Geisinger

POLICIES AND PROCEDURE MANUAL

Policy: MP113

Section: Medical Benefit Policy

Subject: Electrical and Electromagnetic Stimulation to Promote Wound Healing

Applicable Lines of Business

Commercial	**X**	**CHIP**	**X**
Medicare	**X**	**ACA**	**X**
Medicaid	**X**		

I. Policy: Electrical and Electromagnetic Stimulation to Promote Wound Healing

II. Purpose/Objective:

To provide a policy of coverage regarding Electrical and Electromagnetic Stimulation to Promote Wound Healing

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:
Electrical stimulation to promote wound healing involves the application of electrical current through surface electrodes placed in the wound bed and proximal to the wound. Electromagnetic therapy involves the use of a pulsed magnetic field to induce current. Electrical stimulation and electromagnetic therapy for the treatment of wounds are adjunctive therapies to be considered only when standard wound care fails to promote measurable signs of wound healing.

INDICATIONS: Requests for coverage require pre-certification by a Plan Medical Director or designee
Electrical stimulation and electromagnetic therapy for wound healing will be considered only as adjunctive therapies for chronic stage III or stage IV pressure ulcers, arterial ulcers, diabetic ulcers or venous stasis ulcers that show no measurable signs of healing after a minimum of 30 days of appropriate standard wound care.

Measurable signs of healing include:
- Decrease in wound size (surface area or volume)
- Decrease in amount of exudate
- Decrease in amount of necrotic tissue
- Increase in amount of granulation tissue

Standard wound care is defined as:
- Optimization of nutritional status; and
- Debridement to remove devitalized tissue; and
- Maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings; and
- Necessary treatment of any infection that may be present

Standard wound care based on the specific type of wound also includes:
- Frequent repositioning (pressure ulcer)
- Off-loading of pressure and adequate glucose control (diabetic ulcer)
- Establishment of adequate circulation (arterial ulcer)
- Compression system (venous stasis ulcer)

LIMITATIONS:
Coverage for electrical stimulation or electromagnetic therapy for wound healing will be discontinued if:
1. Measurable signs of healing have not been demonstrated within any 30-day period of treatment; **or**
2. The wound demonstrates a 100% epithelialized wound bed

EXCLUSIONS:
The Plan does **NOT** provide coverage for the use of electrical stimulation or electromagnetic therapy for the treatment of wound types not identified under Indications because it is considered **experimental, investigational or unproven.** 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 electrical stimulation or electromagnetic therapy for wound healing not performed under clinical supervision because it is considered **experimental, investigational or unproven**

The Plan does **NOT** provide coverage for the use of anodyne infrared therapy as a treatment for cutaneous ulcers, diabetic neuropathy and musculoskeletal conditions 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 treatment on health outcomes when compared to established treatments or technologies. (See MP142)

Electrical stimulation devices that are used for the treatment of wounds in the home setting are NOT COVERED
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.

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.

CODING ASSOCIATED WITH: Electrical Stimulation to Promote Wound Healing
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.***

G0281	Electrical stimulation, (unattended), 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.
G0282	Electrical stimulation (unattended), to one or more areas, for wound care other than described in G0281
G0295	Electromagnetic therapy, to one or more areas, for wound care other than described in G0329 or for other areas.
G0329	Electromagnetic therapy (unattended), to one or more areas for chronic stage III and stage IV pressure 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.
E0761	Non-thermal pulsed high frequency radiowaves, high peak power electromagnetic energy treatment device
E0769	Electrical stimulation (unattended), 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.

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: 7/03

Revised: 6/04 (add electromagnetic therapy); 6/05; 8/05; 8/06; 8/07

Reviewed: 8/08, 11/09, 1/11, 2/12, 2/13, 2/14, 2/15, 2/16, 2/17, 2/18, 2/19, 2/20, 2/22, 2/23, 2/24

CMS UM Oversight Committee Approval: 12/23