

Electrical Nerve Stimulators (NCD 160.7)

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[↪ Terms and Conditions](#)

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Related Medicare Advantage Policy Guidelines

- [Assessing Patient's Suitability for Electrical Nerve Stimulation Therapy \(NCD 160.7.1\)](#)
- [Bladder Stimulators \(Pacemakers\) \(NCD 230.16\)](#)
- [Category III CPT Codes](#)
- [Deep Brain Stimulation for Essential Tremor and Parkinson's Disease \(NCD 160.24\)](#)
- [Neuromuscular Electrical Stimulation \(NMES\) \(NCD 160.12\)](#)
- [Phrenic Nerve Stimulator \(NCD 160.19\)](#)
- [Sacral Nerve Stimulation for Urinary Incontinence \(NCD 230.18\)](#)
- [Spinal Cord Stimulators for Chronic Pain](#)
- [Transcutaneous Electrical Nerve Stimulation \(TENS\) for Acute Post-Operative Pain \(NCD 10.2\)](#)
- [Transcutaneous Electrical Nerve Stimulation \(TENS\) for Chronic Low Back Pain \(CLBP\) \(NCD 160.27\)](#)
- [Vagus Nerve Stimulation \(VNS\) \(NCD 160.18\)](#)

Related Medicare Advantage Coverage Summaries

- [Complementary and Alternative Medicine](#)
- [Stimulators: Electrical and Spinal Cord Stimulators](#)

Policy Summary

[↪ See Purpose](#)

Overview

Two general classifications of electrical nerve stimulators are employed to treat chronic intractable pain: central nervous system stimulators and peripheral nerve stimulators.

Implanted Peripheral Nerve Stimulators

Payment may be made under the prosthetic device benefit for implanted peripheral nerve stimulators. Use of this stimulator involves implantation of electrodes around a selected peripheral nerve. The stimulating electrode is connected by an insulated lead to a receiver unit which is implanted under the skin at a depth not greater than 1/2 inch. Stimulation is induced by a generator connected to an antenna unit which is attached to the skin surface over the receiver unit. Implantation of electrodes requires surgery and usually necessitates an operating room.

Note: Peripheral nerve stimulators may also be employed to assess a patient's suitability for continued treatment with an electric nerve stimulator. As explained in §160.7.1, such use of the stimulator is covered as part of the total diagnostic service furnished to the beneficiary rather than as a prosthesis.

Central Nervous System Stimulators (Dorsal Column and Depth Brain Stimulators)

The implantation of central nervous system stimulators may be covered as therapies for the relief of chronic intractable pain, subject to the following conditions:

- There are two types of implantations covered by this instruction:
 - Dorsal Column (Spinal Cord) Neurostimulation: The surgical implantation of neurostimulator electrodes within the dura mater (endodural) or the percutaneous insertion of electrodes in the epidural space is covered.
 - Depth Brain Neurostimulation: The stereotactic implantation of electrodes in the deep brain (e.g., thalamus and periaqueductal gray matter) is covered.

Conditions for Coverage

Implantation of depth brain or dorsal column stimulators or services and supplies related to such implantation is covered if all of the conditions listed below have been met:

- The implantation of the stimulator is used only as a late resort (if not a last resort) for patients with chronic intractable pain; and
- Other treatment modalities (surgical, physical, pharmacological, or psychological therapies) have been tried and did not prove satisfactory or are judged to be unsuitable or contraindicated for the given patient; and
- Patients have undergone careful screening, evaluation and diagnosis by a multidisciplinary team prior to implantation. (Such screening must include psychological, as well as physical evaluation); and
- All the facilities, equipment, professional and support personnel required for the proper diagnosis, treatment training, and follow-up of the patient must be available; and
- Demonstration of pain relief with a temporarily implanted electrode precedes permanent implantation.

Coding Clarification: Please refer to the specific electrical nerve stimulator policy for coding information.

References

CMS National Coverage Determinations (NCDs)

[NCD 160.7 Electrical Nerve Stimulators](#)

Reference NCD: [NCD 160.7.1 Assessing Patient's Suitability for Electrical Nerve Stimulation Therapy](#), [NCD 160.19 Phrenic Nerve Stimulator](#)

CMS Benefit Policy Manual

[Chapter 15: § 120 Prosthetic Devices](#)

CMS Transmittal(s)

[Transmittal 4487, Change Request 11570, Dated January 03, 2020 \(CY 2020 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies \(DMEPOS\) Fee Schedule\)](#)

UnitedHealthcare Commercial Policies

[Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation Implanted Electrical Stimulator for Spinal Cord](#)

Other(s)

[DMEPOS Fee Schedule](#)

Guideline History/Revision Information

Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

Date	Summary of Changes
04/01/2021	Template Update <ul style="list-style-type: none">Reformatted policy; transferred content to new template
02/10/2021	Supporting Information <ul style="list-style-type: none">Updated <i>References</i> section to reflect the most current information; no change to guidelinesArchived previous policy version MPG086.07

Purpose

The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers' submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:

- Medicare coding or billing requirements, and/or
- Medical necessity coverage guidelines; including documentation requirements.

UnitedHealthcare follows Medicare guidelines such as NCDs, LCDs, LCAs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the [References](#) section below to view the Medicare source materials used to develop this resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

Terms and Conditions

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document* and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of publication and is provided on an "AS IS" basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided.

UnitedHealthcare Medicare Advantage Policy Guidelines use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

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*For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the [Administrative Guide](#).