PROVIDER POLICIES & PROCEDURES

FUNCTIONAL ELECTRICAL STIMULATION DEVICES (HCPCS Code E0770)

The primary purpose of this document is to assist providers enrolled in the Connecticut Medical Assistance Program (CMAP Providers) with the information needed to support a medical necessity determination for functional electrical stimulation (FES). By clarifying the information needed for prior authorization of services, HUSKY Health hopes to facilitate timely review of requests so that individuals obtain the medically necessary care they need as quickly as possible.

FES attempts to replace stimuli from destroyed nerve pathways to assist neurologically impaired patients with functional movement and to suppress spasticity. FES is a high intensity, short duration therapy that may be delivered for 20 minutes to one hour, several times a week, for months. The use of FES has been proposed for a number of indications.

CLINICAL GUIDELINE

Coverage guidelines for FES are made in accordance with the Department of Social Services (DSS) definition of Medical Necessity. The following criteria are guidelines only. Coverage determinations are based on an assessment of the individual and his or her unique clinical needs. If the guidelines conflict with the definition of Medical Necessity, the definition of Medical Necessity shall prevail. The guidelines are as follows:

Functional electrical stimulation (FES), when used to activate muscles to produce functional movement patterns **is considered investigational and not medically necessary** for all indications. This includes, but is not limited to, the NESS H200®, NESS L300™ Foot Drop System, ODFS Dropped Foot Stimulator, Deluxe Digital Electronic Muscle Stimulator, and the WalkAide system®.

FES exercise devices such as the FES Power Trainer, ERGYS, REGYS, NeuroEDUCATOR, STimMaster Galaxy, RT200 Elliptical, RT300 FES Cycle Ergometer (also referred to as a FES bicycle), RT600 Step and Stand Rehabilitation Therapy System, and SpectraSTIM are considered exercise equipment and **not medically necessary**.

NOTE: EPSDT Special Provision
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a federal Medicaid requirement that requires the Connecticut Medical Assistance Program (CMAP) to cover services, products, or procedures for Medicaid enrollees under 21 years of age where the service or good is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination. The applicable definition of medical necessity is set forth in Conn. Gen. Stat. Section 17b-259b (2011) [ref. CMAP Provider Bulletin PB 2011-36].

PROCEDURE
Prior authorization of FES is required. Requests for coverage of FES will be reviewed in accordance with procedures in place for reviewing requests for durable medical equipment (DME). Coverage determinations will be based upon a review of requested and/or submitted case-specific information.

EFFECTIVE DATE
This policy is effective for prior authorization requests for FES for the foot and ankle for individuals covered under the HUSKY Health Program on or after September 1, 2012.

LIMITATIONS
Not Applicable

CODE:

Code	Definition
E0770	Functional electrical stimulator, transcutaneous stimulation of nerve and/or muscle groups, any type, complete system, not otherwise specified

DEFINITIONS
1. **HUSKY A**: Connecticut children and their parents or a relative caregiver; and pregnant women may qualify for HUSKY A (also known as Medicaid). Income limits apply.
2. **HUSKY B**: Uninsured children under the age of 19 in higher income households may be eligible for HUSKY B (also known as the Children's Health Insurance Program) depending on their family income level. Family cost-sharing may apply.
3. **HUSKY C**: Connecticut residents who are age 65 or older or residents who are ages 18-64 and who are blind, or have another disability, may qualify for Medicaid coverage under HUSKY C (this includes Medicaid for Employees with Disabilities (MED-Connect), if working). Income and asset limits apply.
4. **HUSKY D**: Connecticut residents who are ages 19-64 without dependent children and who: (1) do not qualify for HUSKY A; (2) do not receive Medicare; and (3) are not pregnant, may qualify for HUSKY D (also known as Medicaid for the Lowest-Income populations).
5. **HUSKY Health Program**: The HUSKY A, HUSKY B, HUSKY C, HUSKY D and HUSKY Limited Benefit programs, collectively.
6. **HUSKY Limited Benefit Program or HUSKY, LBP**: Connecticut's implementation of limited health insurance coverage under Medicaid for individuals with tuberculosis or for family planning purposes and such coverage is substantially less than the full Medicaid coverage.
7. **Medically Necessary or Medical Necessity**: (as defined in Connecticut General Statutes § 17b-259b) Those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B) recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration

and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition.

