# Functional Electrical Stimulation

**MEDICAL POLICY NUMBER: 332**

**Effective Date:** 7/1/2023

**Last Review Date:** 6/2023

**Next Annual Review:** 6/2024



**INSTRUCTIONS FOR USE:** Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Company reserves the right to determine the application of medical policies and make revisions to medical policies at any time. The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement. Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

**SCOPE:** Providence Health Plan, Providence Health Assurance and Providence Plan Partners as applicable (referred to individually as “Company” and collectively as “Companies”).

## *PLAN PRODUCT AND BENEFIT APPLICATION*

☒ **Commercial** ☒ **Medicaid/OHP*** ☐ **Medicare****

*Medicaid/OHP Members

*Oregon*: Services requested for Oregon Health Plan (OHP) members follow the OHP Prioritized List and Oregon Administrative Rules (OARs) as the primary resource for coverage determinations. Medical policy criteria below may be applied when there are no criteria available in the OARs and the OHP Prioritized List.

**Medicare Members

This *Company* policy may be applied to Medicare Plan members only when directed by a separate *Medicare* policy. Note that investigational services are considered **"not medically necessary"** for Medicare members.

## COVERAGE CRITERIA

I. Functional electrical stimulation (FES) may be considered **medically necessary** in members with spinal cord injury to enhance their ability to walk when all of the following is met:

   A. Member had intact lower motor units (L1 and below), both muscle and peripheral nerve,
   B. Member has 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,
   C. Member demonstrates brisk muscle contraction to FES and has sensory perception electrical stimulation that is sufficient for muscle contraction,
   D. Member possesses high motivation, commitment, and cognitive ability to use such devices for walking,
   E. Member can transfer independently and can stand independently for at least 3 minutes,
   F. Member can demonstrate hand and finger function to manipulate controls,
   G. Member is at least 6 months post recovery from spinal cord injury and restorative surgery,
   H. Member does not have hip or knee degenerative disease and has no history of long bone fracture secondary to osteoporosis, **AND**
   I. Member is willing to use the device long-term.

II. Functional electrical stimulation is considered **not medically necessary** when criterion I. is not met or when members have any of the following conditions:

   A. Cardiac pacemakers,
   B. Severe scoliosis or severe osteoporosis,
   C. Skin disease or cancer at area of stimulation,

D. Irreversible contracture, or
E. Autonomic dyslexia

III. Replacement of a FES for walking may be considered **medically necessary** if the original FES met criteria I-II and is no longer under warranty and cannot be repaired.

Link to Evidence Summary

## POLICY CROSS REFERENCES

- Electrical Stimulation: Non-covered Therapies, MP331

**The full Company portfolio of current Medical Policies is available online and can be accessed here.**

## POLICY GUIDELINES

**DOCUMENTATION REQUIREMENTS**

In order to determine the medical necessity of the request, the following documentation must be provided at the time of the request. Medical records to include documentation of all of the following:

- All medical records and chart notes pertinent to the request. This includes:
  - History
  - Physical examination
  - Treatment plan

This policy may be primarily based on the following Center for Medicare and Medicaid Services (CMS) guidances:

- NCD for Neuromuscular Electrical Stimulation (NMES) (160.12)[1]
- Noridian webpage for Functional Electrical Stimulation (FES) - Coverage and HCPCS Coding – Revised (Link)[2]

**BACKGROUND**

Functional Electrical Stimulation (FES)

Functional electrical stimulation is a technique that uses electrical impulses to activate paralyzed or weak muscles in precise sequence. The FES device transmits these electrical impulses via surface electrodes in the same manner as neuromuscular electrical stimulation (NMES). For example, through selective and sequential stimulation of various lower extremity muscle groups, FES can enable spinal cord injured (SCI) patients to walk.

## REGULATORY STATUS

**U.S. FOOD AND DRUG ADMINISTRATION (FDA)**

Approval or clearance by the Food and Drug Administration (FDA) does not in itself establish medical necessity or serve as a basis for coverage. Therefore, this section is provided for informational purposes only.

## BILLING GUIDELINES AND CODING

Code A4595 for electrical stimulator supplies has a limit of 2 units per month.

| CODES* | | |
|---|---|---|
| **HCPCS** | 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 |
| | A4595 | Electrical stimulator supplies, 2 lead, per month, (e.g., tens, nmes) |

***Coding Notes:**

- The above code list is provided as a courtesy and may not be all-inclusive. Inclusion or omission of a code from this policy neither implies nor guarantees reimbursement or coverage. Some codes may not require routine review for medical necessity, but they are subject to provider contracts, as well as member benefits, eligibility and potential utilization audit.
- All unlisted codes are reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is submitted for non-covered services addressed in this policy then it will be **denied as not covered**. If an unlisted code is submitted for potentially covered services addressed in this policy, to avoid post-service denial, **prior authorization is recommended**.
- **See the non-covered and prior authorization lists on the Company Medical Policy, Reimbursement Policy, Pharmacy Policy and Provider Information website for additional information.**
- HCPCS/CPT code(s) may be subject to National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) bundling edits and daily maximum edits known as "medically unlikely edits" (MUEs) published by the Centers for Medicare and Medicaid Services (CMS). This policy does not take precedence over NCCI edits or MUEs. Please refer to the CMS website for coding guidelines and applicable code combinations.

## REFERENCES


1. Centers for Medicare & Medicaid Services. Neuromuscular Electrical Stimulation (NMES). Effective 10/1/2006. https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=175. Accessed 4/25/2023.
2. Noridian Healthcare Solutions. Functional Electrical Stimulation (FES) - Coverage and HCPCS Coding - Revised. https://med.noridianmedicare.com/web/jddme/policies/dmd-articles/2019/fes-coverage-and-hcpcs-coding-revised. Published 2019. Accessed 4/25/2023.

## *POLICY REVISION HISTORY*

| DATE | REVISION SUMMARY |
|---|---|
| 2/2023 | Converted to new policy template. |
| 7/2023 | Annual review. No changes. |