Electrical and Spinal Cord Stimulators

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Instructions for Use

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Related Medicare Advantage Policy Guidelines

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Coverage Guidelines

Electrical and spinal cord stimulators are covered in accordance with Medicare coverage criteria.

Notes:

- DME Face to Face Requirement: Effective July 1, 2013, Section 6407 of the Affordable Care Act (ACA) established a face-to-face encounter requirement for certain items of DME (including transcutaneous electrical nerve stimulation; form fitting conductive garments for delivery of TENS or NMES; pelvic floor stimulator; neuromuscular stimulator for scoliosis; neuromuscular stimulator electric shock unit; transcutaneous electrical joint stimulation system; functional neuromuscular stimulator; and FDA approved nerve stimulator for treatment of nausea and vomiting). For DME Face to Face Requirement information, refer to the Coverage Summary titled Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics) and Medical Supplies Grid.
- Specific Coding and Pricing Issues for HCPCS code L8680 and CPT code 63650: For neurostimulator devices, HCPCS code L8680 is no longer separately billable for Medicare because payment for electrodes has been incorporated in CPT code 63650. For additional information, see the MLN Matters® Article MM8645 dated March 11, 2014 at https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/MM8645.pdf. Accessed August 23, 2021)

Neuromuscular Electrical Stimulator (NMES)

NMES is covered when criteria are met. Refer to the National Coverage Determination (NCD) for Neuromuscular Electrical Stimulation (160.12). (Accessed August 23, 2021)

For coverage of supplies necessary for NMES; refer to the NCD for Supplies Used in the Delivery of Transcutaneous Electrical Nerve Stimulation (TENS) and Neuromuscular Electrical Stimulation NMES (160.13).
(Accessed August 23, 2021)

Spinal Cord Stimulators (i.e., Dorsal Column Stimulators and Depth Brain Stimulators)

Spinal cord stimulators are covered when criteria are met. Refer to the NCD for Electrical Nerve Stimulators (160.7).
(Accessed August 23, 2021)

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. These LCDs/ LCAs are available at https://www.cms.gov/medicare-coverage-database/search.aspx
(Accessed October 13, 2021)

Dorsal Root Ganglion (DRG) Stimulators (CPT code 63650)

DRG stimulators may be covered when coverage criteria for spinal cord stimulation are met. Refer to the NCD for Electrical Nerve Stimulators (160.7). (Accessed October 13, 2021)

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. These LCDs/ LCAs are available at https://www.cms.gov/medicare-coverage-database/new-search/search.aspx. (Accessed October 13, 2021)

Implanted Peripheral Nerve Stimulators

Electrical nerve stimulators are covered when criteria are met. Refer to the NCD for Electrical Nerve Stimulators (160.7).
(Accessed August 23, 2021)

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. These LCDs/ LCAs are available at https://www.cms.gov/medicare-coverage-database/new-search/search.aspx. (Accessed October 13, 2021)

Notes:

- When CPT code 64590 is used for gastric electrical stimulation therapy, refer to the Coverage Summary titled Gastroesophageal and Gastrointestinal (GI) Services and Procedures.
- For sacral nerve stimulation for incontinence, refer to the Coverage Summary titled Urinary and Fecal Incontinence, Diagnosis and Treatments.

Transcutaneous Electrical Nerve Stimulator (TENS)

Transcutaneous electrical nerve stimulator (TENS) are covered when coverage criteria are met. Refer to the NCD for Transcutaneous Electrical Nerve Stimulator (TENS) for Acute Post-operative Pain (10.2).
(Accessed August 23, 2021)

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. Refer to the DME MAC LCD for Transcutaneous Electrical Nerve Stimulators (TENS) (L33802).
(Accessed October 13, 2021)

For coverage of supplies necessary for TENS; refer to the NCD for Supplies Used in the Delivery of Transcutaneous Electrical Nerve Stimulation (TENS) and Neuromuscular Electrical Stimulation (NMES) (160.13).
(Accessed August 23, 2021)

For an explanation of coverage for assessing patients suitability for electrical nerve stimulation therapy;
Refer to the:

- NCD for Assessing Patient's Suitability for Electrical Nerve Stimulation Therapy (160.7.1). (Accessed August 23, 2021)
- Coverage Summary Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics) and Medical Supplies Grid.

