ND

Medical Policies

Print

Policy Number:	Z-7		
Policy Name:	Electrical Nerve Stimulation		
Policy Type:	Medical	**Policy Subtype:**	Miscellaneous
Effective Date:	09-15-2025	**End Date:**	11-02-2025

Description

Electrical nerve stimulation is the use of electric current produced by a device to stimulate the nerves for therapeutic purposes.

Policy Application

For Date of Processing (DOP): All claims submitted for this policy 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

For Date of Service (DOS): All claims submitted for this policy will be processed according to the policy effective date and associated revision effective dates in effect on the date of service.

*See below to determine whether the policy rules apply to initial and adjustment claims based on date of processing (DOP) or Date of Service (DOS).

Criteria

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

Electrical Nerve Stimulation, (Transcutaneous Electrical Nerve Stimulation (TENS) and Percutaneous Electrical Nerve Stimulation) (PENS)

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.

Electrical nerve stimulation, (Transcutaneous electrical nerve stimulation (TENS) and Percutaneous electrical nerve stimulation) (PENS) may be considered medically necessary when used for the treatment of acute or chronic pain and as a means of assessing the need for continued treatment with an implanted electrical nerve stimulator.

Electrical nerve stimulation for pain control may be considered medically necessary when the following criteria have been met:

- For acute pain including post-operative pain the first 30-days from the day of surgery; or
- For chronic pain, an individual is unresponsive to at least three (3) months of conservative therapy (i.e., non-steroidal anti-inflammatory medications, ice, rest and/or physical therapy); and
- The individual is responsive to a trial of electrical stimulation for chronic pain control for at least two (2) weeks performed under medical supervision (i.e., physical therapy). For example, a demonstration of a reduction in pain that is clinically significant as defined by accepted documented outcome measures (i.e., pain scale); and
- The trial period is monitored and documented by a licensed professional that is qualified to provide treatment (i.e., physical therapist).

The use of PENS and TENS not meeting the criteria as indicated in this policy is 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 Codes

64555	64596	64597	64598	64999	A4595	E0720
E0730						

Supplies for Electrical Stimulation Device

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.

Supplies for electrical stimulation device may be considered medically necessary when annual documentation is noted in the individual's medical record.

Normal utilization with a covered electrical stimulation device is:

- For two (2) lead devices, four (4) electrodes per month; or
- For four (4) lead devices, eight (8) electrodes per month.

Procedure code A4595 is allowed 12 every one (1) floating month.

Quantity of supplies that exceed the frequency guidelines listed on this policy are considered not medically necessary.

Procedure Codes

A4595	E0720	E0730

Phrenic Nerve Stimulator

The implantation of a United States Food and Drug Administration (U.S. FDA) approved phrenic nerve stimulator may be considered medically necessary:

- The phrenic nerve is viable and intact; **and**
- Diaphragmatic function is sufficient to accommodate chronic stimulation; **and**
- For treatment of chronic ventilator or respiratory insufficiency requiring mechanical ventilation due to **ONE** (1) of the following conditions:
  - Lesions/injury of the spinal cord at or above the C-3 vertebral level; **or**
  - Central alveolar hypoventilation, either primary or secondary to a brain stem disorder; **or**
  - Central sleep apnea (i.e., the Remede System) and central sleep related hypoventilation/hypoxemic syndromes.

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.

Phrenic nerve stimulation not meeting the criteria as indicated in this policy is 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 Codes

33276	33277	33278	33279	33280	33281	33287
33288	64575	64580	64585	64590	64595	64596
64597	64598	64999	93150	93151	93152	93153
95970	95971	L8678	L8680	L8682	L8683	L8685
L8686	L8687	L8688	L8689	L8696		

Vagus Nerve Stimulator

The implantation of a vagus (vagal) nerve stimulator for seizure control may be considered medically necessary only when used as a last resort for individuals with epilepsy (aged four (4) years and older) with partial onset seizures who have not undergone a bilateral or left cervical vagotomy.

A United States Food and Drug Administration (U.S. FDA) approved vagus nerve stimulator for the management of epilepsy with partial onset seizures may be considered medically necessary for individuals when seizures cannot be controlled by any other method, such as:

- Drug-resistant epilepsy ('failure to control seizures with two (2) or more appropriately chosen drugs in adequate doses'); or
- When surgery cannot be performed.

