1. Purpose

The purpose of this policy is to establish the criteria for the medically necessary use of electrical stimulation - unattended.

2. Definitions

Electrotherapy is the use of electrical stimulation for therapeutic purposes. Electrotherapy uses energy waves that are part of the electromagnetic spectrum to produce desired physiological and chemical effects in the body. Electrotherapy is designed for three therapeutic purposes: 1) to relieve pain; 2) to stimulate physiochemical changes; and 3) to stimulate muscle contraction. The use of electrical stimulation devices requires supervision and should be reported for each 15 minute time period.

3. Statement of Policy

3.1. The determination of medical necessity for the use of electrotherapy is always made on a case-by-case basis.

3.2. The use of electrotherapy may be considered medically necessary for pain modulation or documented functional deficit, which has resulted from disease, injury or surgery.

3.3. Although there is a lack of convincing scientific evidence, which demonstrates any meaningful long-term benefit with the use of different forms of electrotherapy, several studies have demonstrated a short-term improvement in patient’s reported pain levels and functional abilities as well as improved patient satisfaction; however, after several weeks these benefits were no longer demonstrable. Triad Healthcare, Inc. recognizes this potential short-term benefit in as an adjunct to a program of evidence-based care.

3.4. The use of passive (adjunctive) modalities, should be used to facilitate and transition the patient to active care (e.g., office or home based exercises and other functional activities), empowering the patient to become a participant in their recovery.

3.5. Any treatment plan involving the use of electrotherapy should ultimately result in a reduction in the patient's pain and/or an improved ability to perform age appropriate activities of daily living. The use of passive modalities, such as electrotherapy, beyond three (3) weeks has not been shown to produce meaningful long-term benefit and is
considered not medically necessary. Care at this point should be focused on transitioning the patient to active and self care strategies.

**Note:** This policy pertains to the in-office application of Electrical Muscle Stimulation, including Sine wave, Interferential Therapy, Transcutaneous Electrical Neuromuscular Stimulation (TENS), Galvanic Stimulation, RS-4i Sequential Stimulation, H-Wave Stimulation as well as other forms of electrotherapy not listed above. Certain types of electrotherapy may be considered experimental or investigational, and may be excluded from coverage in accordance with corresponding health plan policy. This policy does not pertain to home electrotherapy units (DME) and will be addressed in TENS (DME) policy.

4. References

4.1. Scientific:

The following scientific references were utilized in the formulation of this medical policy. Triad Healthcare, Inc. will continue to review clinical evidence surrounding electrical stimulation therapy for the treatment of neuromuscular pain, spasm and edema and may modify this policy at a later date based upon the evolution of the published clinical evidence. Should additional scientific studies become available and they are not included in the list, please forward the reference(s) to Triad Healthcare, Inc. so the information can be reviewed by the Academic Advisory Committee (AAC) and the Medical Quality Improvement Committee (MQIC) to determine if a modification of the policy is in order.


4.2. Related Triad Medical Policies:

- *TMMP 10 - Use of Passive and Active Care*
- *TMMP 13 – Use of adjunctive Modalities and / or Therapeutic Procedures*
- *TMMP 18 - Medical Necessity*

**CPT/HCPCS Codes**

This policy relates to the use of the following CPT Codes:

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>Description (AMA CPT Guide)</th>
</tr>
</thead>
<tbody>
<tr>
<td>97014</td>
<td>Application of a modality to 1 or more areas; electrical stimulation (unattended)</td>
</tr>
<tr>
<td>G0283</td>
<td>Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care</td>
</tr>
</tbody>
</table>

This list may not be all inclusive and is not intended to be used for coding/billing purposes.

**Table of Revisions**

<table>
<thead>
<tr>
<th>Revision Date</th>
<th>Modified By</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>06/23/2014</td>
<td>Level 1, 2, 3</td>
<td>Annual Review. §3.5. 2nd sentence, changed from “without a clinically meaningful reduction in pain levels and clinical signs of functional improvement” to “has not been shown to produce meaningful long term benefit and…” §3.5. last sentence added stating “care at this point should be focused on transitioning the patient to active and self care strategies.”</td>
</tr>
<tr>
<td>06/10/2013</td>
<td>Level 1, 2, 3</td>
<td>Annual Review. Correction to §1. to stress the association of this policy as for unattended electrical stimulation therapy. Other punctuation edits completed.</td>
</tr>
<tr>
<td>08/06/2012</td>
<td>Level 1, 2, 3</td>
<td>Annual Review.</td>
</tr>
</tbody>
</table>
Policy Library: Medical

Title/Subject:
TMMP 102 - Electrical Stimulation Therapy - Unattended

<table>
<thead>
<tr>
<th>Revision Date</th>
<th>Modified By</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>07/22/2011</td>
<td>Level 1, 2, 3</td>
<td>Annual Review. §3.5 replaced ‘carry out’ with ‘perform age appropriate.’ §4.2 added reference to TMMP 13. Removed §5, Attachments and §§5.1 Provider Manual as the provider manual has been re-written administratively. Added CPT Code table.</td>
</tr>
<tr>
<td>08/09/2010</td>
<td>Level 1, 2, 3</td>
<td>Annual Review.</td>
</tr>
<tr>
<td>08/04/2009</td>
<td>Level 1, 2, 3</td>
<td>Annual Review. Correction of titles in §4.2. §5.3, text changed from “the use of electrotherapy beyond two to three (2-3) weeks without a clinically meaningful reduction in pain levels and clinical signs of functional improvement may not be considered medically necessary” to “the use of electrotherapy beyond two to three (2-3) weeks without a clinically meaningful reduction in pain levels and clinical signs of functional improvement is considered not medically necessary.” §4.1 “Triad Healthcare, Inc. will continue to review clinical evidence surrounding electrical stimulation therapy for the treatment of neuromuscular pain, spasm and edema and may modify this policy at a later date based upon the evolution of the published clinical evidence” from “…inferential therapy/electrical stimulation…”</td>
</tr>
<tr>
<td>08/17/2008</td>
<td>Level 1, 2, 3</td>
<td>New medical policy.</td>
</tr>
</tbody>
</table>

Triad’s Medical Policies are not recommendations for treatment and providers are expected to exercise their clinical judgment in providing the most appropriate care. Health care providers and patients should not rely on these Medical Policies in making health care decisions. These Medical Policies are guidelines and do not constitute an authorization, certification, explanation of benefits or guarantee of payment. Applications of Triad’s Medical Policies are determined by the enrollee’s benefit documents and contracts and as such individual benefits must be verified. Determinations of medical necessity apply only if the benefit exists and no contract exclusions are applicable. In the event of a conflict, a participant’s benefit plan document shall supersede the information contained in Triad’s Medical Policies.