dysfunction after stroke
    - Muscle atrophy after stroke
    - Pain caused by necrosis of the femoral head.
    - Treatment of denervated muscles
    - Treatment of knee osteoarthritis
    - Upper extremity hemiplegia
- Percutaneous neuromodulation therapy (PNT)(E1399)
- Percutaneous electrical nerve field stimulation (PENFS) (e.g., NSS-2 Bridge, IB-Stim) (0720T)
- Peripheral subcutaneous field stimulation or peripheral nerve field stimulation (PNFS)

- Pulsed Electrical Stimulator (PES) (E0761)
- Quell device (E1399)
- Reduced impedance non-invasive cortical electrostimulation (RINCE) (64999)
- Spinal Cord Stimulation for:
    - Repeat trials are not considered medically necessary unless appropriate medical documentation proves there was an extenuating circumstance that led to trial failure
    - Cephalgia
    - Headache of any etiology
    - Inguinal pain
    - Occipital neuralgia
    - Trigeminal neuralgia
    - Spasticity
    - Cervical spinal cord stimulation for the treatment of cervical trauma, disc herniation, failed cervical spine surgery syndrome presenting with arm pain, neck pain, and/or cervicogenic headache, radiation-induced brain injury, or stroke
    - Implantable epidural spinal cord stimulation (both temporary and permanent) as a treatment of critical limb ischemia as a technique to forestall amputation
    - Implantable subcutaneous target stimulator devices (both temporary and permanent) for all indications
- Sympathetic therapy (Electrical sympathetic stimulation therapy) (E13999)
- Synaptic electrical stimulator (97032)
- Severe scoliosis or severe osteoporosis (for spinal cord injury) (E0744)
- The ReBuilder (64555)
- Threshold/Therapeutic Electrical stimulation (TES) (E1399, 64999)
- Transcutaneous Electrical Joint Stimulation Devices (TEJSD) (E0762)
- Transcutaneous Electrical Modulation Pain Reprocessing (TEMPR) (Scrambler therapy, Calmare) (0278T)
- Transcutaneous magnetic stimulation (0766T, 0767T, 0768T, 0769T)

Document History:

Revised Dates:

- 2026: February – Administrative update to correct PNFS exception to align with FDA guidelines
- 2025: September – Implementation date of January 1, 2026. Clarification of acupuncture, PNS diabetic pain and housekeeping
- 2025: May – Implementation date of September 1, 2025. New policy created. Imported criteria from DME 07 – Electrical Stimulation, DME 01 – Electrical Stimulation and Electricomagnetic Therapy for Wounds, DME 09 – Electric, Electromagnetic, Ultrasonic Bone Growth Stimulation, DME 17 - Neuromuscular Electrical Stimulation, Surgical 74 – Deep Brain Stimulation, and Surgical 69 – Spinal Cord Electrical Stimulator - Spinal cord stimulator (SPS) and Dorsal MotorGanglion Stimulator (DMG). Removed duplicate information, consolidated not medically necessary section and updated formatting.

Reviewed Dates:

Origination Date: Aug 2025

Coding:

Medically necessary with criteria:

Coding	Description
20974	Electrical stimulation to aid bone healing; noninvasive (nonoperative)
20975	Electrical stimulation to aid bone healing; invasive (operative)
20979	Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative)

61850	Twist drill or burr hole(s) for implantation of neurostimulator electrodes, cortical
61860	Craniectomy or craniotomy for implantation of neurostimulator electrodes, cerebral, cortical
61863	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; first array
61864	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; each additional array (List separately in addition to primary
61867	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globuspallidus, subthalamic nucleus, periventricular, periaqueductal gray), with use of intraoperative microelectrode recording; first array
61868	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), with use of intraoperative microelectrode recording; each additional array (List separately in addition to primary procedure)
61880	Revision or removal of intracranial neurostimulator electrodes
61885	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array
61886	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to 2 or more electrode arrays
61888	Revision or removal of cranial neurostimulator pulse generator or receiver
63650	Percutaneous implantation of neurostimulator electrode array, epidural
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling
64555	Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)
64575	Open implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)
64580	Open implantation of neurostimulator electrode array; neuromuscular
64585	Revision or removal of peripheral neurostimulator electrode array
64590	Insertion or replacement of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver
64595	Revision or removal of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, with detachable connection to electrode array
64596	Insertion or replacement of percutaneous electrode array, peripheral nerve, with integrated neurostimulator, including imaging guidance, when performed; initial electrode array
64597	Insertion or replacement of percutaneous electrode array, peripheral nerve, with integrated neurostimulator, including imaging guidance, when performed; each additional electrode array (List separately in addition to code for primary procedure)
64598	Revision or removal of neurostimulator electrode array, peripheral nerve, with integrated neurostimulator