Vagus (vagal) nerve stimulation not meeting the criteria as indicated in this policy is considered not medically necessary.

Procedure Codes

61885	64553	64568	64569	64570	95970	95976
95977	E1399	L8678	L8679	L8680	L8681	L8682
L8683	L8685	L8686	L8687	L8688	L8689	L8695

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.

Non-Implantable Vagus Nerve Stimulator

U.S. FDA approved non-implantable vagus nerve stimulation devices (i.e. gammaCore) may be considered medically necessary for the abortive treatment of migraine or cluster headache under ALL of the following circumstances:

- The individual is aged eighteen years or older; and
- The individual has a diagnosis of migraine or cluster headache; and
- The individual has failed or has contraindication or has intolerance to at least two (2) medications from each of the following categories: NSAIDS, Triptans, and Ergotamines; and
- The individual must be re-evaluated in 30 days. In order to obtain renewal of the device, there must be documentation of significant efficacy in the medical record.

In order to maintain coverage for gammaCore, the following efficacy must be documented:

- Reduction of pain from moderate or severe to mild or pain free within 60 minutes, without the use of rescue medicine, for at least 50 percent of attacks.

U.S. FDA approved non-implantable vagus nerve stimulation devices (i.e., gammaCore) may be considered medically necessary for the preventive treatment of migraine headache or for the acute treatment of pain associated with migraine headaches under ALL of the following circumstances:

- The individual is aged between 12 to 17 years of age; and
- The individual has a diagnosis of migraine; and
- The individual has failed or has contraindication or has intolerance to at least two (2) medications from each of the following categories: NSAIDS, Triptans, and Ergotamines; and

- The individual must be re-evaluated in 30 days. In order to obtain renewal of the device, there must be documentation of significant efficacy in the medical record.

In order to maintain coverage for gammaCore, the following efficacy must be documented:

- Reduction of pain from moderate or severe to mild or pain free within 60 minutes, without the use of rescue medicine, for at least 50 percent of attacks.

Non-implantable stimulation devices not meeting the criteria as indicated in this policy 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 Codes

E0735	E1399

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.

Percutaneous Neuromodulation Therapy

The use of a Percutaneous nerve field stimulator in opioid withdrawal treatment is 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.

The use of Percutaneous neuromodulation therapy is 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.

Implantable Peripheral Nerve Stimulator

Implantable peripheral nerve stimulation to include temporary and permanent placement of neuromuscular neurostimulation electrodes, for the management of chronic pain is considered experimental/investigational; for ANY indications and therefore non-covered, because the safety and/or effectiveness of this service cannot be established by the available published peer reviewed literature.

Procedure Codes

64555	64580	64999	E1399

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.

Occipital Nerve Stimulation (ONS)

ONS is 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 Codes

61885	64553	64555	64568	64569	64570	64999
L8678	L8680	L8681	L8682	L8683	L8685	L8686
L8687	L8688	L8689				

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.

External Trigeminal Nerve Stimulation System

An external trigeminal nerve stimulation (eTNS) system is 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 Codes

A4541	E0733

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.

External Upper Limb Tremor Stimulator

An external upper limb tremor stimulator is 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 Codes

A4542	E0734

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.

Transcutaneous Electrical Modulation Pain Reprocessing Therapy

Transcutaneous electrical modulation pain reprocessing therapy (TEMPR) (i.e., scrambler therapy) is 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

0278T

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.

Restorative Neurostimulation Therapy

Implanted peripheral electric nerve stimulation (i.e., ReActiv8) for the treatment of low back pain is 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 Codes

64555	64575	64590	64999	L8679	L8680	L8681
L8683	L8688					

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.

Replacement batteries are not eligible for payment and therefore non-covered.

Procedure Code

A4630

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.