8. **Prior Authorization**: A process for approving covered services prior to the delivery of the service or initiation of the plan of care based on a determination by CHNCT as to whether the requested service is medically necessary.

ADDITIONAL RESOURCES AND REFERENCES:

- Allen CB, Williamson TK, Norwood SM, Gupta A. Do Electrical Stimulation Devices Reduce Pain and Improve Function?-A Comparative Review. *Pain Ther*. 2023;12(6):1339-1354. doi:10.1007/s40122-023-00554-6.
- Bulley C, Meagher C, Street T, *et al.* Development of clinical guidelines for service provision of functional electrical stimulation to support walking: mixed method exploration of stakeholder views. BMC Neurol. 2021 July;21(263).
- Centers for Medicare & Medicaid Services. (2006). NCD-Neuromuscular Electrical Stimulation (NMES) (160.12). Retrieved from https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=175&ncdver=2
- Khan MA, Fares H, Ghayvat H, et al. A systematic review on functional electrical stimulation based rehabilitation systems for upper limb post-stroke recovery. *Front Neurol*. 2023;14:1272992. Published 2023 Dec 8. doi:10.3389/fneur.2023.1272992
- Moll I, Vles JSH, Soudant DLHM, Witlox AMA, Staal HM, Speth LAWM, Janssen-Potten YJM, Coenen M, Koudijs SM, Vermeulen RJ. Functional electrical stimulation of the ankle dorsiflexors during walking in spastic cerebral palsy: a systematic review. Dev Med Child Neurol. 2017 Dec;59(12):1230-1236.
- Noridian Healthcare Solutions. (2019). Functional Electrical Stimulation (FES)-Coverage and HCPCS Coding-Revised. Retrieved from https://med.noridianmedicare.com/web/jddme/policies/dmd-articles/2019/fes-coverage-and-hcpcs-coding-revised
- Prenton, Sarah & Hollands, Kristen & Kenney, Laurence. (2016). Functional electrical stimulation versus ankle foot orthoses for foot-drop: A meta-analysis of orthotic effects. J Rehabil Med. 2016 Oct;48(8):646-656. 48.
- Sheffler LR, Hennessey MT, Naples GG, Chae J. Peroneal nerve stimulation versus an ankle foot orthosis for correction of foot drop in stroke: impact on functional ambulation. Neurorehabil Neural Repair. 2006 Sep;20(3):355-360.
- Van der Linden ML, Hooper JE, Cowan P, Weller BB, Mercer TH. Habitual functional electrical stimulation therapy improves gait kinematics and walking performance, but not patient-reported functional outcomes, of people with multiple sclerosis who present with foot-drop. PLoS One. 2014 Aug;9(8):e103368.

PUBLICATION HISTORY

Status	Date	Action Taken
Original publication	September 2012	
Reviewed	September 2013	Clinical Quality Sub-Committee Review. References Updated.

