Geisinger

Geisinger Health Plan Policies and Procedure Manual

Policy: MP219

Section: Medical Benefit Policy

Subject: Percutaneous Electrical Nerve Stimulation (PENS) and Neuromodulation Therapy (PTN)

Applicable Lines of Business

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

I. Policy: Percutaneous Electrical Nerve Stimulation (PENS) and Neuromodulation Therapy (PTN)

II. Purpose/Objective:
To provide a policy of coverage regarding Percutaneous Electrical Nerve Stimulation (PENS) and Neuromodulation Therapy (PTN)

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:
PENS is performed with needle electrodes to stimulate peripheral sensory nerves in the soft tissue. Percutaneous neuromodulation therapy (PNT) is a variant form of Percutaneous Electrical Nerve Stimulation (PENS) in which up to 10 fine filament electrodes are temporarily placed at specific anatomical landmarks in the back. Treatment regimens consist of 30-minute sessions, once or twice a week for approximately eight to ten sessions. This modality is thought to offer symptomatic relief and management of chronic or intractable pain.

EXCLUSIONS:
The Plan does **NOT** provide coverage for Percutaneous Electrical Nerve Stimulation (PENS) or Neuromodulation Therapy (PTN)for any indication 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

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: Percutaneous Neuromodulation Therapy
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.***

64999 Unlisted procedure, nervous system

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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Nayak R and Banik R. Current innovations in peripheral nerve stimulation. Pain Res Treat 2018; 2018:9091216.

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

Devised: 08/22/08

Revised: 10/23 (expand title and exclusions)

Reviewed: 11/09; 11/10, 11/11, 11/12, 11/13, 11/14, 11/15; 10/16, 10/17, 10/18, 10/19, 10/20, 10/21, 10/22