Outpatient HCPCS (C Codes)

C1767	C1778	C1816	C1822	C1823	C1826	C1883

C1897	

Professional Statements and Societal Positions Guidelines

Not Applicable

Diagnosis Codes

Covered Diagnosis Codes for Vagus Nerve Stimulation

61885; 64553; 64568; 64569; and 64570

G40.001	G40.009	G40.011	G40.019	G40.101	G40.109	G40.111
G40.119	G40.201	G40.209	G40.211	G40.219	G40.C01	G40.C09
G40.C11	G40.C19	Z45.42				

Covered Diagnosis Codes for Non-implantable Vagus Nerve Stimulation (E0735) for individuals aged 18 or older

G43.001	G43.009	G43.011	G43.019	G43.101	G43.109	G43.111
G43.119	G44.011	G44.019	G44.021	G44.029	G44.001	G44.009

Covered Diagnosis Codes for Non-implantable Vagus Nerve Stimulation (E0735) for Individuals aged 12-17

G43.001	G43.009	G43.011	G43.019	G43.101	G43.109	G43.111
G43.119						

Covered Diagnosis Codes for Phrenic Nerve Stimulation

33276; 33277; 33278; 33279; 33280; 33281; 33287; 33288; 93150; 93151; 93152; and 93153

G47.31	G47.34	G47.35	G47.36	G47.37

Non-Covered Diagnosis Codes for Restorative Neuromodulation Therapy

64555; 64575; 64590; 64999; L8679; L8680; L8681; L8683; and L8688

M62.5A2	M53.86	M53.87	M54.41	M54.42	M54.51	M54.59

M54.89	M62.85	

CURRENT CODING

CPT:

0278T	TRNSCUT ELECT MODLATION PAIN REPROCES EA TX SESS	Medicaid Expansion
33276	INSERTION PHRENIC NERVE STIMULATOR SYSTEM	Medicaid Expansion
33277	INSJ PHRENIC NRV STIMULATOR TRANSVNS SENSING LD	Medicaid Expansion
33278	REMOVAL PHRENIC NERVE STIMULATOR SYSTEM	Medicaid Expansion
33279	RMVL PHRNC NRV STIMULATOR TRANSVNS STIMJ/SNSG LD	Medicaid Expansion
33280	RMVL PHRENIC NRV STIMULATOR PULSE GENERATOR ONLY	Medicaid Expansion
33281	REPOSITIONING PHRENIC NRV STIMULATOR TRANSVNS LD	Medicaid Expansion
33287	RMVL&RPLCMT PHRENIC NRV STIMULATOR PLS GENERATOR	Medicaid Expansion
33288	RMVL&RPLCMT PHRNC NRV STIM TRNSVNS STIMJ/SNSG LD	Medicaid Expansion
61885	INSJ/RPLCMT CRANIAL NEUROSTIM PULSE GENERATOR	Medicaid Expansion
64553	PRQ IMPLTJ NEUROSTIMULATOR ELTRD CRANIAL NERVE	Medicaid Expansion
64555	PRQ IMPLTJ NEUROSTIMULATOR ELTRD PERIPHERAL NRV	Medicaid Expansion
64568	OPEN IMPLANTATION CRANIAL NERVE NEA & PULSE GEN	Medicaid Expansion
64569	REVISION/REPLMT NEUROSTIMLATOR ELTRD CRANIAL NRV	Medicaid Expansion
64570	REMOVAL CRNL NRV NSTIM ELTRDS & PULSE GENERATO	Medicaid Expansion

