# Electrical Stimulators

**Policy Number**: MMP090.13
**Last Committee Approval Date**: May 8, 2024
**Effective Date**: June 1, 2024

➲ Instructions for Use

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**Related Medicare Advantage Policy**

- Spinal Cord Stimulators for Chronic Pain

## Coverage Rationale

### Electrical Stimulation for Dysphagia

Medicare does not have a National Coverage Determination (NCD) specifically for 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 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.

For speech-language pathology services for the treatment of dysphagia, refer the Coverage Summary titled Skilled Nursing Facility, Rehabilitation, and Long-Term Acute Care Hospital.

### Occipital Nerve Stimulation for Occipital Neuralgia or Headaches

Medicare does not have an NCD specifically for occipital nerve stimulation for the treatment of occipital neuralgia or headaches. 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 Occipital Nerve Stimulation for Occipital Neuralgia or Headaches.

**For coverage guidelines for states/territories with no LCDs/LCAs,** refer to the UnitedHealthcare Commercial Medical Policy titled Occipital Nerve Injections and Ablation (Including Occipital Neuralgia and Headache).

### Percutaneous Electrical Nerve Stimulation (PENS) or Percutaneous Neuromodulation Therapy (PNT) for Pain Therapy

Medicare does not have an NCD for PENS or PNT for pain therapy. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

**For coverage guidelines**, refer to the UnitedHealthcare Commercial Medical Policy titled Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation.

### Percutaneous Peripheral Nerve Stimulation (PNS)

Medicare does not have an NCD specifically for PNS. 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 Peripheral Nerve Stimulation (PNS).

**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.

### Vagus Nerve Stimulation for Chronic Pain Syndrome

Medicare does not have an NCD specifically for vagus nerve stimulation for the treatment of chronic pain syndrome. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

**For coverage guidelines,** refer to the UnitedHealthcare Commercial Medical Policy titled Vagus and External Trigeminal Nerve Stimulation.

## Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy 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.

| CPT Code | Description |
|---|---|
| 61885 | Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array |
| 61886 | Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to 2 or more electrode arrays |
| 63650 | Percutaneous implantation of neurostimulator electrode array, epidural |
| 64553 | Percutaneous implantation of neurostimulator electrode array; cranial nerve |
| 64555 | Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve) |
| 64590 | Insertion or replacement of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver) |
| 64999 | Unlisted procedure, nervous system |



| HCPCS Code | Description |
|---|---|
| E0745 | Neuromuscular stimulator, electronic shock unit |
| E0764 | Functional neuromuscular stimulation, transcutaneous stimulation of sequential muscle groups of ambulation with computer control, used for walking by spinal cord injured, entire system, after completion of training program |
| E0770 | Functional electrical stimulator, transcutaneous stimulation of nerve and/or muscle groups, any type, complete system, not otherwise specified |

## Centers for Medicare and Medicaid Services (CMS) Related Documents

After checking the table below and searching the Medicare Coverage Database, if no NCD, LCD, or LCA is found, refer to the criteria as noted in the Coverage Rationale section above.

| NCD | LCD | LCA | Contractor Type | Contractor Name |
|---|---|---|---|---|
| **Electrical Stimulation for Dysphagia** | | | | |
| N/A | L34578 Surface Electrical Stimulation in the Treatment of Dysphagia | A56584 Billing and Coding: Surface Electrical Stimulation in the Treatment of Dysphagia | Part A and B MAC | Palmetto |
| | L34565 Home Health-Surface Electrical Stimulation in the Treatment of Dysphagia | A56648 Billing and Coding: Home Health - Surface Electrical Stimulation in the Treatment of Dysphagia | Part A and B MAC | Palmetto |

| NCD | LCD | LCA | Contractor Type | Contractor Name |
|---|---|---|---|---|
| **Occipital Nerve Stimulation for Occipital Neuralgia or Headaches** | | | | |
| N/A | L34328 Peripheral Nerve Stimulation | A55530 Billing and Coding: Peripheral Nerve Stimulation | Part A and B MAC | Noridian |
| | L37360 Peripheral Nerve Stimulation | A55531 Billing and Coding: Peripheral Nerve Stimulation | Part A and B MAC | Noridian |
| **Percutaneous Peripheral Nerve Stimulation (PNS)** | | | | |
| N/A | L34328 Peripheral Nerve Stimulation | A55530 Billing and Coding: Peripheral Nerve Stimulation | Part A and B MAC | Noridian |
| | L37360 Peripheral Nerve Stimulation | A55531 Billing and Coding: Peripheral Nerve Stimulation | Part A and B MAC | Noridian |

