ND

Medical Policies

Print

Policy Number:	Y-16		
Policy Name:	Chronic Wound Management		
Policy Type:	Medical	**Policy Subtype:**	Therapy
Effective Date:	09-15-2025	**End Date:**	11-02-2025

Description

Electrical stimulation, also known as electrostimulation, refers to the application of electrical current through electrodes placed directly on the skin. Electromagnetic therapy involves the application of electromagnetic fields rather than direct electrical current. Both are proposed as treatments for wounds, generally chronic wounds.

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 processing, regardless of service date; or

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 may be considered medically necessary for the management of the following types of chronic ulcers when it is used as adjunctive therapy after there are no measurable signs of healing for at least 30 days of treatment with conventional wound treatments.

- Arterial ulcers; or
- Diabetic ulcers; or
- Pressure ulcers (Stage III or Stage IV); or

- Venous stasis ulcers.

Continued treatment considered not medically necessary if measurable signs of healing have not been demonstrated within any 30-day period of treatment.

• Measurable signs of improved healing include a decrease in wound size either in surface area or volume, decrease in amount of exudates, and decrease in amount of necrotic tissue

• If electrical stimulation is being used, wounds must be evaluated at least monthly by the treating physician.

All other uses of electrical stimulation for the treatment of chronic ulcers not meeting the criteria as indicated in this policy are considered not medically necessary.

Electrical stimulation for wound healing is not covered in the home setting.

Procedure Codes

E0769	G0281	G0282

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 processing, regardless of service date; or

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.

Electromagnetic therapy may be considered medically necessary for the management of the following types of chronic ulcers when it is used as adjunctive therapy after there are no measurable signs of healing for at least 30 days of treatment with conventional wound treatments.

- Arterial ulcers; or
- Diabetic ulcers; or
- Pressure ulcers (Stage III or Stage IV); or
- Venous stasis ulcers.

Continued treatment is considered not medically necessary if measurable signs of healing have not been demonstrated within any 30-day period of treatment. Measurable signs of improved healing include a decrease in wound size either in surface area or volume, decrease in amount of exudates, and decrease in amount of necrotic tissue. If electromagnetic therapy is being used, wounds must be evaluated at least monthly by the treating physician.

All other uses of electromagnetic therapy for the treatment of chronic ulcers not meeting the criteria as indicated in this policy are considered not medically necessary.

Electromagnetic therapy for wound healing is non-covered in the home setting.

It would not be appropriate for an individual to receive both electrical stimulation and electromagnetic therapy for the treatment of these wounds.

Procedure Codes

E0761	E0769	G0281	G0295	G0329

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 processing, regardless of service date.

Noncontact Ultrasound Therapy

Noncontact ultrasound therapy for the treatment of chronic wound treatment is considered experimental/investigational.

Procedure Code

97610

Professional Statements and Societal Positions Guidelines

Not Applicable

Diagnosis Codes

Covered Diagnosis Codes for G0281 and G0329

E10.51	E10.52	E10.620	E10.621	E10.630	E10.638	E10.69
E11.51	E11.618	E11.620	E11.628	E11.630	E11.65	E11.69
E13.59	E13.618	E13.622	E13.628	E13.65	E13.69	I70.233
I70.234	I70.239	I70.241	I70.244	I70.245	I70.25	I70.261
I70.268	I70.269	I70.333	I70.334	I70.339	I70.341	I70.344
I70.345	I70.35	I70.431	I70.434	I70.435	I70.441	I70.442
I70.445	I70.448	I70.531	I70.532	I70.535	I70.538	I70.542
I70.543	I70.548	I70.549	I70.632	I70.633	I70.638	I70.639
I70.643	I70.644	I70.649	I70.65	I70.733	I70.734	I70.739
I70.741	I70.744	I70.745	I70.75	I83.001	I83.004	I83.005