64575	OPEN IMPLANTATION NEA PERIPHERAL NERVE	Medicaid Expansion
64580	OPEN IMPLANTATION NEA NEUROMUSCULAR	Medicaid Expansion
64585	REVJ/RMVL PERPH NEUROSTIMULATOR ELECTRODE ARRAY	Medicaid Expansion
64590	INS/RPLC PERPH SAC/GSTRC NPG/RCVR PCKT CRTJ&CONN	Medicaid Expansion
64595	REV/RMV PRPH SAC/GSTRC NPG/RCV DTCH CONN ELTR RA	Medicaid Expansion
64596	INSJ/RPLCMT PERQ ELTRD RA PN W/INT NSTIM 1ST RA	Medicaid Expansion
64597	INSJ/RPLCMT PERQ ELTRD RA PN INT NSTIM EA ADD RA	Medicaid Expansion
64598	REVISION/REMOVAL NSTIM ELTRD ARRAY PN INT NSTIM	Medicaid Expansion
64999	UNLISTED PROCEDURE NERVOUS SYSTEM	Medicaid Expansion
93150	THER ACTIVATION IMPL PHRENIC NRV STIMULATOR SYS	Medicaid Expansion
93151	INTERROG&PRGRMG IMPL PHRENIC NRV STIMULATOR SYS	Medicaid Expansion
93152	INTERROG&PRGRMG IPNSS DURING POLYSOMNOGRAPHY	Medicaid Expansion
93153	INTERROGATION WITHOUT PROGRAMMING IPNSS	Medicaid Expansion
95970	ELEC ALYS IMPLT NPGT PHYS/QHP W/O PROGRAMMING	Medicaid Expansion
95971	ELEC ALYS IMPLT NPGT SMPL SP/PN NPGT PRGRMG	Medicaid Expansion
95976	ELEC ALYS IMPLT SMPL CN NPGT PRGRMG	Medicaid Expansion
95977	ELEC ALYS IMPLT CPLX CN NPGT PRGRMG	Medicaid Expansion
0278T	TRNSCUT ELECT MODLATION PAIN REPROCES EA TX SESS	Commercial
33276	INSERTION PHRENIC NERVE STIMULATOR SYSTEM	Commercial
33277	INSJ PHRENIC NRV STIMULATOR TRANSVNS SENSING LD	Commercial

33278	REMOVAL PHRENIC NERVE STIMULATOR SYSTEM	Commercial
33279	RMVL PHRNC NRV STIMULATOR TRANSVNS STIMJ/SNSG LD	Commercial
33280	RMVL PHRENIC NRV STIMULATOR PULSE GENERATOR ONLY	Commercial
33281	REPOSITIONING PHRENIC NRV STIMULATOR TRANSVNS LD	Commercial
33287	RMVL&RPLCMT PHRENIC NRV STIMULATOR PLS GENERATOR	Commercial
33288	RMVL&RPLCMT PHRNC NRV STIM TRNSVNS STIMJ/SNSG LD	Commercial
61885	INSJ/RPLCMT CRANIAL NEUROSTIM PULSE GENERATOR	Commercial
64553	PRQ IMPLTJ NEUROSTIMULATOR ELTRD CRANIAL NERVE	Commercial
64555	PRQ IMPLTJ NEUROSTIMULATOR ELTRD PERIPHERAL NRV	Commercial
64568	OPEN IMPLANTATION CRANIAL NERVE NEA & PULSE GEN	Commercial
64569	REVISION/REPLMT NEUROSTIMLATOR ELTRD CRANIAL NRV	Commercial
64570	REMOVAL CRNL NRV NSTIM ELTRDS & PULSE GENERATO	Commercial
64575	OPEN IMPLANTATION NEA PERIPHERAL NERVE	Commercial
64580	OPEN IMPLANTATION NEA NEUROMUSCULAR	Commercial
64585	REVJ/RMVL PERPH NEUROSTIMULATOR ELECTRODE ARRAY	Commercial
64590	INS/RPLC PERPH SAC/GSTRC NPG/RCVR PCKT CRTJ&CONN	Commercial
64595	REV/RMV PRPH SAC/GSTRC NPG/RCV DTCH CONN ELTR RA	Commercial
64596	INSJ/RPLCMT PERQ ELTRD RA PN W/INT NSTIM 1ST RA	Commercial
64597	INSJ/RPLCMT PERQ ELTRD RA PN INT NSTIM EA ADD RA	Commercial

64598	REVISION/REMOVAL NSTIM ELTRD ARRAY PN INT NSTIM	Commercial
64999	UNLISTED PROCEDURE NERVOUS SYSTEM	Commercial
93150	THER ACTIVATION IMPL PHRENIC NRV STIMULATOR SYS	Commercial
93151	INTERROG&PRGRMG IMPL PHRENIC NRV STIMULATOR SYS	Commercial
93152	INTERROG&PRGRMG IPNSS DURING POLYSOMNOGRAPHY	Commercial
93153	INTERROGATION WITHOUT PROGRAMMING IPNSS	Commercial
95970	ELEC ALYS IMPLT NPGT PHYS/QHP W/O PROGRAMMING	Commercial
95971	ELEC ALYS IMPLT NPGT SMPL SP/PN NPGT PRGRMG	Commercial
95976	ELEC ALYS IMPLT SMPL CN NPGT PRGRMG	Commercial
95977	ELEC ALYS IMPLT CPLX CN NPGT PRGRMG	Commercial

