Electrical Stimulators-Neuromuscular

Origination:       June 30, 1988
Review Date:      April 15, 2015
Next Review:      April 15, 2017

DESCRIPTION OF PROCEDURE OR SERVICE
Neuromuscular Electrical Stimulation (NMES) involves the use of a device that transmits an electrical impulse to the skin over selected muscle groups by way of electrodes. Neuromuscular stimulator devices transmit an electrical impulse to stimulate motor nerves thus contracting the muscle. There are two broad categories of NMES:

1. One type stimulates the muscle when the patient is in a resting state to treat muscle atrophy.
2. The second type is used to enhance functional activity of neurologically impaired patients. These devices are commonly referred to as functional electrical stimulation (FES).

POLICY STATEMENT
Coverage will provide for neuromuscular stimulators when it is determined to be medically necessary because the medical criteria and guidelines shown below are met.

BENEFIT APPLICATION
Please refer to the member’s individual Evidence of Coverage (E.O.C.) for benefit determination. Coverage will be approved according to the E.O.C. limitations, if the criteria are met.

Coverage decisions will be made in accordance with:
- The Centers for Medicare & Medicaid Services (CMS) national coverage decisions;
- General coverage guidelines included in original Medicare manuals unless superseded by operational policy letters or regulations; and
- Written coverage decisions of local Medicare carriers and intermediaries with jurisdiction for claims in the geographic area in which services are covered.

Benefit payments are subject to contractual obligations of the Plan. If there is a conflict between the general policy guidelines contained in the Medical Coverage Policy Manual and the terms of the member’s particular Evidence of Coverage (E.O.C.), the E.O.C. always governs the determination of benefits.
INDICATIONS FOR COVERAGE

1. Preauthorization by the Plan is required;

AND

2. Muscle Atrophy:
   Coverage of neuromuscular stimulators may be considered for the treatment of disuse atrophy providing the following criteria are met:

   a. The nerve supply to the muscle must be intact, including brain, spinal cord and peripheral nerves;

   or

   b. Other non-neurological reasons for disuse atrophy, e.g., casting/splinting of a limb, contractures caused by scarring of burn lesions and hip replacement surgery (only until orthotic training can be instituted).

3. Functional Electrical Stimulation (FES) For Walking in Patients with Spinal Cord Injury (SCI):
   These devices are surface units that use electrical impulses to activate paralyzed or weak muscles in a precise sequence. Coverage is limited to those patients who have completed a training program that consists of at least 32 physical therapy sessions with the device over a period of three months.

Coverage for NMES/FES may be considered, and is limited for walking in SCI patients with the following characteristics:

1. Persons with intact lower motor unit (L1 and below) (both muscle and peripheral nerve);
2. Persons with muscle and joint stability for weight bearing at upper and lower extremities that can demonstrate balance and control to maintain an upright support posture independently.
3. Persons that demonstrate brisk muscle contraction to NMES and have sensory perception electrical stimulation sufficient for muscle contraction;
4. Persons that possess high motivation, commitment and cognitive ability to use such devices for walking;
5. Persons that can transfer independently and can demonstrate independent standing tolerance for at least 3 minutes;
6. Persons that can demonstrate hand and finger function to manipulate controls;
7. Persons with at least 6-month post recovery spinal cord injury and restorative surgery;
8. Persons with hip and knee degenerative disease and no history of long bone fracture secondary to osteoporosis;
9. Persons who have demonstrated a willingness to use the device long-term.
WHEN COVERAGE WILL NOT BE APPROVED

NMES/FES for walking will not be covered in SCI patients with any of the following:

1. Persons with cardiac pacemakers;
2. Severe scoliosis or severe osteoporosis;
3. Skin disease or cancer at area of stimulation;
4. Irreversible contracture; or
5. Autonomic dysflexia.

Special Note:
The initial provision of E0770 includes all the necessary supplies. Supplies can then be billed per month with code A4595 and is all inclusive of all supplies.

BILLING/ CODING/PHYSICIAN DOCUMENTATION INFORMATION

This policy may apply to the following codes. Inclusion of a code in the section does not guarantee that it will be reimbursed.

Applicable codes: E0744, E0745, E0764, E0770 (WalkAide device and NESS H200; L300) E0731

The Plan 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.

References:

Policy Implementation/Update Information:
Revision Date: May 3, 1998; February 9, 1999; June 28, 1999; November 22, 1999; January 24, 2000; April 24, 2000; February 23, 2006.
Revision Date: November 30, 2006: Updated Codes to include finalized codes E0762 & E0764; No criteria changes made.
Revision Date: September 2009: No changes proposed to the review criteria. Formatting and minor wording changes only.
Revision Date: October 28, 2010: Changed wording under “Indications For Coverage” item #2 to reflect current NCD language
Revision Date: January 28, 2013: Minor edit to criteria to mirror LCD. Added HCPCS code E0731.
Revision Date: February 3/27/15: No CMS criteria changes, minor revisions to policy for device clarification.

Approval Dates:
Medical Coverage Policy Committee: April 15, 2015

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