Regence Oregon and Utah | Regence Idaho and select counties of Washington

Medical Policy Manual Durable Medical Equipment, Policy No. 83

Electrical Stimulation Devices Index

Effective: November 1, 2018

Next Review: August 2019
Last Review: September 2018

IMPORTANT REMINDER

Medical Policies are developed to provide guidance for members and providers regarding coverage in accordance with contract terms. Benefit determinations are based in all cases on the applicable contract language. To the extent there may be any conflict between the Medical Policy and contract language, the contract language takes precedence.

PLEASE NOTE: Contracts exclude from coverage, among other things, services or procedures that are considered investigational or cosmetic. Providers may bill members for services or procedures that are considered investigational or cosmetic. Providers are encouraged to inform members before rendering such services that the members are likely to be financially responsible for the cost of these services.

ELECTRICAL STIMULATION POLICIES

Note: These policies are not intended to address transcutaneous electrical nerve stimulation (TENS) which may be considered medically necessary.

Cranial Electrostimulation Therapy (CES)

Electrical Bone Growth Stimulators (Osteogenic Stimulation)

Electrical Stimulation and Electromagnetic Therapy for the Treatment of Arthritis

Electrostimulation and Electromagnetic Therapy for the Treatment of Wounds

Functional Neuromuscular Electrical Stimulation

Galvanic Stimulation

H-wave Stimulation

Implantable Peripheral Nerve Stimulation for Chronic Pain of Peripheral Nerve Origin

Interferential Current Stimulation

Microcurrent Stimulation (MENS)

Pelvic Floor Stimulation as a Treatment of Urinary and Fecal Incontinence

Spinal Cord and Dorsal Root Ganglion Stimulation

Threshold Electrical Stimulation as a Treatment of Motor Disorders

Date of Origin: *January 2012*