Medicaid Neurostimulator Benefits To Change
Information posted March 19, 2007

Effective for dates of service on and after May 1, 2007, benefit changes will be implemented for neurostimulators for the Texas Medicaid Program. The application/implantation of transcutaneous electrical nerve stimulation (TENS), neuromuscular electrical nerve stimulation (NMES), intracranial neurostimulator (ICN), dorsal column neurostimulator (DCN), vagal neurostimulator (VNS), sacral neurostimulator (SNS), and the associated devices require prior authorization and are subject to the conditions listed below. Supplies are considered to be part of the rental and will not be separately reimbursed.

The supplies for TENS, NMES, intracranial, dorsal column, sacral, and vagal neurostimulators are separately payable with frequency limitations when the device is client-owned; additional documentation, such as the purchase date, serial number, and purchasing entity of the device may be required.

**Note:** Prior authorization is a condition for reimbursement; it is not a guarantee of payment. Prior authorization of Texas Medicaid Program services may be requested in writing by completing a Prior Authorization Request Form, attaching the necessary supportive documentation as detailed below, and mailing or faxing it to:

Texas Medicaid & Healthcare Partnership
Attn: Special Medical Prior Authorization (SMPA)
12357-A Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 1-512-514-4213

**Neuromuscular Electrical Stimulation (NMES)**

The client must have a condition that indicates a spinal cord injury or disuse atrophy that is refractory to conventional therapy. Rental of an NMES device is limited to a one-month trial period with consideration for an additional month’s trial with documentation of medical necessity.

Purchase of an NMES device is limited to once every five years and may be considered for prior authorization when there is documentation of all of the following:

- A successful test stimulation (during rental or other therapeutic period) that showed improvement as measured by a demonstrated increase in range of motion.
- The client’s ability to complete activities of daily living (ADL) or perform activities outside the home.

**NMES use for muscle atrophy**

Coverage of NMES to treat muscle atrophy is limited to the treatment of disuse atrophy where nerve supply to the muscle is intact, including brain, spinal cord, and peripheral nerves, and other non-neurological reasons for disuse atrophy. Some examples would be casting or splinting of a limb, contracture due to scarring of soft tissue as in burn lesions, and hip replacement surgery (until orthotic training begins).

**NMES use for Walking in Clients with Spinal Cord Injury (SCI)**

The type of NMES that is used to enhance the ability to walk of SCI clients is commonly referred to as functional electrical stimulation (FES). These FES devices are surface units that use electrical impulses to activate paralyzed or weak muscles in precise sequence. Coverage for the use of NMES/FES is limited to SCI clients for walking, who have completed a training program which consists of at least 32 physical therapy sessions with the device over a period of three months. The trial period of physical therapy will enable the physician treating the SCI client for his or her spinal cord injury to properly evaluate the client’s ability to use these devices frequently and for the long term. The physical therapy necessary to perform this training must be directly performed by the physical therapist as part of a one-on-one training program.
**Note:** The goal of physical therapy must be to train SCI clients on the use of NMES/FES devices to achieve walking, not to reverse or retard muscle atrophy.

Coverage for NMES/FES for walking will be covered in SCI clients with all of the following characteristics:

- Clients with intact lower motor unit (L1 and below) (both muscle and peripheral nerve)
- Clients with muscle and joint stability for weight bearing at upper and lower extremities that can demonstrate balance and control to maintain an upright support posture independently
- Clients that demonstrate brisk muscle contraction to NMES and have sensory perception electrical stimulation sufficient for muscle contraction
- Clients that possess high motivation, commitment, and cognitive ability to use such devices for walking
- Clients that can transfer independently and can demonstrate independent standing tolerance for at least three minutes
- Clients that can demonstrate hand and finger function to manipulate controls
- Clients with at least six-month post recovery spinal cord injury and restorative surgery
- Clients with hip and knee degenerative disease and no history of long bone fracture secondary to osteoporosis
- Clients who have demonstrated a willingness to use the device long-term

NMES/FES for walking will not be covered for SCI clients with any of the following:

- Clients with cardiac pacemakers
- Severe scoliosis or severe osteoporosis
- Skin disease or cancer at area of stimulation
- Irreversible contracture
- Autonomic dyslexia

**TENS**

The client must have documentation of a condition that indicates acute postoperative pain or chronic pain that is refractory to conventional therapy. Rental of a TENS device is limited to one-month trial period with consideration for an additional month's trial with documentation of medical necessity.

For TENS trial periods, when the device is rented rather than supplied by the provider, the combined payment made for professional services and the rental of the stimulator should not exceed the amount which would be payable for the total service, including the stimulator, if furnished by the provider alone.