HCPCS:

A4541	Monthly supp use with e0733	Medicaid Expansion
A4542	Supp ext up limb tremor stim	Medicaid Expansion
A4595	Tens suppl 2 lead per month	Medicaid Expansion
A4630	Repl bat t.e.n.s. own by pt	Medicaid Expansion
C1767	Generator, neuro non-recharg	Medicaid Expansion
C1778	Lead, neurostimulator	Medicaid Expansion
C1816	Receiver/transmitter, neuro	Medicaid Expansion
C1822	Gen, neuro, hf, rechg bat	Medicaid Expansion
C1823	Gen, neuro, trans sen/stim	Medicaid Expansion
C1826	Gen, neuro, clo loop, rechg	Medicaid Expansion
C1883	Adapt/ext, pacing/neuro lead	Medicaid Expansion
C1897	Lead, neurostim test kit	Medicaid Expansion
E0720	Tens two lead	Medicaid Expansion
E0730	Tens four lead	Medicaid Expansion
E0733	Trans elec nerv for trigemin	Medicaid Expansion

E0734	Ext up limb tremor stim wris	Medicaid Expansion
E0735	Non-invasive vagus nerv stim	Medicaid Expansion
L8678	Ext sply implt neurostim	Medicaid Expansion
L8679	Imp neurosti pls gn any type	Medicaid Expansion
L8680	Implt neurostim elctr each	Medicaid Expansion
L8681	Pt prgrm for implt neurostim	Medicaid Expansion
L8682	Implt neurostim radiofq rec	Medicaid Expansion
L8683	Radiofq trsmtr for implt neu	Medicaid Expansion
L8685	Implt nrostm pls gen sng rec	Medicaid Expansion
L8686	Implt nrostm pls gen sng non	Medicaid Expansion
L8687	Implt nrostm pls gen dua rec	Medicaid Expansion
L8688	Implt nrostm pls gen dua non	Medicaid Expansion
L8689	External recharg sys intern	Medicaid Expansion
L8695	External recharg sys extern	Medicaid Expansion
L8696	Ext antenna phren nerve stim	Medicaid Expansion
A4541	Monthly supp use with e0733	Commercial
A4542	Supp ext up limb tremor stim	Commercial
A4595	Tens suppl 2 lead per month	Commercial
A4630	Repl bat t.e.n.s. own by pt	Commercial
C1767	Generator, neuro non-recharg	Commercial
C1778	Lead, neurostimulator	Commercial
C1816	Receiver/transmitter, neuro	Commercial
C1822	Gen, neuro, hf, rechg bat	Commercial
C1823	Gen, neuro, trans sen/stim	Commercial
C1826	Gen, neuro, clo loop, rechg	Commercial
C1883	Adapt/ext, pacing/neuro lead	Commercial
C1897	Lead, neurostim test kit	Commercial
E0720	Tens two lead	Commercial
E0730	Tens four lead	Commercial
E0733	Trans elec nerv for trigemin	Commercial

E0734	Ext up limb tremor stim wris	Commercial
E0735	Non-invasive vagus nerv stim	Commercial
L8678	Ext sply implt neurostim	Commercial
L8679	Imp neurosti pls gn any type	Commercial
L8680	Implt neurostim elctr each	Commercial
L8681	Pt prgrm for implt neurostim	Commercial
L8682	Implt neurostim radiofq rec	Commercial
L8683	Radiofq trsmtr for implt neu	Commercial
L8685	Implt nrostm pls gen sng rec	Commercial
L8686	Implt nrostm pls gen sng non	Commercial
L8687	Implt nrostm pls gen dua rec	Commercial
L8688	Implt nrostm pls gen dua non	Commercial
L8689	External recharg sys intern	Commercial
L8695	External recharg sys extern	Commercial
L8696	Ext antenna phren nerve stim	Commercial

