ELECTRICAL STIMULATION (ES) AND ELECTROMAGNETIC THERAPY FOR THE TREATMENT OF WOUNDS (NCD 270.1)

Guideline Number: MPG087.02

Table of Contents

TERMS AND CONDITIONS ............................................. 1
PURPOSE ................................................................. 2
POLICY SUMMARY .................................................... 2
APPLICABLE CODES ................................................... 3
REFERENCES ............................................................. 3
GUIDELINE HISTORY/REVISION INFORMATION .............. 4

Related Medicare Advantage Policy Guidelines

- Assessing Patient’s Suitability for Electrical Nerve Stimulation Therapy (NCD 160.7.1)
- Electrotherapy for Treatment of Facial Nerve Paralysis (Bell's Palsy) (NCD 160.15)
- Neuromuscular Electrical Stimulation (NMES) (NCD 160.12)
- Non-Implantable Pelvic Floor Electrical Stimulator (NCD 230.8)
- Treatment of Motor Function Disorders with Electric Nerve Stimulation (NCD 160.2)

Related Medicare Advantage Coverage Summaries

- Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics) and Medical Supplies Grid
- Wound Treatments

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.

Medicare Advantage Policy Guidelines are the property of UnitedHealthcare. Unauthorized copying, use and distribution of this information are strictly prohibited.
**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 LCDs, NCDs, 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.

**POLICY SUMMARY**

**Overview**

ES and electromagnetic therapy have been used or studied for many different applications, one of which is accelerating wound healing. ES for the treatment of wounds is the application of electrical current through electrodes placed directly on the skin in close proximity to the wound. Electromagnetic therapy uses a pulsed magnetic field to induce current. CMS was asked to reconsider its national noncoverage determination for electromagnetic therapy. After thorough review, CMS determined that the results from the use of electromagnetic therapy for the treatment of wounds were similar to the results from the use of ES. Therefore, effective July 1, 2004, Medicare will cover electromagnetic therapy for the same settings and conditions for which ES is covered. This means Medicare will allow either one covered ES therapy or one covered electromagnetic therapy for the treatment of wounds.

**Guidelines**

**Nationally Covered Indications**

The use of ES and electron therapy for the treatment of wounds are considered adjunctive therapies, and will only be covered for chronic Stage III or Stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers. Chronic ulcers are defined as ulcers that have not healed within 30 days of occurrence. ES or electromagnetic therapy will be covered only after appropriate standard wound therapy has been tried for at least 30 days and there are no measurable signs of improved healing. This 30-day period may begin while the wound is acute.

Standard wound care includes: optimization of nutritional status, debridement by any means to remove devitalized tissue, maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings, and necessary treatment to resolve any infection that may be present. Standard wound care based on the specific type of wound includes: frequent repositioning of a patient with pressure ulcers (usually every 2 hours), offloading of pressure and good glucose control for diabetic ulcers, establishment of adequate circulation for arterial ulcers, and the use of a compression system for patients with venous ulcers.

Measurable signs of improved healing include: a decrease in wound size (either surface area or volume), decrease in amount of exudates, and decrease in amount of necrotic tissue. ES or electromagnetic therapy must be discontinued when the wound demonstrates 100% epithelialized wound bed.

ES and electromagnetic therapy services can only be covered when performed by a physician, physical therapist, or incident to a physician service. Evaluation of the wound is an integral part of wound therapy. When a physician, physical therapist, or a clinician incident to a physician, performs ES or electromagnetic therapy, the practitioner must evaluate the wound and contact the treating physician if the wound worsens. If ES or electromagnetic therapy is being used, wounds must be evaluated at least monthly by the treating physician.

**Nationally Non-Covered Indications**

- ES and electromagnetic therapy will not be covered as an initial treatment modality.
- Continued treatment with ES or electromagnetic therapy is not covered if measurable signs of healing have not been demonstrated within any 30-day period of treatment.
- Unsupervised use of ES or electromagnetic therapy for wound therapy will not be covered, as this use has not been found to be medically reasonable and necessary.
Other
All other uses of ES and electromagnetic therapy not otherwise specified for the treatment of wounds remain at local contractor discretion.

