



CLINICAL MEDICAL POLICY	
Policy Name:	Assessing Patient’s Suitability for Electrical Nerve Stimulation Therapy (160.7.1 & 160.7)
Policy Number:	MP-065-MC-PA
Responsible Department(s):	Medical Management
Provider Notice/Issue Date:	02/01/2023; 01/21/2022; 01/15/2021; 04/15/2019; 03/15/2018
Effective Date:	03/01/2023; 02/21/2022; 02/15/2021; 05/20/2019; 04/15/2018
Next Annual Review:	12/2023
Revision Date:	12/21/2022; 12/15/2021; 12/16/2020; 3/20/2019; 04/15/2018
Products:	Pennsylvania Medicare Assured
Application:	All participating and nonparticipating practitioners and facilities unless contractually precluded
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Policy History

Date	Activity
03/01/2023	Provider Effective date
12/21/2022	QI/UM Committee review
12/21/2022	Annual Review: No changes to clinical criteria. Updated ‘Reference Sources’ section.
02/21/2022	Provider Effective date
12/15/2021	QI/UM Committee review
12/15/2021	Annual Review: No changes to clinical criteria. Updated CMS links and Reference Sources.
02/15/2021	Provider Effective Date
12/16/2020	QI/UM Committee review
12/16/2020	Annual Review: Updated title, added links and references to NCD 160.7, updated to new Medicare policy format with links directly to CMS/NCDs.
05/20/2019	Provider Effective Date
03/20/2019	QI/UM Committee review
03/20/2019	Annual Review: Removed the hyperlinks in the reference section; no changes to the procedure section
04/15/2018	Provider effective date

02/21/2018	QI/UM Committee review
02/08/2018	Initial policy developed

Disclaimer

Highmark WholecareSM medical policy is intended to serve only as a general reference resource regarding coverage for the services described. This policy does not constitute medical advice and is not intended to govern or otherwise influence medical decisions.

Policy Statement

Highmark WholecareSM provides coverage under the DME benefits of the Company's Medicare products for the medically necessary assessment of patient's suitability for Electrical Nerve Stimulation Therapy.

This policy is designed to address medical necessity guidelines that are appropriate for the majority of individuals with a particular disease, illness or condition. Each person's unique clinical circumstances warrant individual consideration, based upon review of applicable medical records.

Procedures

1. Please review the specific National Coverage Determination (NCD), Local Coverage Determination (LCD), and/or Local Coverage Article (LCA) information, as well as other CMS sources, using the links below.
2. Post-payment Audit Statement
The medical record must include documentation that reflects the medical necessity criteria and is subject to audit by Highmark WholecareSM at any time pursuant to the terms of your provider agreement.
3. Place of Service
The proper place of service for assessing a patient's suitability for ongoing treatment with a transcutaneous or implanted nerve stimulator is outpatient.
4. Related Policy
 - MP-066-MC-PA Spinal Cord Stimulation (Dorsal Column Stimulation) (L35450)
 - MP-092-MC-PA Peripheral Nerve Stimulation (L37360)

Coverage Determination and Links

Highmark WholecareSM follows the coverage determinations made by CMS as outlined in either the NCD or the state-specific LCD/LCA.

CMS Link

- [CMS Website](#)

NCD/LCD Links

- [NCD: Assessing Patient's Suitability for Electrical Nerve Stimulation Therapy \(160.7.1\)](#)
- [NCD: Electrical Nerve Stimulators \(160.7\)](#)
- There are no current LCDs related to this topic.

Reference Sources

Centers for Medicare and Medicaid Services (CMS). National Coverage Determination (NCD) Assessing Patient's Suitability for Electrical Nerve Stimulation Therapy (106.7.1). Effective date June 19, 2006. Implementation date June 19, 2006. Accessed on November 22, 2022.

Centers for Medicare and Medicaid Services (CMS). National Coverage Determination (NCD) Electrical Nerve Stimulators (160.7). Effective date August 7, 1995. Accessed on November 22, 2022.

Reimbursement

Participating facilities will be reimbursed per their Highmark WholecareSM contract.