MEDICAL POLICY	Percutaneous Neuromodulation Therapy (PNT) and Percutaneous Electrical Nerve Stimulation (PENS) (Medicare Only)
Effective Date: 4/1/2022  4/1/2022 Medical Officer Date	Medical Policy Number: 287 Medical Policy Committee Approved Date: 2/2021; 3/2022

See Policy CPT/HCPCS CODE section below for any prior authorization requirements

SCOPE:

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as "Company" and collectively as "Companies").

APPLIES TO:

Medicare Only

MEDICARE POLICY CRITERIA

The following Centers for Medicare & Medicaid Service (CMS) guidelines should be utilized for medical necessity coverage determinations. Click the link provided in the table below to access applicable medical necessity criteria. All listed guidelines apply.

Service	Medicare Guidelines
Percutaneous Electrical Nerve Stimulation (PENS)	• When used to treat **motor function disorders** (e.g., multiple sclerosis): NCD for Treatment of Motor Function Disorders with Electric Nerve Stimulation (160.2) • When used to **determine suitability of an implanted nerve stimulator:** National Coverage Determination (NCD) for Assessing Patient's Suitability for Electrical Nerve Stimulation Therapy (160.7.1) **NOTE:** According to NCD 160.7.1, PENS may be covered, but it is reserved for patients who fail to get pain relief from TENS **and** it is used to determine potential therapeutic usefulness of an electrical nerve stimulator. This is not a true "treatment." Rather, if the pain is effectively controlled by PENS in the physician's office, then implantation of peripheral nerve stimulators may be warranted for continued treatment and a trial period using an implanted nerve stimulator can be attempted.

	See *Policy Guidelines* below for additional treatments of PENS in a physician's office.

In the absence of a Medicare coverage policy or guidance (e.g., manual, NCD, local coverage determination [LCD] article [LCA], etc.), Medicare guidelines allow a Medicare Advantage Organization (MAO) to make coverage determinations, applying an objective, evidence-based process, based on authoritative evidence. (Medicare Managed Care Manual, Ch. 4, §90.5) Therefore, the commercial medical policy, **Percutaneous Neuromodulation Therapy (PNT) and Percutaneous Electrical Nerve Stimulation (PENS) (All Lines of Business Except Medicare),** *applies to the following services:*

- Percutaneous Neuromodulation Therapy (PNT)
- Use of PENS ***other than*** for determining suitability of an implanted nerve stimulator

POLICY GUIDELINES

General

Percutaneous electrical nerve stimulation (PENS) and percutaneous neuromodulation therapy (PNT) have both as treatments of various conditions, such as low back pain, neck pain, diabetic neuropathy, chronic headache, and surface hyperalgesia. These chronic pain conditions have typically failed other treatments, making the goal of PENS and PNT to relieve this pain.

PENS is similar in concept to transcutaneous electrical nerve stimulation (TENS). Where PENS and TENS differ is that for PENS, needles are inserted either around or immediately adjacent to the nerves serving the painful area and are then stimulated. PENS is generally reserved for patients who fail to get pain relief from TENS.

PNT is an electrical stimulation therapy in which fine filament electrodes are temporarily placed in the deep tissues near the area causing pain.

While some use the terms PENS and PNT interchangeably, PNT differs from PENS in the varying length of the needles and its placement which creates an electrical field that hyperpolarizes C-fibers, thus preventing action potential propagation along the pain pathway.

Examples of devices approved by the US Food and Drug Administration (FDA) include, but may not be limited to, the following:

- The Percutaneous Neuromodulation Therapy™ (Vertis Neurosciences) system (approved in 2002);

- The Deepwave® Percutaneous Neuromodulation Pain Therapy System (Biowave Corp.), listing the Vertis Neuromodulation system and a Biowave TENS unit as predicate devices (approved in 2006).

Continued Treatments

According to Medicare, patients are able to be instructed how to use the electrical stimulation equipment without direct physician supervision. Therefore, ongoing visits to a physician or provider for continued treatment of pain using electrical stimulation is inappropriate and is not covered. *(NCD 160.7.1)*

See Cross References for separate medical policies related to coverage requirements for TENS devices.

BILLING GUIDELINES

There are no specific codes for percutaneous neuromodulation therapy (PNT) or percutaneous nerve stimulation (PENS). Therefore, the appropriate code for claim submission is the unlisted CPT code 64999. CPT codes for percutaneous implantation of neurostimulator electrodes (i.e., 64553-64561, 64590) are not appropriate as these codes represent procedures with percutaneously implanted electrodes that are left in place, rather than percutaneously temporarily inserted needles and wires seen in PENS and PNT.

CPT/HCPCS CODES

Medicare Only	
Unlisted Codes All unlisted codes will be reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is billed related to services addressed in this policy then **prior-authorization is required.**	
64999	Unlisted procedure, nervous system
E1399	Durable medical equipment, miscellaneous

INSTRUCTIONS FOR USE

Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days notice of policy changes that are restrictive in nature.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement.

REGULATORY STATUS

Mental Health Parity Statement

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

CROSS REFERENCES

Transcutaneous Electrical Nerve Stimulators (TENS) and Related Supplies (Medicare Only), MP299