Geisinger

# Geisinger Health Plan Policies and Procedure Manual

**Policy: MP183**

**Section: Medical Benefit Policy**

**Subject: Cranial Electrotherapy Stimulation**

**Applicable Lines of Business**

| | | | |
|---|---|---|---|
| **Commercial** | **X** | **CHIP** | **X** |
| **Medicare** | **X** | **ACA** | **X** |
| **Medicaid** | **X** | | |

**I. Policy:** Cranial Electrotherapy Stimulation

**II. Purpose/Objective:**

To provide a policy of coverage regarding Cranial Electrotherapy Stimulation

**III. Responsibility:**

A. Medical Directors
B. Medical Management

**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
e. 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**

Medically Necessary — A service, item, procedure, or level of care that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an

illness, condition, injury or disability.
- 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**:
Cranial Electrotherapy Stimulation has been proposed as a treatment for anxiety, depression and insomnia as well as many other conditions such as fibromyalgia and substance abuse. Also known as transcranial electrical stimulation, cranial transcutaneous electrical nerve stimulation, and neuroelectric therapy, it is hypothesized that this device uses low levels of electrical current to stimulate the hypothalamic area of the brain causing the synthesis and release various neurotransmitters. Generally, these devices are small in size and easy to transport. Each treatment is thought to control symptoms for up to 24 hours.

The Alpha-Stim CES, provides pulsed, low-intensity current via clip electrodes that attach to the earlobes. Other devices place the electrodes on the eyelids, frontal scalp, mastoid processes, or behind the ears. The P-Stim™, is a single-use electrical stimulator for auricular acupuncture points that is worn behind the ear via a self-adhesive electrode patch.

## NOTE:
## For Percutaneous Electrical Nerve Field Stimulation (PENFS) (0783T), please refer to MP343 Percutaneous Electrical Nerve Field Stimulation (PENFS)

**EXCLUSIONS**:
The Plan does NOT provide coverage for Cranial Electrotherapy Stimulation of the brain as a treatment for any indication including but not limited to the treatment of anxiety, stress related conditions, depression, headache, substance abuse and cognitive dysfunction because it is considered unproven. Although the device is FDA approved, there is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this treatment on health outcomes when compared to established treatments or technologies.

The Plan does NOT provide coverage for at home neuro-stimulation therapy (i.e. Fisher Wallace Stimulator) for any indication because it is considered unproven. Although the device is FDA approved, there is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this treatment on health outcomes when compared to established treatments or technologies.

The Plan does NOT provide coverage for transcutaneous supraorbital nerve stimulation (t-SNS), neuromodulation or external trigeminal nerve stimulation (e-TNS), with the Cefaly Prevent, Cefaly Acute, and Cefaly Dual.) for any indication because it is considered unproven. Although the device is FDA approved there is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this treatment on health outcomes when compared to established treatments or technologies.

The Plan does NOT provide coverage for the use of auricular electrostimulation, including but not limited to the BRIDGE and the Drug Relief® Devices for opioid withdrawal, P-stim, E-Pulse, or ANSiStim devices for any indication because it is considered unproven. Although the device is FDA approved there is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this treatment 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 services 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:** Cranial Electrotherapy 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***

0720T Percutaneous electrical nerve field stimulation, cranial nerves, without implantation
0783T Transcutaneous auricular neurostimulation, set-up, calibration, and patient education on use of equipment
S8930 Electrical stimulation of auricular acupuncture points; each 15 minutes of personal one-on-one contact with the patient.
A4596 Cranial electrotherapy stimulation (CES) system supplies and accessories, per month
E1399 Durable Medical Equipment, Miscellaneous
K1002 Cranial electrotherapy stimulation (CES) system, includes all supplies and accessories, any type



**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.**

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

**Devised:** 06/20/06

**Revised:** 8/15 (revised description); 7/19 (add exclusions); 7/24 (clarify exclusions, add cross reference)

**Reviewed:** 09/07, 9/08, 9/09, 9/10, 8/11, 8/12, 8/13, 8/14; 7/16, 7/17, 6/18, 7/20, 7/21, 7/22, 7/23

**CMS UM Oversight Committee Approval:** 12/23, 7/24