ND

Medical Policies

Print

Policy Number:	E-46		
Policy Name:	Electrical Stimulation Devices for the Treatment of Arthritis		
Policy Type:	Medical	**Policy Subtype:**	Durable Medical Equipment (DME)
Effective Date:	09-15-2025	**End Date:**	11-02-2025

Description

Electrical stimulation has been used as an adjunctive therapy to improve functional status and relieve pain related to osteoarthritis and rheumatoid arthritis unresponsive to other standard therapies.

Policy Application

All claims submitted under this policy's section will be processed according to the policy effective date and associated revision effective dates in effect on the date of service.

Criteria

Coverage is subject to the specific terms of the member's benefit plan.

Electrical stimulation devices for the treatment of osteoarthritis or rheumatoid arthritis (e.g., BioniCare Stimulator System - Bio-1000 System) are considered experimental/investigational and therefore non-covered, because the safety and/or effectiveness of this service cannot be established by the available published peer-reviewed literature.

Procedure Code

E0762

Professional Statements and Societal Positions Guidelines

Not Applicable

Diagnosis Codes

Not Applicable

CURRENT CODING

HCPCS:

E0762	Trans elec jt stim dev sys	Medicaid Expansion
E0762	Trans elec jt stim dev sys	Commercial

References

1. Hayes, Inc. Hayes Medical Technology Directory. Transcutaneous Electrical Nerve Stimulation For Knee Osteoarthritis. Lansdale, PA :Hayes, Inc.; 1/1/2019.
2. Shimoura K, Iijima H, Suzuki Y, Aoyama T. Immediate effects of transcutaneous electrical nerve stimulation on pain and physical performance in individuals with preradiographic knee osteoarthritis. Arch Phy Med Rehab. 2019; 100(2):300-306.
3. Tong J, Chen Z, Sun G, et al. The efficacy of pulsed electromagnetic fields on pain, stiffness, and physical function in osteoarthritis: A systematic review and meta-analysis. Pain Res Manag. 2022;2022:9939891.
4. de Paula Gomes CAF, Politti F, de Souza Bacelar Pereira C, et al. Exercise program combined with electrophysical modalities in subjects with knee osteoarthritis: A randomised, placebocontrolled clinical trial. BMC Musculoskelet Disord. 2020;21(1):258.
5. Kolasinski SL, Neogi T, Hochberg MC, et al. 2019 American College of Rheumatology/Arthritis Foundation guideline for the management of osteoarthritis of the hand, hip, and knee [published correction appears in Arthritis Care Res (Hoboken). 2021 May;73(5):764]. Arthritis Care Res (Hoboken). 2020;72(2):149-162.
6. Bannuru RR, Osani MC, Vaysbrot EE, et al. OARSI guidelines for the non- surgical management of knee, hip, and polyarticular osteoarthritis. Osteoarthritis Cartilage. 2019;27(11):1578-1589.
7. Sultan AA, Samuel LT, Bhave A. Utilization and outcomes of neuromuscular electric stimulation in patients with knee osteoarthritis: A retrospective analysis. Ann Transl Med. 2019;7(Suppl7):S246.

ND Committee Review

Internal Medical Policy Committee 7-22-2020 Annual Review

Internal Medical Policy Committee 7-22-2021 Annual Review

Internal Medical Policy Committee 7-21-2022 Revision

- *Updated* to clarifying language.

Internal Medical Policy Committee 3-19-2024 Annual Review-no changes in criteria

- *Added* Policy Application

Internal Medical Policy Committee 3-11-2025 Annual Review-no changes in criteria

- *Updated* references

Disclaimer

Current medical policy is to be used in determining a Member's contract benefits on the date that services are rendered. Contract language, including definitions and specific inclusions/exclusions, as well as state and federal law, must be considered in determining eligibility for coverage. Members must consult their applicable benefit plans or contact a Member Services representative for specific coverage information. Likewise, medical policy, which addresses the issue(s) in any specific case, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and the Company reserves the right to review and update medical policy periodically.