Purchase of a TENS device is limited to once every five years and may be considered when there is documentation of a condition that indicates chronic pain that is refractory to conventional therapy. Documentation must include all of the following:

- A successful test stimulation that showed improvement as measured by demonstrated increase in range of motion
- The client's ability to complete ADL or perform activities outside the home

**Garments for NMES/TENS**
The rental of the NMES/TENS garment is not covered during the trial rental period unless the client has a documented skin problem prior to the start of the trial period; and HHSC or its designee is satisfied that the use of such an item is medically necessary for the client, such as when the client has a condition that would be indicated in the purchase criteria outlined below.

The purchase of conductive garments for NMES/TENS devices may be considered when all of the following conditions are met:

- It has been prescribed by a physician for use in delivering covered NMES/TENS treatment.
- The client has had a NMES/TENS device purchased.
- The client meets one of the following medical conditions:
  - The client cannot manage without the conductive garment because there is such a large area or so many sites to be stimulated and the stimulation would have to be delivered so frequently that it is not feasible to use conventional electrodes, adhesive tapes, and lead wires.
  - The client cannot manage the treatment for chronic intractable pain without the conductive garment because the areas or sites to be stimulated are inaccessible with the use of conventional electrodes, adhesive tapes, and lead wires.
  - The client has a documented medical condition such as skin problems that preclude the application of conventional electrodes, adhesive tapes, and lead wires.

**Application of NMES and TENS**

Procedure codes 2-64550 and 2-64580 may be considered for reimbursement with prior authorization in a nursing home and other locations when submitted by the County Indigent Health Care Program (CIHCP), advanced practice nurse, physician, and rural health clinic providers.

Procedure codes F-64550 and F-64580 may be considered for reimbursement with prior authorization in the outpatient hospital setting when submitted by an ambulatory surgical center.

**NMES and TENS Devices**

Procedure codes J/L-E0720, J/L-E0730, J/L-E0731, J/L-E0745, J/L-E0762, and J/L-E0764:

- May be considered for reimbursement with prior authorization in the office and home settings when submitted by a home health durable medical equipment (DME) or medical supplier (DME) provider.
- Are no longer payable to a custom DME or medical supply company provider.

Procedure codes J-E0730, J-E0731, J-E0762, and J-E0764 are limited to once every five years. If procedure codes J-E0730 and J-E0762 are requested within a five-year period, only one is considered for reimbursement.

Procedure codes L-E0730, L-E0731, L-E0762, and L-E0764 are limited to once a month. If procedure codes L-E0730 and L-E0762 are requested within one month, only one is considered for reimbursement.

**NMES and TENS Supplies**

The supply procedure codes 9-A4556, 9-A4557, and 9-A4595 are benefits of the Texas Medicaid Program only if there is documentation of a client-owned device. Additional documentation such as the purchase date, serial number, and purchasing entity of the device may be required if a claim is submitted and is denied for lack of history. The claim may be considered for reimbursement on appeal with documentation of a client-owned device.
Additionally, the procedure codes 9-A4556, 9-A4557, and 9-A4595:

- May be considered for reimbursement in the office and home setting when submitted by a home health DME or medical supplier (DME) provider.
- Are no longer payable to a medical supply company.
- Procedure code 9-A4595 is limited to one per month.
- If additional electrodes are required, procedure code 9-A4556 may be considered for reimbursement at a maximum of 15 per month.
- If additional lead wires are required, procedure code 9-A4557 may be considered for reimbursement at a maximum of two per month.
- Procedure codes 9-A4556 and 9-A4557 are no longer age restricted.

**PENS**

All PENS services may be considered for prior authorization when all of the following conditions are met:

- The client has a diagnosis that indicates chronic pain that is refractory to conventional therapy.
- Treatment with TENS has failed or is contraindicated for the client.
- The device and supplies are considered to be part of the PENS service and will not be separately reimbursed.

**Placement of PENS**

Procedure codes 2-64553, 2-64555, 2-64590, and 2-64595 may be considered for reimbursement with prior authorization in the office, home, inpatient hospital, and outpatient hospital setting when submitted by CIHCP providers, advanced practice nurses, and physicians.

Procedure codes F-64553, F-64555, F-64590, and F-64595 may be considered for reimbursement in the outpatient hospital setting when submitted by an ambulatory surgical center.

