

## Corporate Medical Policy

### Interferential Stimulation

**File Name:** interferential\_stimulation  
**Origination:** 11/2003  
**Last CAP Review:** 11/2011  
**Next CAP Review:** 11/2012  
**Last Review:** 11/2011

#### Description of Procedure or Service

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Interferential stimulation (IFS) is a type of electrical stimulation. It is believed that IFS permeates the tissues more effectively and thus is more comfortable than transcutaneous electrical nerve stimulation (TENS). Interferential stimulation has been investigated as a technique to reduce pain, improve range of motion, or promote local healing following various tissue injuries.

Interferential stimulation (IFS) is a type of electrical stimulation that uses paired electrodes of 2 independent circuits carrying high-frequency (4,000 Hz) and medium-frequency (150 Hz) alternating currents. The superficial electrodes are aligned on the skin around the affected area. It is believed that IFS permeates the tissues more effectively and, with less unwanted stimulation of cutaneous nerves, is more comfortable than transcutaneous electrical stimulation (TENS). There are no standardized protocols for the use of interferential therapy; the therapy may vary according to the frequency of stimulation, the pulse duration, treatment time, and electrode-placement technique.

**Regulatory Status:**

A number of interferential stimulator devices have received 510(k) marketing clearance from the U.S. Food and Drug Administration (FDA), including the Medstar™ 100 (MedNet Services) and the RS-4i® (RS Medical).

**Related Policies:**

Transcutaneous Electrical Stimulation (TENS)  
Percutaneous Electrical Nerve Stimulation (PENS) or Percutaneous Neuromodulation Therapy (PNT)

*\*\*\*Note: This Medical Policy is complex and technical. For questions concerning the technical language and/or specific clinical indications for its use, please consult your physician.*

#### Policy

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**Interferential Stimulation is considered investigational for all applications. BCBSNC does not cover investigational services or procedures.**

#### Benefits Application

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This medical policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits. Member's benefits may vary according to benefit design; therefore member benefit language should be reviewed before applying the terms of this medical policy.

# Interferential Stimulation

## When Interferential Stimulation is covered

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Not applicable

## When Interferential Stimulation is not covered

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Interferential current stimulation is considered investigational for treatment of pain.

## Policy Guidelines

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There is insufficient evidence from well-designed trials that interferential stimulation improves health outcomes for patients diagnosed with painful musculoskeletal conditions. The limited amount of evidence from trials comparing IFC alone to a placebo intervention does not suggest benefit. Other trials do not control for potential placebo effects and/or do not adequately evaluate the incremental effects of IFC beyond that of a co-intervention.

## Billing/Coding/Physician Documentation Information

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This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at [www.bcbsnc.com](http://www.bcbsnc.com). They are listed in the Category Search on the Medical Policy search page.

*Applicable service codes: S8130, S8131.*

BCBSNC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

## Scientific Background and Reference Sources

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BCBSA Medical Policy Reference Manual, 1.01.24, 7/17/03

Specialty Matched Consultant Advisory Panel - 6/2004

BCBSA Medical Policy Reference Manual [Electronic Version], 1.01.24, 12/14/2005

Specialty Matched Consultant Advisory Panel - 5/2006

BCBSA Medical Policy Reference Manual [Electronic Version], 1.01.24, 12/12/2006

Specialty Matched Consultant Advisory Panel - 5/2008

# Interferential Stimulation

BCBSA Medical Policy Reference Manual [Electronic Version], 1.01.24, 10/6/2009

Specialty Matched Consultant Advisory Panel – 11/29/2010

BCBSA Medical Policy Reference Manual [Electronic Version], 1.01.24, 11/11/2010

Specialty Matched Consultant Advisory Panel – 11/2011

BCBSA Medical Policy Reference Manual [Electronic Version], 1.01.24, 12/8/2011

## **Policy Implementation/Update Information**

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- 11/03 New policy.
  
- 4/8/04 Added, "Sequential stimulators that combine interferential current and muscle stimulation such as the RS-4i Sequential Stimulator are considered investigational. BCBSNC does not cover investigational services." to the noncovered section of the policy. Statement removed from Policy Guidelines.
  
- 7/29/04 Specialty Matched Consultant Advisory Panel review 6/22/04. No changes to criteria. Format changes for consistency. References added.
  
- 6/5/06 Specialty Matched Consultant Advisory Panel review 5/3/2006. No changes to policy statement. Rationale added to "Policy Guidelines" section. References added.
  
- 12/3/07 "Next Review Date" corrected. Policy number added to "Key Word" section.
  
- 6/30/08 Specialty Matched Consultant Advisory Panel review 5/29/08. No changes to policy statement. Policy status changed to Active policy, no longer scheduled for routine literature review. (btw)
  
- 6/22/10 Policy Number(s) removed (amw)
  
- 12/21/10 Removed from "Active policy, no longer scheduled for routine literature review." To active policy. Policy "Description" revised. Policy statements reworded no change to policy intent. "Policy Guidelines" revised. References added. Specialty Matched Consultant Advisory Panel review 11/29/2010. References added. (btw)
  
- 1/1/12 Specialty Matched Consultant Advisory Panel review 11/30/11. "Description" revised. No change to policy intent. Rationale in "Policy Guidelines" updated. Added 2012 HCPCS codes S8130 and S8131 to the "Billing/Coding" section. (btw)
  
- 4/17/12 Reference added. (btw)

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Medical policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of

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disease. Medical practices and knowledge are constantly changing and BCBSNC reserves the right to review and revise its medical policies periodically.