I83.011	I83.012	I83.015	I83.018	I83.022	I83.023	I83.028
I83.029	I83.203	I83.204	I83.209	I83.211	I83.214	I83.215
I83.221	I83.222	I83.225	I83.228	I87.012	I87.013	I87.032
I87.033	I87.311	I87.312	I87.331	I87.332	I87.9	L89.003
L89.014	L89.023	L89.104	L89.113	L89.124	L89.133	L89.144
L89.153	L89.204	L89.213	L89.224	L89.303	L89.314	L89.323
L89.44	L89.500	L89.503	L89.504	L89.511	L89.512	L89.519
L89.520	L89.523	L89.524	L89.601	L89.602	L89.609	L89.610
L89.613	L89.614	L89.621	L89.622	L89.629	L89.810	L89.813
L89.814	L89.891	L89.892	L89.899	L89.93	L97.102	L97.103
L97.105	L97.106	L97.108	L97.111	L97.112	L97.115	L97.116
L97.118	L97.119	L97.121	L97.124	L97.125	L97.126	L97.128
L97.129	L97.203	L97.204	L97.205	L97.206	L97.208	L97.212
L97.213	L97.215	L97.216	L97.218	L97.221	L97.222	L97.225
L97.226	L97.228	L97.229	L97.301	L97.304	L97.305	L97.306
L97.308	L97.309	L97.313	L97.314	L97.315	L97.316	L97.318
L97.322	L97.323	L97.325	L97.326	L97.328	L97.401	L97.402
L97.405	L97.406	L97.408	L97.409	L97.411	L97.414	L97.415
L97.416	L97.418	L97.419	L97.423	L97.424	L97.425	L97.426
L97.428	L97.502	L97.503	L97.505	L97.506	L97.508	L97.511
L97.512	L97.515	L97.516	L97.518	L97.519	L97.521	L97.524
L97.525	L97.526	L97.528	L97.529	L97.803	L97.804	L97.805
L97.806	L97.808	L97.812	L97.813	L97.815	L97.816	L97.818
L97.821	L97.822	L97.825	L97.826	L97.828	L97.829	L97.901

L97.904	L97.905	L97.906	L97.908	L97.909	L97.913	L97.914
L97.915	L97.916	L97.918	L97.922	L97.923	L97.925	L97.926
L97.928	L98.411	L98.412	L98.415	L98.416	L98.418	L98.419
L98.421	L98.424	L98.425	L98.426	L98.428	L98.429	L98.493
L98.494	L98.495	L98.496	L98.498			

CURRENT CODING

CPT:

97610	LOW FREQUENCY NON-THERMAL ULTRASOUND PER DAY	Medicaid Expansion
97610	LOW FREQUENCY NON-THERMAL ULTRASOUND PER DAY	Commercial

HCPCS:

E0761	Nontherm electromgntc device	Medicaid Expansion
E0769	Electric wound treatment dev	Medicaid Expansion
G0281	Elec stim unattend for press	Medicaid Expansion
G0282	Elect stim wound care not pd	Medicaid Expansion
G0295	Electromagnetic therapy onc	Medicaid Expansion
G0329	Electromagntic tx for ulcers	Medicaid Expansion
E0761	Nontherm electromgntc device	Commercial
E0769	Electric wound treatment dev	Commercial
G0281	Elec stim unattend for press	Commercial
G0282	Elect stim wound care not pd	Commercial
G0295	Electromagnetic therapy onc	Commercial
G0329	Electromagntic tx for ulcers	Commercial

References

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5. Girgis B, Duarte JA. High Voltage Monophasic Pulsed Current (HVMPC) for stage II-IV pressure ulcer healing. A systematic review and meta-analysis. *J Tissue Viability*. 2018;4:274-284.
6. Arora M, Harvey L, Glinsky J, et al. Electrical stimulation for treating pressure ulcers. *Cochrane Database Stys Rev.* 2020;1(1).1-95.
7. Ruizeng L, Jieyu, D, Zhou L. Accelerated skin wound healing by electrical stimulation. *Adv Healthc Mater.* 2021; 10:16 https://doi.org/10.1002/adhm.202100557

ND Committee Review

Internal Medical Policy Committee 7-22-2020 Annual Review *Effective September 7, 2020*

Internal Medical Policy Committee 1-19-2021 Revision *Effective March 1, 2021*

- *Updated* language within policy

Internal Medical Policy Committee 1-20-2022 Revision *Effective March 7, 2022*

- *Updated* with clarifying language

Internal Medical Policy Committee 1-26-2023 Annual Review - no changes in criteria *Effective March 6, 2023*

Internal Medical Policy Committee 7-26-2023 Annual Review - no changes in criteria *Effective September 4, 2023*

Internal Medical Policy Committee 7-16-2024 Annual Review -*Effective September 02, 2024*

- *Added* Coverage statement; and
- *Added* Policy Application.

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.