Geisinger

Geisinger Health Plan Policies and Procedure Manual

Policy: MP202

Section: Medical Benefit Policy

Subject: Interferential Stimulation

I. Policy: Interferential Stimulation

II. Purpose/Objective:

To provide a policy of coverage regarding Interferential Stimulation

III. Responsibility:

A. Medical Directors

B. Medical Management Department

IV. Required Definitions

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions

Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
c. in accordance with current standards of good medical treatment practiced by the general medical community;
d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment

Medical Necessity shall mean a service or benefit that is compensable under the Medical Assistance Program and if it meets any one of the following standards:

(i) the service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.

(ii) the service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or development effects of an illness, condition, injury or disability.

(iii) the service or benefit will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for members of the same age.

DESCRIPTION: Interferential stimulation is a type of electrical stimulation that uses paired electrodes of two independent circuits carrying medium-frequency alternating currents. The electrodes are aligned on the skin so that the current flowing between each pair intersects at an underlying target. This is thought to maximize the current which permeates the tissues while reducing to a minimum unwanted stimulation of cutaneous nerves.

EXCLUSIONS: The Plan does **NOT** provide coverage for the use of *Interferential Therapy* as a "stand alone" modality for any indication because it is considered **experimental, investigational or unproven.** Although the device is FDA approved, there is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this modality on health outcomes when compared to established treatments or technologies.

Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven is outlined in **MP 15 - Experimental Investigational or Unproven Services or Treatment.**

Medicaid Business Segment:

Any requests for services, that do not meet criteria set in the PARP, may be evaluated on a case by case basis.

CODING ASSOCIATED WITH: Interferential Stimulation

The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at www.cms.gov or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements

64550 Application of surface (transcutaneous) neurostimulator
97014 Application of a modality to 1 or more areas; electrical stimulation, unattended**.**
S8130 INTERFERENTIAL CURRENT STIMULATOR, 2 CHANNEL
S8131 INTERFERENTIAL CURRENT STIMULATOR, 4 CHANNEL

LINE OF BUSINESS:

Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD's and NCD's will supercede this policy. For PA Medicaid Business segment, this policy applies as written.

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This policy will be revised as necessary and reviewed no less than annually.

Devised: 05/2007

Revised: 09/08 (updated exclusion)

Reviewed: 9/09, 9/10, 8/11, 8/12, 8/13, 8/14; 8/15; 7/16, 7/17, 6/18, 7/19, 7/20, 7/21, 7/22