Reviewed	September 2014	Clinical Quality Sub-Committee review. Reference updated. These changes approved at the September 15, 2014 Clinical Quality Subcommittee meeting.
Updated	August 2015	Updated definitions for HUSKY A, B, C and D programs at request of DSS.
Reviewed	September 2015	Clinical Quality Subcommittee Review. Reference Updated. Removed "included use on varied terrain" as part of criteria for customary environment from Procedure section. Added need for information from PCP or specialist regarding conditions which typically indicate a contraindication for FES in Information Required For Review section. These changes approved at the September 21, 2015 Clinical Quality Subcommittee meeting.
Updated	March 2016	Updates to language in introductory paragraph pertaining to purpose of policy. Updates to Clinical Guideline section pertaining to definition of Medical Necessity. Updates throughout policy to reflect importance of person-centeredness when reviewing requests for FES. These changes approved at the March 21, 2016 Clinical Quality Subcommittee meeting. Updates by DSS in Clinical Guideline section removing references to specific medical conditions. All changes approved by DSS on May 23, 2016.
Updated	February 2017	Updated reference. Change approved at the February 23, 2017 Medical Policy Review Committee meeting. Approved by Clinical Quality Subcommittee on March 20, 2017. Approved by DSS on March 27, 2017.
Updated	April 2018	Medical Policy Committee review. Updated reference. Update to *Procedures* section, #7, under "*The following information is needed to review requests for FES:"* Added *"As applicable,"* to beginning of sentence. Approved by CHNCT Medical Policy Review Committee on February 14, 2018. Approved by CHNCT Clinical Quality Subcommittee on March 19, 2018. Approved by DSS on April 5, 2018.
Updated	February 2019	Medical Policy Committee review. Changes throughout Policy to limit the focus of the FES policy to guidelines pertaining to HCPCS code E0770, based on updated guidance from CMS regarding use of this HCPCS code. Removed brand name WalkAide to allow for inclusion of other FDA approved devices for this purpose. Omitted specific diagnoses to change focus to the medical conditions and other criteria needed for medical necessity determinations. Updates to reference section.

		Changes approved at the February 13, 2019 Medical Reviewer meeting. Changes approved by the CHNCT Clinical Quality Subcommittee on March 18, 2019. Approved by DSS on March 27, 2019.
Updated	April 2020	Update to introductory paragraphs Update to *Clinical Guideline* section • Policy changed to reflect that the use of functional electrical stimulation (FES) to activate muscles of the lower limb to produce functional movement patterns **is considered investigational and not medically necessary** for all indications. • Added the following language FES exercise devices such as the FES Power Trainer, ERGYS, REGYS, NeuroEDUCATOR, STimMaster Galaxy, RT200 Elliptical, RT300 FES Cycle Ergometer (also referred to as a FES bicycle), RT600 Step and Stand Rehabilitation Therapy System, and SpectraSTIM are considered exercise equipment and **not medically necessary**. Update to *Procedure* section: • Removed list of specific documentation needed for review. Replaced with *documentation from the requesting physician supporting the medical necessity of FES* • Removed language regarding review process Update to *Definition* Section: • Removed definition of functional electrical stimulation as already defined in introduction References updated. All changes approved at the February 12, 2020 Medical Reviewer meeting. Approved by the CHNCT Clinical Quality Subcommittee on March 16, 2020. Approved by DSS on April 16, 2020.
Reviewed	March 2021	Reviewed and approved without changes at the January 13, 2021 CHNCT Medical Reviewer meeting. Approved by the CHNCT Clinical Quality Subcommittee on March 15, 2021. Approved by DSS on March 22, 2021.
Reviewed	March 2022	Reviewed and approved without changes at the February 9, 2022 CHNCT Medical Reviewer meeting. Approved by the CHNCT Clinical Quality Subcommittee on March 21, 2022. Approved by DSS on March 24,

		2022.
Reviewed	March 2023	Reviewed and approved without changes at the January 11, 2023, CHNCT Medical Reviewer meeting. Approved by the CHNCT Clinical Quality Subcommittee on March 20, 2023. Approved by DSS on March 27, 2023.
Updated	November 2023	Update to Clinical Guidelines to remove lower limb and to update the list of products considered as FES devices. Update to Procedure to include prescription from a licensed physician, APRN, or PA enrolled in the Connecticut Medical Assistance Program (CMAP). Update to Additional Resources and References section. All changes approved at the December 13, 2023 Medical Reviewer meeting. Approved by the CHNCT Clinical Quality Subcommittee on December 18, 2023. Approved by DSS on January 03, 2024.
Updated	November 2024	Update to Procedure section to remove documentation requirements. Update to Additional Resources and References section. All changes approved at the November 13, 2024 Medical Reviewer meeting. Approved by the CHNCT Clinical Quality Subcommittee on December 16, 2024. Approved by DSS on December 27, 2024.