Note for Transcutaneous Electrical Nerve Stimulation (TENS) for Chronic Low Back Pain (CLBP):
Effective June 8, 2012, the Centers for Medicare and Medicaid Services (CMS) allowed coverage for TENS for CLBP only when the criteria outlined in the NCD for Transcutaneous Electrical Nerve Stimulation (TENS) for Chronic Low Back Pain (CLBP) (160.27) are met; and member enrolled in an approved clinical study within three years after the publication of the CMS statement for TENS for Chronic Low Back Pain (i.e., June 8, 2015) under coverage with evidence development (CED) available at http://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/TENS.html.
(Accessed August 23, 2021)

Refer to the Coverage Summary titled Experimental Procedures and Items, Investigational Devices and Clinical Trials for coverage and payment rules for clinical trials.

Phrenic Nerve Stimulators

Phrenic nerve stimulator is covered for selected patients with partial or complete respiratory insufficiency; refer to the NCD for Phrenic Nerve Stimulatory (160.19). (Accessed August 23, 2021)

Electric Nerve Stimulators for the Treatment of Motor Function Disorders

Electric nerve stimulators for the treatment of motor function disorders are not covered. Refer to the NCD for Treatment of Motor Function Disorders with Electric Stimulation (160.2). (Accessed August 23, 2021)

Electrical Stimulation for the Treatment of Dysphagia

Medicare does not have a National Coverage Determination (NCD) specifically for the use electrical stimulation for the treatment of dysphagia. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for Electrical Stimulation for the Treatment of Dysphagia.

For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation.
Note: After checking the Electrical Stimulation for the Treatment of Dysphagia table and searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.

For speech-language pathology services for the treatment of dysphagia, refer the Coverage Summary titled Rehabilitation: Medical Rehabilitation (OT, PT and ST, Including Cognitive Rehabilitation).

Electrotherapy for the Treatment of Facial Nerve Paralysis (Bell's Palsy)

Electrotherapy for the treatment of facial nerve paralysis (Bell's Palsy) is not covered because its clinical effectiveness has not been established; refer to the NCD for Electrotherapy for Treatment of Facial Nerve Paralysis (Bell's Palsy) (160.15).
(Accessed August 23, 2021)

Note: Electrotherapy for the treatment of facial nerve paralysis is the application of electrical stimulation to affected facial muscles to provide muscle innervation with the intention of preventing muscle degeneration. A device that generates an electrical current with controlled frequency, intensity, wave form and type (galvanic or faradic) is used in combination with a pad electrode and a hand applicator electrode to provide electrical stimulation.

Percutaneous Electrical Nerve Stimulation (PENS) as Diagnostic Procedure

This diagnostic procedure which involves stimulation of peripheral nerves by a needle electrode inserted through the skin is performed only in a physician's office, clinic, or hospital outpatient department. Therefore, it is covered only when performed by a physician or incident to physician's service. If pain is effectively controlled by percutaneous stimulation, implantation of

electrodes is warranted. Refer to the NCD for Assessing Patient's Suitability for Electrical Nerve Stimulation Therapy (160.7.1). (Accessed August 23, 2021)

Percutaneous Electrical Nerve Stimulation (PENS)/Percutaneous Neuromodulation Therapy (PNT) for Pain Therapy (e.g., BioWave)

Medicare does not have a National Coverage Determination (NCD) for PENS and PNT for pain therapy. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for Percutaneous Electrical Nerve Stimulation (PENS)/Percutaneous Neuromodulation Therapy (PNT) for Pain Therapy (e.g., BioWave).

For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation.
Note: After checking the Percutaneous Electrical Nerve Stimulation (PENS)/Percutaneous Neuromodulation Therapy (PNT) for Pain Therapy (e.g., BioWave) table and searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.

