ELECTROTHERAPY FOR TREATMENT OF FACIAL NERVE PARALYSIS (BELL'S PALSY) (NCD 160.15)

Guideline Number: MPG093.04

**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.

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**Related Medicare Advantage Coverage Summary**

- Stimulators: Electrical and Spinal Cord Stimulators

**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
Electrotherapy for the treatment of facial nerve paralysis, commonly known as Bell's Palsy, 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 intensity, frequency, wave form and type (faradic or galvanic) is used in combination with a pad electrode and a hand applicator electrode to provide electrical stimulation.

Guidelines
Electrotherapy for the treatment of facial nerve paralysis, commonly known as Bell’s Palsy, is not covered under Medicare because its clinical effectiveness has not been established.

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.

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<tr>
<th>CPT Code</th>
<th>Description</th>
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<tr>
<td>97032</td>
<td>Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes</td>
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<tr>
<th>HCPCS Code</th>
<th>Description</th>
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<tr>
<td>G0283</td>
<td>Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care</td>
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<thead>
<tr>
<th>Modifier</th>
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<tr>
<td>GO</td>
<td>Service delivered personally by an occupational therapist or under an outpatient occupational therapy plan of care</td>
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<td>GP</td>
<td>Service delivered personally by a physical therapist or under an outpatient physical therapy plan of care</td>
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<th>ICD-10 Diagnosis Code</th>
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<tr>
<td>G51.0</td>
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REFERENCES

CMS National Coverage Determinations (NCDs)
NCD 160.15 Electrotherapy for Treatment of Facial Nerve Paralysis (Bell's Palsy)

CMS Local Coverage Determinations (LCDs)

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Electrotherapy for Treatment of Facial Nerve Paralysis (Bell's Palsy) (NCD 160.15)

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.

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<th>Date</th>
<th>Action/Description</th>
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<td>09/12/2018</td>
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CMS Articles

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<td>A53064 (Outpatient Occupational Therapy Supplemental Instructions</td>
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CMS Claims Processing Manual

Chapter 15; § 220 Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services) Under Medical Insurance

CMS Transmittals


UnitedHealthcare Commercial Policies

Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation

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