Sentara® Health Plans

Commercial

Electrical Stimulation

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Effective Date	03/2008
Next Review Date	02/2025
Coverage Policy	DME 07
Version	2

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.

Description & Definitions:

Electrical stimulation devices are made of leads, pads and a control unit. The control unit delivers either a continuous or intermittent low voltage to the site of pain. These include, but are not limited to, the following:

- Bioelectric Nerve Block is a non-invasive therapy that uses electrodes applied to the skin in a painful area on the body. The electrodes are connected to a computer program that send out alternating electrical currents for electrical stimulation to block pain
- H-Wave Stimulators are non-invasive multifunctional electrical stimulation devices (High and/or low frequency delivery) to that stimulate a muscle with electrical impulses.
- Interferential Therapy (IF) Neurostimulator Devices use low frequency electrical stimulation to deliver therapy to a specific body site.
- Microcurrent Electrical Nerve Stimulation Devices send electrical impulses to specific areas of the body.
- Percutaneous electrical stimulation places small needles 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.
- Transcutaneous Electrical Joint Stimulation Devices (Bionicare) can be used on various joints to help control pain by using patches connected to the skin and allow low electrical current to flow through.
- 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:

Electrical stimulation is considered medically necessary for **1 or more** of the following devices:

- Transcutaneous Electrical Nerve Stimulator (TENS unit) is considered medically necessary with **1 or more** of the following:
  - Initial trial therapy is considered medically necessary with **ALL** of the following:
    - Documentation verifies that other alternative equipment and conservative treatment modalities have been exhausted without success

        - The use of the TENS unit will benefit the individual to a degree not attainable by the use of other methods of care and treatment
        - A practitioner must direct the home treatment regimen, which will include the use of treatment modalities including, but not limited to, nursing services and physical therapy
        - Rental of the transcutaneous electrical nerve stimulator will be approved for the first two months, and purchase will be made after that period
    - Continued therapy, after initial trial therapy is considered medically necessary with **ALL** of the following:
        - Individual has met criteria and completed a trial therapy to include **ALL** of the following**:**
            - Documentation verifies that other alternative equipment and conservative treatment modalities have been exhausted without success
            - The use of the TENS unit will benefit the individual to a degree not attainable by the use of other methods of care and treatment
            - A practitioner must direct the home treatment regimen, which will include the use of treatment modalities including, but not limited to, nursing services and physical therapy
        - The treatment regimen must be evaluated at least bi-monthly and can be determined effective after one month's use
        - The absence of this device would require that the individual visit the practitioner or therapist for treatment or medications more often than with the device
        - There must be documentation that the individual or the caregiver is able to manage the application of the device
        - Purchase of the unit is considered medically necessary for **1 or more** of the following:
            - If the unit device that was supplied for the required 2 month rental period is new upon delivery, the Department of Medical Assistance Services will consider paying the full purchase price listed in the Appendix B "Medicaid Durable medical Equipment and Supplies Listing" in addition to the initial 2 month rental period for these items
            - The purchase of the unit is considered medically necessary after the 60 day trial rental with **ALL** of the following:
                - Documentation indicates that the individual is complaint with treatment
                - Documentation described how the transcutaneous electrical nerve stimulation treatment modality is effective
                - Use of the transcutaneous electrical nerve stimulator is not contraindicated and/or not effective
- FDA approved form-fitting garment as durable medical equipment for delivering transcutaneous electrical stimulation as prescribed by a doctor is considered medically necessary for **1 or more** of the following:
    - Individual must have a conductive garment, 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
- Percutaneous electrical nerve stimulation (PENS) 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
- Peripheral Nerve Stimulator (PNS) is considered medically necessary for **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
    - Individual had undergone a successful stimulation trial with greater than or equal to 50% reduction in pain intensity before implantation
    - Device is FDA approved.
- Peripheral Nerve Stimulator (PNS) 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
        - Individual had undergone a successful stimulation trial with greater than or equal to 50% reduction in pain intensity before implantation
        - Device is FDA approved.
    - Removal with or without replacement is considered medically necessary when **1 or more** the following criteria are met:
        - The device malfunctions or breaks and individual continues to meet placement criteria
        - Becomes infected
        - No longer warranted with a documented reason

Electrical Stimulation for the following does not **meet the definition of medical necessity**, to include but not limited to:

- Auricular electrical stimulation
- Auricular electroacupuncture
- Bioelectric Nerve Block (Electroceutical Therapy)
- Blockade of the stellate ganglion using transcutaneous electrical nerve stimulator
- Electro-Acuscope Myopulse Therapy System
- Electro-therapeutic point stimulation (ETPSSM) (Microcurrent point stimulation)
- H-Wave Type Stimulators
- Interferential Therapy (IF) Neurostimulator Devices (e.g., RS Medical TENS Plus, Sequential Stimulation with 4 leads or RS-4i)
- Intramuscular stimulation device
- Microcurrent Electrical Nerve Stimulation Devices (e.g., Algonix, Alpha-Stim 100, Electro-Myopulse 75L, electro-Lyoscope 85P, KFH Energy, MENS 2000-D, MICROCURRENT or Myopulse 75C)
- Percutaneous neuromodulation therapy (PNT)
- Peripheral subcutaneous field stimulation or peripheral nerve field stimulation (PNFS)
- Sympathetic therapy (Electrical sympathetic stimulation therapy)
- The ReBuilder
- Transcutaneous Electrical Joint Stimulation Devices (TEJSD)

- Transcutaneous Electrical Modulation Pain Reprocessing (TEMPR) (Scrambler therapy, Calmare)
- Transcutaneous magnetic stimulation

Transcutaneous electrical nerve stimulators for the following **do not meet the definition of medical necessity**, to include but not limited to:

- Abdominal pain, including pregnancy
- Acute pain (less than three months duration) other than post-operative pain
- In individuals with convulsive disorders of the head and neck
- In individuals with implantable electrical devices such as pacemakers or defibrillators
- Pelvic pain, including labor and delivery
- Temporomandibular joint (TMJ) pain
- To reduce subjective pain intensity during dental procedures
- To reduce subjective pain intensity during medical procedures

Coding:

Medically necessary with criteria:

Coding	Description
64575	Open implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)
64585	Revision or removal of peripheral neurostimulator electrode array
64590	Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive
64595	Revision or removal of peripheral or gastric neurostimulator pulse generator or receiver
64999	Unlisted procedure, nervous system
A4595	Electrical stimulator supplies, 2
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
E1399	Durable medical equipment, miscellaneous
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, nonrechargeable, includes extension
L8687	Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension
L8688	Implantable neurostimulator pulse generator, dual array, nonrechargeable, includes extension

Considered Not Medically Necessary:

Coding	Description
0278T	Transcutaneous electrical modulation pain reprocessing (eg, scrambler therapy), each treatment session (includes
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
E0745	Neuromuscular stimulator, electronic shock unit
E0762	Transcutaneous electrical joint stimulation device system, includes all accessories
S8130	Interferential current stimulator, 2
S8131	Interferential current stimulator, 4
S8930	Electrical stimulation of auricular acupuncture points; each 15

Document History:

Revised Dates:

- 2024: February

- 2022: February
- 2019: November
- 2016: April
- 2015: July
- 2014: April
- 2013: July
- 2012: November
- 2011: February, March, April, May, June, November
- 2010: June

Reviewed Dates:

- 2023: February
- 2019: October
- 2018: October
- 2017: November
- 2016: July
- 2014: July
- 2012: June
- 2009: May

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 Electrical Stimulation, SHP Durable Medical Equipment 07, Transcutaneous Electrical Nerve Stimulator, TENS unit, SHP DME 07, TENS, transcutaneous electrical stimulation, therapeutic electrical nerve stimulation, SHP Durable Medical Equipment 07, Bioelectric Nerve Block, electric current, brain, pain, electroceutical therapy, Bioelectric therapy, non-invasive neuron blockade, electroceutical neuron blockade, bioelectric treatment system, nerve conduction block, SHP H-Wave Type Stimulators, electrical impulse, pain relief, increase blood circulation, lymphatic drainage, range of motion, muscle spasms, atrophy, SHP Interferential Therapy (IF) Neurostimulator Devices, low frequency electrical stimulation, pain, muscle spasms, muscle strain, physical therapy, RS Medical TENS Plus, Sequential Stimulation with 4 leads, RS-4i, BioStim® INF, INF Plus™, Endomed Interferential Stimulators, Flex-IT™, Soleo Galva Electrotherapy System, IF 4000, IF 8000, FastStart® IF, OrthoStim4™, SurgiStim4™, VQ™ Vector, RSJ, RS JC, RS-4i® Sequential Stimulator; RS-2i® Interferential Stimulator, Stereodynator®, PRO ElecDT® 2000, Vectorsurge 5 Model 470, interferential current (IFC), IFT, SHP Microcurrent Electrical Nerve Stimulation Devices, electrical impulse, pain, healing, analog device, SHP Percutaneous Electrical Nerve Stimulation, PENS, chronic low back pain, degenerative disc disease, exercise, SHP Transcutaneous Electrical Joint Stimulation Devices, TEJSD, SHP Durable Medical Equipment 227, electrical impulses, brace, BioniCare Knee System, OActive Knee Brac), BIO-1000™ System, Diatermed II, OrthoCor™ Active Knee System™, neoGEN-Series® system, SofPulse®, SofPulse® 912-M10, Roma3™, Torino II™, StimRouter Neuromodulation System, Peripheral Nerve Stimulation, Electro-Acuscope Myopulse Therapy System, DyAnsys auricular electrical nerve stimulator