| Medicare Administrative Contractor (MAC) with Corresponding States/Territories | |
|---|---|
| **MAC Name (Abbreviation)** | **States/Territories** |
| CGS Administrators, LLC (CGS) | KY, OH |
| First Coast Service Options, Inc. (First Coast) | FL, PR, VI |
| National Government Services, Inc. (NGS) | CT, IL, MA, ME, MN, NH, NY, RI, VT, WI |
| Noridian Healthcare Solutions, LLC (Noridian) | AS, AK, AZ, CA, GU, HI, ID, MT, NV, ND, Northern Mariana Islands, OR, SD, UT, WA, WY |
| Novitas Solutions, Inc. (Novitas) | AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX, |
| Palmetto GBA (Palmetto) | AL, GA, NC, SC, TN, VA, WV |
| Wisconsin Physicians Service Insurance Corporation (WPS)* | IA, IN, KS, MI, MO, NE |
| ***Note**: Wisconsin Physicians Service Insurance Corporation Contract Number 05901 - applies only to WPS Legacy Mutual of Omaha MAC A Providers | |

# Policy History/Revision Information

| Date | Summary of Changes |
|---|---|
| 06/01/2024 | **Title Change/Template Update**<br>• Previously titled *Electrical and Ultrasonic Stimulators*<br>• Reformatted and reorganized policy; transferred content to new template<br>• Changed policy type classification from "Coverage Summary" to "Medical Policy"<br>• Updated *Instructions for Use*<br>**Related Policies**<br>• Added reference link to the UnitedHealthcare Medicare Advantage Medical Policy titled *Spinal Cord Stimulators for Chronic Pain*<br>• Removed reference link to the UnitedHealthcare Medicare Advantage Policy Guideline titled *Transcutaneous Electrical Nerve Stimulation (TENS)*<br>**Coverage Rationale**<br>• Removed notation pertaining to:<br>  ○ Face to face encounter requirement for durable medical equipment (Affordable Care Act §6407)<br>  ○ Specific coding and pricing issues for HCPCS code L8680 and CPT code 63650 (MLN Matters® Article MM8645)<br>• Removed content/language addressing:<br>  ○ Dorsal root ganglion (DRG) stimulators (CPT code 63650)<br>  ○ Deep brain stimulation for essential tremor and Parkinson's disease<br>  ○ Implanted peripheral nerve stimulators |

| Date | Summary of Changes |
|---|---|
| | ○ Electrical osteogenic stimulators<br>▪ Invasive (implantable) stimulator (HCPCS code E0749)<br>▪ Noninvasive stimulator (HCPCS codes E0747 and E0748)<br>○ Ultrasonic osteogenic stimulator (HCPCS code E0760)<br>**Applicable Codes**<br>• Updated list of applicable CPT/HCPCS codes (previously located in the *Coverage Guidelines* section); added 61885, 61886, 64553, 64999, E0745, E0764, and E0770<br>**Supporting Information**<br>• Removed *Definitions* section<br>• Archived previous policy version MCS090.12 |

# Instructions for Use

The Medicare Advantage Policy documents are generally used to support UnitedHealthcare coverage decisions. It is expected providers retain or have access to appropriate documentation when requested to support coverage. This document may be used as a guide to help determine applicable:

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

Medicare Advantage Policies are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates. This Policy is provided for informational purposes and does not constitute medical advice. It is intended to serve only as a general reference 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. 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 this policy. 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.

Medicare Advantage Policies 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 Policies at any time by publishing a new version on this website. Medicare source materials used to develop these policies may include, but are not limited to, CMS statutes, regulations, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and manuals. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. The information presented in this Policy is believed to be accurate and current as of the date of publication. Where there is a conflict between this document and Medicare source materials, the Medicare source materials apply. Medicare Advantage Policies are the property of UnitedHealthcare. Unauthorized copying, use, and distribution of this information are strictly prohibited.

UnitedHealthcare follows Medicare coverage guidelines found in statutes, regulations, NCDs, and LCDs to determine coverage. The clinical coverage criteria governing certain items or services referenced in this Medical Policy have not been fully established in applicable Medicare guidelines because there is an absence of any applicable Medicare statutes, regulations, NCDs, or LCDs setting forth coverage criteria and/or the applicable NCDs or LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD. As a result, in these circumstances, UnitedHealthcare applies internal coverage criteria as referenced in this Medical Policy. The internal coverage criteria in this Medical Policy was developed through an evaluation of the current relevant clinical evidence in acceptable clinical literature and/or widely used treatment guidelines. UnitedHealthcare evaluated the evidence to determine whether it was of sufficient quality to support a finding that the items or services discussed in the policy might, under certain circumstances, be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

You are responsible for submission of accurate claims. Medicare Advantage Policies are intended to ensure that coverage decisions are made accurately. UnitedHealthcare Medicare Advantage Policies 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.

For members in UnitedHealthcare Medicare Advantage plans where a delegate manages utilization management and prior authorization requirements, the delegate's requirements need to be followed.