**DCN**

The surgical implantation of a DCN may be considered for prior authorization for clients with chronic intractable pain when documentation indicates all of the following:

- That other treatment modalities, including pharmacological, surgical, physical, and/or psychological therapies have been tried and shown to be unsatisfactory, unsuitable, or contraindicated for the client
- The client has undergone careful screening, evaluation, and diagnosis by a multidisciplinary team prior to implantation
- There has been demonstration of pain relief with a temporarily implanted electrode preceding the permanent implantation
- All the facilities, equipment, and professional and support personnel required for the proper diagnosis, treatment, training, and follow-up of the client are available

Revision or removal of a DCN (procedure codes 2/8-63660 and 2/8-63688) does not require prior authorization.

Procedure codes 2/8-63660 and 2/8-63688 may be considered for reimbursement in the inpatient hospital and outpatient hospital setting when submitted by CIHCP providers and physicians.
ICN

The surgical implantation of an ICN and purchase of a device may be considered for prior authorization with documentation of chronic intractable pain or treatment of intractable tremors due to idiopathic Parkinson’s disease or essential tremors when more conservative methods such as TENS and PENS or pharmacological management have failed or were contraindicated. The treatment of motor function disorders such as multiple sclerosis is not considered.

Revision or removal of an ICN (procedure codes 2/8-61880 and 2/8-61888) does not require prior authorization.

Procedure codes 2/8-61880 and 2/8-61888 may be considered for reimbursement in the inpatient hospital and outpatient hospital setting when submitted by CIHCP providers and physicians.

Insertion of Neurostimulator (ICN, DCN, VNS, SNS)

Procedure codes 2/8-61850, 2/8-61860, 2/8-61863, 2/8-61864, 2/8-61867, 2/8-61868, 2/8-61870, 2/8-61875, 2/8-63650, 2/8-63655, 2/8-63685, 2/8-64573, 2/8-64577, 2/8-64581, and 2/8-64590:

- May be considered for reimbursement with prior authorization in the inpatient or outpatient hospital setting when submitted by CIHCP and physicians.
- Are no longer payable to an advanced practice nurse and registered nurse/nurse midwife.

Procedure codes F-61850, F-61860, F-61863, F-61864, F-61870, F-61875, and F-63655 may be considered for reimbursement in the outpatient hospital setting when submitted by an ambulatory surgical center.

VNS

The surgical implantation of a VNS and purchase of a device may be considered for prior authorization with documentation of one of the following diagnoses codes: 34511, 34541, and 34551.

Revision or removal of a VNS (procedure code 2/8-61888) does not require prior authorization.

SNS

The surgical implantation of an SNS and purchase of a device may be considered for prior authorization with diagnoses codes 59655, 78820, 78831, 78841, and 7876 when the medical record documentation indicates that the urinary retention, urinary frequency, or urinary/fecal incontinence is refractory to conventional therapy (documented behavioral, pharmacologic, and/or surgical corrective therapy), and the client is an appropriate surgical candidate such that implantation with anesthesia can occur.

Revision or removal of an SNS (procedure codes 2-64585 and 2-64595) does not require prior authorization.

Supplies for ICN, DCN, VNS, SNS

Supply procedure codes 9-A4290, 9-C1778, 9-C1883, 9-C1897, and 9-L8680 may be considered for reimbursement if there is documentation of a client-owned device. Additional documentation, such as the purchase date, serial number, and purchasing entity, may be required if a claim is submitted and is denied for lack of history. The claim may be considered for reimbursement on appeal with documentation of a client-owned device.

Procedure codes 9-A4290, 9-C1778, 9-C1883, 9-C1897, and 9-L8680 may be considered for reimbursement without prior authorization in the office and home setting when submitted by a home health DME or medical supplier (DME) provider.

Devices for ICN, DCN, VNS, and SNS
Procedure codes J-C1767, J-C1787, J-C1816, J-E0740, J-L8681, J-L8682, J-L8683, J-L8684, J-L8685, J-L8686, J-L8687, J-L8688, and J-L8689 may be considered for reimbursement with prior authorization in the office and home setting when submitted by a home health DME or medical supplier (DME) provider.

Procedure codes 9-C1767, 9-C1787, 9-C1816, 9-E0740, 9-L8681, 9-L8682, 9-L8683, 9-L8684, 9-L8685, 9-L8686, 9-L8687, 9-L8688, and 9-L8689 may be considered for reimbursement with prior authorization in the outpatient hospital setting when submitted by an ambulatory surgical center. The devices listed above must be submitted for reimbursement with the same date of service as the surgery performed to implant the device.

**Outpatient Electronic Analysis**

Procedure codes 5-95970, 5-95971, 5-95972, 5-95973, 5-95974, 5-95975, 5-95978, and 5-95979 may be considered for reimbursement in the office and outpatient hospital setting, without prior authorization, for the electronic analysis of the implanted neurostimulator when submitted by rehabilitation centers.

The following device codes are now a benefit of the Texas Medicaid Program:

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