Medical Policy

Electrical Stimulation (ES) and Electromagnetic Therapy for the Treatment of Wounds in the Home Setting

Description

Electrical stimulation (ES) refers to the application of electrical current through electrodes placed directly on the skin in close proximity to the wound. The types of electrical stimulation and devices can be categorized into four groups based on the type of current:

- Low intensity direct current (LIDC)
- High voltage pulsed current (HVPC)
- Alternative current (AC)
- Transcutaneous electrical nerve stimulation (TENS)

Electromagnetic therapy is a related but distinct form of treatment that uses a machine that creates an electromagnetic field rather than direct electrical current.

Policy

Electrical stimulation and electromagnetic therapy for the treatment of wounds performed by the patient in the home setting is considered investigational.

Policy Guidelines

It is unknown whether electrical stimulation or electromagnetic therapy in the home setting without supervision by a healthcare provider improves wound healing compared with conventional wound care techniques.

Electrical stimulation for the prevention of ulcers and pressure sores and the treatment of infected wounds is considered experimental and investigational because its effectiveness for this indication has not been established.

The combined use of modulated ultrasound and electric current stimulation for the treatment of diabetic foot ulcers is considered experimental and investigational because the effectiveness of this approach has not been established.

Microcurrent therapy as an adjunctive therapy to enhance chronic wound healing is considered experimental and investigational because the effectiveness of this approach has not been established.

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The VeinoPlus device for the treatment of venous ulcers is considered experimental and investigational because its effectiveness has not been established.

The combined use of electrical stimulation and fibrin glue is considered experimental and investigational for the treatment of decubitus ulcers because the effectiveness of this approach has not been established.

The current body of evidence in the published literature only addresses the use of electrical stimulation therapy applied and supervised by healthcare professionals.

HCPCS Level II Codes and Description

E0761	Non-thermal pulsed high frequency radio waves, high peak power electromagnetic energy treatment device
E0769	Electrical stimulation or electromagnetic wound treatment device, not otherwise classified
G0281	Electrical stimulation, (unattended), to one or more areas, for chronic Stage i and Stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care, as part of a therapy plan of care.
G0282	Electrical stimulation, unattended, to one or more areas, for wound care other than described in G0281
G0283	Electrical stimulation, unattended, to one or more areas for indication(s) other than wound care, as part of a therapy plan of care
G0329	Electromagnetic therapy, to one or more areas for chronic Stage III and Stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care as part of a therapy plan of care.

Important Note:

Northwood's Medical Policies are developed to assist Northwood in administering plan benefits and determining whether a particular DMEPOS product or service is reasonable and necessary. Equipment that is used primarily and customarily for a non-medical purpose is not considered durable medical equipment.

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Coverage determinations are made on a case-by-case basis and are subject to all of the terms, conditions, limitations, and exclusions of the member's contract including medical necessity requirements.

The conclusion that a DMEPOS product or service is reasonable and necessary does not constitute coverage. The member's contract defines which DMEPOS product or service is covered, excluded or limited. The policies provide for clearly written, reasonable and current criteria that have been approved by Northwood's Medical Director.

The clinical criteria and medical policies provide guidelines for determining the medical necessity for specific DMEPOS products or services. In all cases, final benefit determinations are based on the applicable contract language. To the extent there are any conflicts between medical policy guidelines and applicable contract language, the contract language prevails. Medical policy is not intended to override the policy that defines the member's benefits, nor is it intended to dictate to providers how to direct care. Northwood Medical policies shall not be interpreted to limit the benefits afforded to Medicare or Medicaid members by law and regulation Northwood will use the applicable state requirements to determine required quantity limit guidelines.

Northwood's policies do not constitute medical advice. Northwood does not provide or recommend treatment to members. Members should consult with their treating prescriber in connection with diagnosis and treatment decisions.

Northwood follows all CMS National Coverage Determination (NCD) and Local Coverage Determinations (LCD), as applicable.

References

Centers for Medicare and Medicaid Services (CMS), National Coverage Determination (NCD), DME reference 280.1 Last accessed/reviewed 11-12-24.

Aetna: Electrical Stimulation for Chronic Ulcers.
http://www.aetna.com/cpb/medical/data/600_699/0680.html
Last accessed and reviewed 11/12/24.

Blue Cross Blue Shield Regence: Electrostimulation and Electromagnetic Therapy for Wounds.
https://www.bluecrossnc.com/sites/default/files/document/attachment/services/public/pdfs/medicalpolicy/electrostimulation_and_electromagnetic_therapy_for_wounds.pdf
Last accessed and reviewed 11/12/24.

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Change/Authorization History

Revision Number	Date	Description of Change	Prepared / Reviewed by	Approved by	Review Date:	Effective Date:
A	11-20-08	Initial Release	Rosanne Brugnoni	Ken Fasse	n/a	
01		Annual Review – no changes	Susan Glomb	Ken Fasse	12-2008	
02	12-22-09	Annual Review- No changes	Susan Glomb	Ken Fasse	Dec.2009	
03	12-02-10	Annual Review – no changes	Susan Glomb	Ken Fasse	Dec.2010	
04	02-04-11	Policy updated to identify treatment as investigational/experimental	Susan Glomb	Ken Fasse		
05	07-20-11	Added Important Note to all Medical Policies	Susan Glomb	Dr. B. Almasri		
06	11-28-11	Annual Review. Added References to Policy	Susan Glomb	Dr. B. Almasri	Nov. 2011	
07	04-13-12	Added reference to NH Medicaid	Susan Glomb	Dr. B. Almasri		
08	12-10-12	Annual Review. No changes.	Susan Glomb	Dr. B. Almasri		
09	12-18-13	Annual review. No changes	Susan Glomb	Dr. B. Almasri		
10	11-24-14	Annual Review. No changes	Susan Glomb	Dr. B. Almasri		
11	11-25-	Annual Review. No Changes.	Lisa Wojno	Dr. B. Almasri	November 2015	

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12	12-01-16	Annual Review. No Changes.	Lisa Wojno	Dr. B. Almasri	December 2016	
13	12-12-17	Annual review. No changes.	Carol Dimech	Dr. C. Lerchin	December 2017	
14	12-01-18	Annual Review. No Changes.	Lisa Wojno	Dr. C. Lerchin	December 2018	
15	12-05-19	Annual review. Microcurrent therapy and VeinoPlus device considered experimental and investigational.	Carol Dimech	Dr. C. Lerchin	December 2019	December 2019
16	11-19-20	Annual Review. Updated References.	Lisa Wojno	Dr. C. Lerchin	November 2020	
17	11-23-21	Annual review. Added NCD, LCD verbiage to "Important Note"	Carol Dimech/Susan Glomb	Dr. C. Lerchin	November 23, 2021	11-23-21
18	11-16-22	Annual review. Added to Policy Guidelines additional criteria as experimental and investigational.	Carol Dimech	Dr. C. Lerchin	11-16-22	11-16-22
19	11-14-23	Annual Review. No Changes.	Carol Dimech	Dr. C. Lerchin	11-14-23	11-14-23
20	11-12-24	Annual Review. Updated References.	Carol Dimech	Dr. C. Lerchin	11-12-24	11-12-24