64999	Unlisted procedure, nervous system
A4541	Monthly supplies for use of device coded at E0733
A4542	Supplies and accessories for external upper limb tremor stimulator of the peripheral nerves of the wrist
A4545	Supplies and accessories for external tibial nerve stimulator (e.g., socks, gel pads, electrodes, etc.), needed for one month
A4558	Conductive gel or paste, for use with electrical device (e.g., TENS, NMES), per oz.
A4595	Electrical stimulator supplies, 2 lead, per month, (e.g. TENS, NMES)
E0720	Transcutaneous electrical nerve stimulation (TENS) device, 2
E0730	Transcutaneous electrical nerve stimulation (TENS) device, 4
E0731	Form - fitting conductive garment for delivery of TENS or NMES (with conductive fibers separated from the patient's skin by layers of fabric)
E0733	Transcutaneous electrical nerve stimulator for electrical stimulation of the trigeminal nerve
E0734	External upper limb tremor stimulator of the peripheral nerves of the wrist
E0736	Transcutaneous tibial nerve stimulator
E0737	Transcutaneous tibial nerve stimulator, controlled by phone application
E0745	Neuromuscular stimulator, electronic shock unit
E0747	Osteogenesis stimulator, electrical, noninvasive, other than spinal applications
E0748	Osteogenesis stimulator, electrical, noninvasive, spinal applications
E0749	Osteogenesis stimulator, electrical, surgically implanted
E0760	Osteogenesis stimulator, low intensity ultrasound, noninvasive 61850 – Twist drill or burr hole(s) for implantation of neurostimulator electrodes, cortical
E0764	Functional neuromuscular stimulator, transcutaneous stimulation of muscles of ambulation with computer control, used for walking by spinal cord injured, entire system, after completion of training program
E0769	Electrical stimulation or electromagnetic wound treatment device, not otherwise classified
E0770	Functional electrical stimulator, transcutaneous stimulation of nerve and / or muscle groups, any type, complete system, not otherwise specified
G0281	Electrical stimulation, (unattended), to one or more areas, for chronic Stage III and Stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care, as part of a therapy plan of care (Not Covered effective 1/1/2025)

G0282	Electrical stimulation, (unattended), to one or more areas, for wound care other than described in G0281
G0295	Electromagnetic therapy, to one or more areas, for wound care other than described in G0329 or for other uses
G0329	Electromagnetic therapy, to one or more areas for chronic Stage III and Stage IV pressure ulcers, arterial ulcers, diabetic ulcers and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care as part of a therapy plan of care
L8680	Implantable neurostimulator electrode, each
L8682	Implantable neurostimulator radiofrequency receiver
L8683	Radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver
L8685	Implantable neurostimulator pulse generator, single array, rechargeable, includes extension
L8686	Implantable neurostimulator pulse generator, single array, non-rechargeable, includes extension
L8687	Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension
L8688	Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension

Considered Not Medically Necessary:

Coding	Description
0278T	Transcutaneous electrical modulation pain reprocessing (eg, scrambler therapy), each treatment session (includes placement of electrodes)
0720T	Percutaneous electrical nerve field stimulation, cranial nerves, without implantation
0766T	Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, initial treatment, with identification and marking of the treatment location, including noninvasive electroneurographic localization (nerve conduction localization), when performed; first nerve
0767T	Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, initial treatment, with identification and marking of the treatment location, including noninvasive electroneurographic localization (nerve conduction localization), when performed; each additional nerve (List separately in addition to code for primary procedure)
0768T	Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, subsequent treatment, including noninvasive electroneurographic localization (nerve conduction localization), when performed; first nerve
0769T	Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, subsequent treatment, including noninvasive electroneurographic localization (nerve conduction localization), when performed; each additional nerve (List separately in addition to code for primary procedure)
0783T	Transcutaneous auricular neurostimulation, set-up, calibration, and patient education on use of equipment
A4543	Supplies for transcutaneous electrical nerve stimulator, for nerves in the auricular region, per month
A4544	Electrode for external lower extremity nerve stimulator for restless legs syndrome
A4596	Cranial electrotherapy stimulation (CES) system supplies and accessories, per month
E0721	Transcutaneous electrical nerve stimulator for nerves in the auricular region

E0732	Cranial electrotherapy stimulation (CES) system, any type
E0743	External lower extremity nerve stimulator for restless legs syndrome, each
E0744	Neuromuscular stimulator for scoliosis
E0755	Electronic salivary reflex stimulator (intraoral/noninvasive)
E0761	Non-thermal pulsed high frequency radiowaves, high peak power electromagnetic energy treatment device
E0762	Transcutaneous electrical joint stimulation device system, includes all accessories
E0765	FDA approved nerve stimulator, with replaceable batteries, for treatment of nausea and vomiting
G0283	Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care
S8130	Interferential current stimulator, 2
S8131	Interferential current stimulator, 4
S8930	Electrical stimulation of auricular acupuncture points; each 15

The preceding codes are included above for informational purposes only and may not be all inclusive. Additionally, inclusion or exclusion of a treatment, procedure, or device-code(s) does not constitute or imply member coverage or provider reimbursement.

Policy Approach and Special Notes: *

- Coverage
  - See the appropriate benefit document for specific coverage determination. Member specific benefits take precedence over medical policy.
- Application to products
  - Policy is applicable to Sentara Health Plan Virginia Medicaid Products
- Authorization requirements
  - Precertification required by Plan
- Special Notes:
  - This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.
  - Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.
  - The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for

the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. EPSDT Supplement B (updated 5.19.22)_Final.pdf

- Service authorization requests must be accompanied by sufficient clinical records to support the request. Clinical records must be signed and dated by the requesting provider withing 60 days of the date of service requested.

References:

Including but not limited to: Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

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Keywords:

Electrical Stimulation, Electromagnetic Therapy, Electric, Electromagnetic, Ultrasonic Bone Growth Stimulation, Deep Brain Stimulation, Spinal Cord Electrical Stimulator, Spinal cord stimulator, Dorsal Motor Ganglion Stimulator, Neuromuscular.