APPLICABLE CODES

The following list(s) of codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. 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 inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0281</td>
<td>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</td>
</tr>
<tr>
<td>G0282</td>
<td>Electrical stimulation, (unattended), to one or more areas, for wound care other than described in G0281 (Not Covered by Medicare)</td>
</tr>
<tr>
<td>G0295</td>
<td>Electromagnetic stimulation, to one or more areas, for wound care other than described in G0329 or for other uses (Not Covered by Medicare)</td>
</tr>
<tr>
<td>G0329</td>
<td>Electromagnetic therapy, 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</td>
</tr>
</tbody>
</table>

REFERENCES

**CMS National Coverage Determinations (NCDs)**

NCD 270.1 Electrical Stimulation (ES) and Electromagnetic Therapy for the Treatment of Wounds
Reference NCD: [NCD 280.1 Durable Medical Equipment Reference List](https://www.cms.gov/Medicare/Coverage/index.html)

**CMS Local Coverage Determinations (LCDs)**

<table>
<thead>
<tr>
<th>LCD</th>
<th>Medicare Part A</th>
<th>Medicare Part B</th>
</tr>
</thead>
<tbody>
<tr>
<td>L34587 (Wound Care) WPS</td>
<td>AK, AL, AR, AZ, CT, FL, GA, IA, ID, IL, IN, KS, KY, LA, MA, ME, MI, MN, MO (Entire State), MS, MT, NC, ND, NE, NH, NJ, OH, OR, RI, SC, SE, TN, UT, VA, VI, VT, WA, WI, WV, WY</td>
<td>IA, IN, KS, MI, MO (Entire State), NE</td>
</tr>
<tr>
<td>L35125 (Wound Care) Novitas</td>
<td>AR, CO, LA, MS, NM, OK, TX</td>
<td>AR, CO, LA, MS, NM, OK, TX</td>
</tr>
<tr>
<td>L28572 (Wound Care) WPS</td>
<td>AK, AL, AR, AZ, CT, FL, GA, IA, ID, IL, IN, KS, KY, LA, MA, ME, MI, MN, MO (Entire State), MT, NC, ND, NE, NH, NJ, OH, OR, RI, SC, SD, TE, UT, VA, VI, VT, WA, WI, WV, WY</td>
<td>IA, IN, KS, MI, MO (Entire State), NE</td>
</tr>
<tr>
<td>Retired 09/30/2015</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**CMS Claims Processing Manual**

Chapter 32; § 11.1 Electrical Stimulation, § 11.2 Electromagnetic Therapy

**CMS Transmittals**

Transmittal 7, Change Request 3149, Dated 03/19/2004 (Electrical Stimulation (ES) and Electromagnetic Therapy for the Treatment of Wounds)
Transmittal 124, Change Request 3149, Dated 03/19/2004 (Billing and Coding Requirements for Electromagnetic therapy for the Treatment of Wounds)

**MLN Matters**

Article MM3149, Electrical Stimulation and Electromagnetic Therapy for the Treatment of Wounds
Article SE1113, Foot Care Coverage Guidelines

**UnitedHealthcare Commercial Policies**

Electrical Stimulation and Electromagnetic Therapy for Wounds

**Others**

Decision Memo for Electro-stimulation for Wounds, CMS Website
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.

<table>
<thead>
<tr>
<th>Date</th>
<th>Action/Description</th>
</tr>
</thead>
</table>
| 08/01/2017 | - Updated policy template:  
  - Removed and replaced Instructions for Use; added Terms and Conditions and Purpose language  
  - Updated Guideline History/Revision Information; added disclaimer language to indicate 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 |
| 01/11/2017 | - Annual review                                                                                                                                 |

Proprietary Information of UnitedHealthcare. Copyright 2017 United HealthCare Services, Inc.