Clinical Policy: Neuromuscular Electrical Stimulation (NMES)

Reference Number: CP.MP.48 Coding Implications
Date of Last Revision: 07/21 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
This policy describes the medical necessity requirements for the use of neuromuscular electrical stimulation (NMES) and functional electrical stimulation (FES).

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that neuromuscular electrical stimulation is **medically necessary** when used as one component of a comprehensive rehab program for the treatment of disuse atrophy when the nerve supply to the atrophied muscle is intact and has any of the following atrophy indications:
   A. Contractures due to burn scarring;
   B. Previous casting or splinting of a limb;
   C. Major knee surgery with failure to respond to physical therapy;
   D. Recent hip replacement until physical therapy begins.

II. It is the policy of health plans affiliated with Centene Corporation that functional neuromuscular stimulation is **medically necessary** for spinal cord injury (SCI) when all of the following criteria are met:
   A. Intact lower motor units (L1 and below, including both muscle and peripheral nerve);
   B. Muscle and joint stability adequate for weight bearing at upper and lower extremities and can demonstrate balance and control to maintain an upright support posture independently;
   C. Brisk muscle contraction to stimulation and sensory perception of electrical stimulation sufficient for muscle contraction;
   D. Transfers independently and demonstrates independent standing tolerance for at least three minutes;
   E. Demonstrates hand and finger function to manipulate controls;
   F. At least six months post recovery from spinal cord injury and restorative surgery;
   G. No hip and knee degenerative disease and no history of long bone fracture secondary to osteoporosis;
   H. Highly motivated, committed, and the cognitive ability to use such devices for walking;
   I. Successfully completed a training program consisting of at least 32 physical therapy sessions with the device over a 3-month period;
   J. Demonstrates a willingness to use the device long-term;
   K. None of the following contraindications:
      1. Cardiac pacemaker;
      2. Severe scoliosis or severe osteoporosis;
      3. Skin disease or cancer at area of stimulation;
      4. Irreversible contracture;
      5. Autonomic dysflexia.

III. It is the policy of health plans affiliated with Centene Corporation that peroneal nerve stimulators (e.g., NESS L300, NESS L300 Plus, L300 Go System, WalkAide, ODFS Dropped Foot Stimulator) are medically necessary for incomplete spinal cord injury.

IV. It is the policy of health plans affiliated with Centene Corporation that peroneal nerve stimulators (e.g., NESS L300, NESS L300 Plus, L300 Go System, WalkAide, ODFS Dropped Foot Stimulator) have not been proven safe and effective for any indication other than incomplete spinal cord injury, including, but not limited to: foot drop in cerebral palsy, multiple sclerosis, traumatic brain injury, or stroke, as not proven safe and effective for these indications.

V. It is the policy of health plans affiliated with Centene Corporation that neuromuscular electrical stimulation for any other indication (e.g., idiopathic scoliosis, heart failure) is not proven safe and effective.

Background

NMES involves the use of a device which transmits an electrical impulse to the skin over selected muscle groups by way of electrodes. There are two broad categories of NMES. One type of device stimulates the muscle when the patient is in a resting state to treat muscle atrophy. The second type, also known as FES, is used to enhance functional activity of neurologically impaired patients.[2] NMES can be performed at low, medium, or high intensity to elicit mild, moderate, or strong muscle contractions. When used at very low intensity to stimulate barely perceptible contractions, this technique is referred to as threshold NMES or threshold electrical stimulation (TES). To avoid muscle strain, patients undergo high-intensity NMES for only 30 to 60 minutes per day; low-intensity and threshold NMES can be applied for much longer periods, such as all night while the patient is sleeping.[1,2] Regardless of the intensity of NMES, patients are encouraged to exercise the affected muscles voluntarily to maintain and improve their strength and function. For chronic disorders, this exercise may be in the form of regular participation in sports activities. For acute conditions, such as rehabilitation shortly after surgery or a stroke, patients must often undergo intensive physical and occupational therapy. Electrical stimulation can also be used to activate muscles of the upper or lower limbs to produce functional movement patterns, such as standing and walking, in patients with paraplegia. This application of electrical stimulation is called functional electrical stimulation (FES). The only settings where therapists with the sufficient skills to provide these services are employed are inpatient hospitals; outpatient hospitals; comprehensive outpatient rehabilitation facilities; and outpatient rehabilitation facilities. The physical therapy necessary to perform this training must be part of a one-on-one training program. Additional therapy after the purchase of the DME would be limited by our general policies detailing skilled physical therapy. [1,2]

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2020, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage.

Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS ®* Codes	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

HCPCS codes that do not support coverage criteria

HCPCS Codes	Description
E0744	Neuromuscular stimulator for scoliosis

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

+ Indicates a code(s) requiring an additional character

ICD-10-CM Code	Description
M62.50 - M62.59	Muscle wasting and atrophy, not elsewhere classified
S14.0xxA – S14.0xxS	Concussion and edema of cervical spinal, cord
S14.101A - S14.109S	Unspecified injury of cervical spinal cord
S24.101A - S24.109S	Unspecified injury at unspecified level of thoracic spinal cord
S34.101A - S34.109S	Unspecified injury to unspecified level to lumbar spinal cord
S34.131A - S34.139S	Unspecified injury to sacral spinal cord

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Original approval date 09/11. References reviewed and updated.Template update and approved 12/11. References reviewed and updated. Approved with no changes 9/12-9/14.	09/11	09/11
References reviewed and updated. Approved by MPC. Coding update only.	09/15	09/15
References reviewed and updated. Approved by MPC. No changes.	09/16	09/16
References reviewed and updated. Approved by MPC. No changes.	07/17	07/17
References reviewed and updated. Approved by MPC. No changes.	07/18	07/18
References reviewed and updated. Approved by MPC. No changes.	07/19	07/19
References reviewed and updated. Approved by MPC. No changes.	07/20	07/20
Transitioned to CNC template. Replaced “members” with “members/enrollees’ in all instances.	12/20	
Annual review completed. References reviewed and updated. Changed “review date” in the header to “date of last revision” and “date” in the revision log header to “revision date.” Integrated NMES, FES, and	07/21	07/21

Reviews, Revisions, and Approvals	Revision Date	Approval Date
peroneal stimulator criteria from CP.MP.107 DME and Legacy WellCare Neuromuscular Electrical Stimulation (NMES) CP.MP.48 policy. Added section III and IV criteria. Added code E0744 to "HCPCS codes that do not support coverage criteria." Specialist reviewed.		

References

1. Neuromuscular electrical stimulation for muscle rehabilitation. Hayes Directory website. http://www.hayesinc.com. Published December 27, 2010. (archived January 3, 2013). Accessed June 15, 2021.
2. National coverage determination. Neuromuscular electrical stimulation (NMES) (160.12). Centers for Medicare and Medicaid Services website. http://www.cms.hhs.gov/mcd/search.asp. Published October 1, 2006. Accessed June 15, 2021.
3. Functional electrical stimulation for rehabilitation following spinal cord injury. Hayes website. www.hayesinc.com. Published November 16, 2017. Reviewed April 5, 2021. Accessed June 15, 2021.
4. Functional electrical stimulation (FES) for treatment of foot drop in multiple sclerosis patients. Hayes website. www.hayesinc.com. Published July 16, 2015. (archived August 16, 2018). Accessed June 18, 2021.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a

discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.