Sentara Health Plans

Commercial

Electrical Stimulation and Electromagnetic Therapy for Wounds, DME 01

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Effective Date	07/2008
Next Review Date	10/2025
Coverage Policy	DME 01
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Member-specific benefits take precedence over medical policy and benefits may vary across plans. Refer to the individual's benefit plan for details *.

Purpose:

This policy addresses Electrical Stimulation and Electromagnetic Therapy for Wounds.

Description & Definitions:

Electrical stimulation is used for a variety of clinical applications, such as fracture repair, pain management, and wound healing.

Criteria:

Electrical Stimulation (ES) and Electromagnetic Therapy for the Treatment of Wounds may be covered for **ALL** of the following:

- Used as adjunctive therapy
- Appropriate condition, as indicated by 1 or more of the following:
  - Chronic Stage III or Stage IV pressure ulcer (defined as ulcer that has not healed within 30 days of occurrence)
  - Arterial ulcer
  - 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

Electrical stimulation and electromagnetic therapy **does not meet the definition of medical necessity**, to include but not limited to:

- As initial treatment modality or prevention
- Unsupervised use for wound therapy
- Wound previously treated with ES or electromagnetic therapy demonstrates 100% epithelialized wound bed.
- Continuation of electrical stimulation or electromagnetic therapy for wound healing is considered not medically necessary if no evidence of healing is noted within any 30-day period of treatment.
- Devices used for pulsed electromagnetic therapy including but not limited to Diapulse, SofPulse, and Provant Therapy System for any indication
- Electromagnetic therapy for **1 or more** the following:
    - Prevention of ulcers and pressure sores.
    - Tinnitus
    - Treatment and prevention of osteoporosis
    - Treatment of acute post-operative pain and edema
    - Treatment of fibromyalgia
    - Treatment of mechanical neck disorders
    - Treatment of neuropathic pain (e.g., painful diabetic peripheral neuropathy)
    - Treatment of osteoarthritis
    - Treatment of soft tissue injuries
    - Treatment of subacromial impingement syndrome
- High-frequency pulsed electromagnetic stimulation (also known as therapeutic magnetic resonance) for all indications, including but not limited to the following:
    - Treatment and prevention of osteoporosis
    - Treatment of acute post-operative pain and edema
    - Treatment of fibromyalgia
    - Treatment of mechanical neck disorders
    - Treatment of neuropathic pain (e.g., painful diabetic peripheral neuropathy)
    - Treatment of osteoarthritis
    - Treatment of soft tissue injuries
    - Treatment of subacromial impingement syndrome
    - Treatment of wounds

Coding:

Medically necessary with criteria:

Coding	Description
E0769	Electrical stimulation or electromagnetic wound treatment device, not otherwise classified
G0329	Electromagnetic therapy, to one or more areas for chronic Stage III and Stage IV pressure ulcers, arterial ulcers, diabetic ulcers and venous stasis

Considered Not Medically Necessary:

Coding	Description
E0761	Non-thermal pulsed high frequency radiowaves, high peak power electromagnetic energy treatment device
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

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

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. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Document History:

Revised Dates:

- 2025: January – Procedure codes updated to align with changes in service authorization status.
- 2022: October
- 2021: December
- 2020: November
- 2019: October
- 2015: July
- 2014: July
- 2013: July
- 2012: July
- 2011: August

Reviewed Dates:

- 2024: October – No criteria changes. References and coding updated.
- 2023: October
- 2018: July
- 2017: November
- 2016: July
- 2010: July
- 2009: July

Effective Date:

- July 2008

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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NCD: Electrical Stimulation (ES) and Electromagnetic Therapy for the Treatment of Wounds. (2004, Jul 01). Retrieved Sep 17, 2024, from Centers for Medicare and Medicaid Services: https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=131&ncdver=3&keyword=electrical%20stimulation&keywordType=starts&areaId=s53&docType=NCA,CAL,NCD,MEDCAC,TA,MCD,6,3,5,1,F,P&contractOption=all&sortBy=relevance&bc=1

Peripheral electromagnetic field (pemf) to aid wound healing. (2024). Retrieved Sep 17, 2024, from U.S. Food and Drug Administration: https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPCD/classification.cfm?id=MBQ

Special Notes: *

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.

Services mean both medical and behavioral health (mental health) services and supplies unless We specifically tell You otherwise. We do not cover any services that are not listed in the Covered Services section unless required to be covered under state or federal laws and regulations. We do not cover any services that are not Medically Necessary. We sometimes give examples of specific services that are not covered but that does not mean that other similar services are covered. Some services are covered only if We authorize them. When We say You or Your We mean You and any of Your family members covered under the Plan. Call Member Services if You have questions.

MUST SEE MEMBER BENEFIT FOR DETERMINATION.

We only cover DME that is Medically Necessary and prescribed by an appropriate Provider. We also cover colostomy, ileostomy, and tracheostomy supplies, and suction and urinary catheters. We do not cover DME used primarily for the comfort and wellbeing of a Member. We will not cover DME if We deem it useful, but not absolutely necessary for Your care. We will not cover DME if there are similar items available at a lower cost that will provide essentially the same results as the more expensive items.

Pre-Authorization is Required for All Rental Items.

Pre-Authorization is Required for All Repair and Replacement.

Keywords:

SHP Electrical Stimulation and Electromagnetic Therapy, SHP Durable Medical Equipment 01, Wound, healing, electrical, electromagnetic, magnetic, stimulation, stage, pressure, ulcer, venous, diabetic, arterial, Stage III pressure ulcers, Stage IV pressure ulcers, Arterial ulcers, Diabetic ulcers, Venous stasis ulcers, wound care, Pulsed Electromagnetic Therapy, Diapulse, SofPulse, Provant Wound Closure System, increased, blood flow, nerve regeneration, tissue regeneration