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ND Committee Review

Internal Medical Policy Committee 1-22-2020

- ***Removed*** Deep Brain Stimulation and made it, it's own policy

Internal Medical Policy Committee 11-19-2020 Revision of policy

- ***Expanded*** indications; definitions of indications; and E/I statements; **and**
- ***Removed*** Procedure Codes; **and**
- ***Added*** Procedure Codes; **and**
- ***Added*** Diagnosis codes: G47.31; G47.34; G47.35; G47.36; and G47.37 for Phrenic Nerve Stimulation (64575; 64580; 64585; 64590; 64595; L8680; L8682; L8683; L8685; L8686; L8687; L8688; L8689; L8696; 0424T; 0425T; 0426T; 0427T; 0428T; 0429T; 0430T; 0431T; 0432T; 0433T; 0434T; 0435T; 0436T)

Internal Medical Policy Committee 1-19-2021 Coding update:

- ***Removed*** procedure codes 64561; and 64581; **and**
- ***Added*** procedure codes 64999

Internal Medical Policy Committee 3-17-2021 Coding update - ***Effective April 01, 2021***

- ***Added*** Procedure code K1020

Internal Medical Policy Committee 9-21-2021 Coding update ***Effective October 01, 2021*** :

- ***Added*** Procedure codes: 64555; 64999; 95976; E1399; **and**
- ***Added*** Diagnosis codes: G43.001; G43.009; G43.011; G43.019; G43.101; G43.109; G43.111; G43.119; G44.021; G44.029; G44.001; and G44.009; **and**
- **Revised** language for clarity

Internal Medical Policy Committee 11-23-2021

- ***Added*** statement regarding PENFS device

Internal Medical Policy Committee 7-21-2022 Revision with Coding - **Effective July 01, 2022**

- ***Added*** Procedure code 0720T

- Revision that is ***Effective September 05, 2022***
  - *Revision of criteria throughout policy*
    - ***Added*** *Procedure codes 0278T; 95977; K1016; K1017; L8679; and L8695;* ***and***
    - ***Added*** *Diagnosis code Z45.42;* ***and***
    - ***Added*** subtitle '***Implantable Peripheral Nerve Stimulator***'
      to that section of policy.

Internal Medical Policy Committee *11-29-2022 Coding update -****Effective January 01, 2023***

- *Added* Procedure code C1826

Internal Medical Policy Committee 3-23-2023 Coding update - *Effective April 01, 2023*

- *Added* Procedure code L8678

Internal Medical Policy Committee 1-16-2024 Coding update - *Effective January 01, 2024*

- *Removed* procedure codes 0424T; 0425T; 0426T; 0427T; 0428T; 0429T; 0430T; 0431T; 0432T; 0433T; 0434T; 0435T; 0436T; K1016; K1017; K1018; K1019; K1020; and
- *Added* procedure codes 33276; 33277; 33278; 33279; 33280; 33281; 33287; 33288; 64596; 64597; 64598; 93150; 93151; 93152; 93153; A4541; A4542; E0733; E0734; E0735; and
- *Removed* section Remote Electrical Neuomodulation as it is now found in policy E-88 Nerivio - *Effective March 04, 2024.*

Internal Medical Policy Committee 3-19-2024 Revision with coding update - *Effective May 06, 2024*

- *Updated* criteria; and
- *Removed* sections Percutaneous Electrical Nerve Field Stimulator; and
- *Removed* section Percutaneous Electrical Nerve Field Stimulator - see policy Z-108; and
- *Removed* procedure code 0720T; and
- *Added* Percutaneous Electrical Nerve Field Stimulator; and
- *Added* non-covered diagnosis codes section for Restorative Neurostimulation Therapy; and
- *Added* diagnosis codes M62.5A2; M56.83; M53.87; M54.41; M54.42; M54.51; M54.59; M54.89; and
- *Added* Policy Application.

Internal Medical Policy Committee 9-17-2024 Revision with coding update - *Effective October 01, 2024*

Added Non-covered Diagnosis code M62.85

Internal Medical Policy Committee 3-11-2025 Coding update - *Effective May 05, 2025*

- *Removed* procedure codes 61886 and C1820

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.