Sentara Health Plans

Commercial

# Cranial Electrotherapy Stimulation (e.g. Alpha-Stim, Fisher Wallace Stimulator)

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| | |
|---|---|
| Effective Date | 03/2008 |
| Next Review Date | 01/2025 |
| Coverage Policy | DME 59 |
| Version | 6 |

**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 Cranial Electrotherapy Stimulation (e.g. Alpha-Stim, Fisher Wallace Stimulator).

## Description & Definitions:

Cranial Electrotherapy Stimulation is a noninvasive, battery-operated device for home use that stimulates the brain with short duration, low-amp pulses of direct current via externally placed electrodes.

## Criteria:

Cranial Electrotherapy Stimulation is considered not medically necessary for any indication.

## Coding:

Medically necessary with criteria:

| Coding | Description |
|---|---|
| | None |

Considered Not Medically Necessary:

| Coding | Description |
|---|---|
| 0720T | Percutaneous electrical nerve field stimulation, cranial nerves, without implantation |
| A4541 | Monthly supplies for use of device coded at E0733 |
| A4596 | Cranial electrotherapy stimulation (CES) system supplies and accessories, per month |
| E0732 | Cranial electrotherapy stimulation (CES) system, any type |
| E0733 | Transcutaneous electrical nerve stimulator for electrical stimulation of the trigeminal nerve |

*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.
- 2024: January
- 2022: February
- 2019: October
- 2016: April
- 2015: July, September, November
- 2014: January, April, November
- 2013: March, November
- 2012: May, August, September
- 2011: August, September

Reviewed Dates:

- 2023: January
- 2021: February
- 2020: February
- 2017: December
- 2015: January
- 2012: July
- 2011: July
- 2010: March
- 2009: March

Effective Date:

- March 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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## 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 Cranial Electrotherapy Stimulation, SHP Durable Medical Equipment 59, Alpha Stim, Fisher Wallace Stimulator, Cranial Electrotherapy Stimulation, behavioral health, Liss Body Stimulator, Electrosleep Therapy, CES, cerebral electrotherapy, craniofacial electrostimulation, electric cerebral stimulation, electrosleep, electrotherapeutic sleep,

transcerebral electrotherapy, transcranial electrotherapy, CES Ultra, transcranial direct current stimulation (tDCS), and cranial alternating current stimulation