Definitions

Neuromuscular Electrical Stimulation (NMES): NMES involves the use of a device which transmits an electrical impulse to the skin over selected muscle groups by way of electrodes. There are two broad categories of NMES. One type of device stimulates the muscle when the patient is in a resting state to treat muscle atrophy. The second type is used to enhance functional activity of neurologically impaired patients. NCD for Neuromuscular Electrical Stimulation (160.12). (Accessed August 23, 2021)

Spinal Cord Stimulation: Blocks pain conduction pathways and stimulates endorphins. The neurostimulator electrodes used for this purpose are implanted percutaneously in the epidural space through a special needle. LCD for Spinal Cord Stimulation (Dorsal Column Stimulation) (L35450). (Accessed October 13, 2021)

Supporting Information

Important Note: When searching the Medicare Coverage Database, if no LCD/LCA is found, then use the applicable referenced default policy below for coverage guidelines.

Electrical Stimulation for the Treatment of Dysphagia
Accessed October 13, 2021

LCD/LCA ID	LCD/LCA Title	Contractor Type	Contractor Name	Applicable States/Territories
L34578 (A56584)	Surface Electrical Stimulation in the Treatment of Dysphagia	Part A and B MAC	Palmetto GBA	AL, GA, NC, SC, TN, VA, WV
L34565 (A56648)	Home Health – Surface Electrical Stimulation in the Treatment of Dysphagia	Part A and B MAC	Palmetto GBA	AL, AR, FL, GA, IL, IN, KY, LA, MS, NC, NM, OH, OK, SC, TN, TX

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Percutaneous Electrical Nerve Stimulation (PENS)/
Percutaneous Neuromodulation Therapy (PNT) for Pain Therapy (e.g., BioWave)
Accessed October 13, 2021

LCD/LCA ID	LCD/LCA Title	Contractor Type	Contractor Name	Applicable States/Territories
A54794	Percutaneous Electrical Nerve stimulation (PENS) and Percutaneous	Part A and B MAC	First Coast Service Options, Inc.	FL, PR, VI

Percutaneous Electrical Nerve Stimulation (PENS)/ Percutaneous Neuromodulation Therapy (PNT) for Pain Therapy (e.g., BioWave) Accessed October 13, 2021				
LCD/LCA ID	LCD/LCA Title	Contractor Type	Contractor Name	Applicable States/Territories
	Neuromodulation Therapy (PNT)			
A56062	Percutaneous Electrical Nerve Stimulation (PENS) and Percutaneous Neuromodulation Therapy (PNT)	Part A MAC	Wisconsin Physicians Service Insurance Corporation	AK, AL, AR, AZ, CA, CO, CT, DE, FL*, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV, WY Note: States notated with an asterisk (*) should follow the other available state-specific LCD/LCA listed on this table. This WPS LCD/LCA only applies to states without asterisk.
A56062	Percutaneous Electrical Nerve Stimulation (PENS) and Percutaneous Neuromodulation Therapy (PNT)	Part B MAC	Wisconsin Physicians Service Insurance Corporation	IA, IN, KS, MI, MO, NE
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Policy History/Revision Information

Date	Summary of Changes

10/19/2021	Coverage Guidelines
	Dorsal Root Ganglion (DRG) Stimulators (CPT code 63650) (new to policy)
	• Added language to indicate:
	  ○ DRG stimulators may be covered when coverage criteria for spinal cord stimulation are met
	  ○ Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable
	  ○ For coverage guidelines, refer to the National Coverage Determination (NCD) for *Electrical Nerve Stimulators (160.7)*
	Supporting Information
	• Archived previous policy version MCS090.02

Instructions for Use

This information is being distributed to you for personal reference. The information belongs to UnitedHealthcare and unauthorized copying, use, and distribution are prohibited. This information is intended to serve only as a general reference resource and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the Member's Evidence of Coverage (EOC)/Summary of Benefits (SB). If there is a discrepancy between this policy and the member's EOC/SB, the member's EOC/SB provision will govern. The information contained in this document is believed to be current as of the date noted.

The benefit information in this Coverage Summary is based on existing national coverage policy; however, Local Coverage Determinations (LCDs) may exist and compliance with these policies are required where applicable.

There are instances where this document may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG). In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).