

***Effective November 1, 2023, refer to CMS Manual 100-02, Chapter 16-General Exclusions from Coverage for services included in this policy.***



**BlueCross BlueShield  
of Alabama**

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**Name of Blue Advantage Policy:**  
**Interferential Stimulator/Stimulation Devices**

Policy #: 073

Latest Review Date: June 2023

Category: DME

**ARCHIVED EFFECTIVE 11/1/2023**

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**BACKGROUND:**

*Blue Advantage medical policy does not conflict with Local Coverage Determinations (LCDs), Local Medical Review Policies (LMRPs) or National Coverage Determinations (NCDs) or with coverage provisions in Medicare manuals, instructions or operational policy letters. In order to be covered by Blue Advantage the service shall be reasonable and necessary under Title XVIII of the Social Security Act, Section 1862(a)(1)(A). The service is considered reasonable and necessary if it is determined that the service is:*

1. *Safe and effective;*
2. *Not experimental or investigational\*;*
3. *Appropriate, including duration and frequency that is considered appropriate for the service, in terms of whether it is:*
  - *Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member;*
  - *Furnished in a setting appropriate to the patient's medical needs and condition;*
  - *Ordered and furnished by qualified personnel;*
  - *One that meets, but does not exceed, the patient's medical need; and*
  - *At least as beneficial as an existing and available medically appropriate alternative.*

*In accordance with Title XVIII of the Social Security Act, Section 1862 (a)(10) cosmetic surgery or expenses incurred in connection with such surgery is not covered except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member.*

*\*Routine costs of qualifying clinical trial services with dates of service on or after September 19, 2000 which meet the requirements of the Clinical Trials NCD are considered reasonable and necessary by Medicare. Providers should bill **Original Medicare** for covered services that are*

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*related to **clinical trials** that meet Medicare requirements (Refer to Medicare National Coverage Determinations Manual, Chapter 1, Section 310 and Medicare Claims Processing Manual Chapter 32, Sections 69.0-69.11).*

**POLICY:**

**Blue Advantage** will treat the **IFS or IFS Sequential Stimulator unit for home use** as a **non-covered benefit** and as **investigational**.

*Blue Advantage does not approve or deny procedures, services, testing, or equipment for our members. Our decisions concern coverage only. The decision of whether or not to have a certain test, treatment or procedure is one made between the physician and his/her patient. Blue Advantage administers benefits based on the members' contract and medical policies. Physicians should always exercise their best medical judgment in providing the care they feel is most appropriate for their patients. Needed care should not be delayed or refused because of a coverage determination.*

**DESCRIPTION OF PROCEDURE OR SERVICE:**

Interferential current stimulation (IFS) is a type of electrical stimulation used to reduce pain. The technique has been proposed to decrease pain and increase function in patients with osteoarthritis and to treat other conditions such as constipation, irritable bowel syndrome, dyspepsia, and spasticity.

Interferential current stimulation (IFS) is a type of electrical stimulation that has been investigated as a technique to reduce pain, improve function and range of motion, and treat gastrointestinal disorders.

This stimulation uses paired electrodes of 2 independent circuits carrying high-frequency and medium-frequency alternating currents. The superficial electrodes are aligned on the skin around the affected area. It is believed that IFS permeates tissues more effectively with less unwanted stimulation of cutaneous nerves, is more comfortable than transcutaneous electrical nerve stimulation. There are no standardized protocols for the use of IFS; IFS may vary by the frequency of stimulation, the pulse duration, treatment time, and electrode-placement technique.

**KEY POINTS:**

The most recent literature was reviewed through April 19, 2023. Following is a summary of the key literature to date.

**Summary of Evidence:**

For individuals who have musculoskeletal conditions who receive IFS, the evidence includes randomized controlled trials (RCTs) and meta-analyses. Relevant outcomes are symptoms, functional outcomes, quality of life, medication use, and treatment-related morbidity. Placebo-controlled RCTs of IFS for treating musculoskeletal pain and impaired function have mostly

found that it does not significantly improve outcomes. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have gastrointestinal disorders who receive IFS, the evidence includes RCTs. Relevant outcomes are symptoms, functional outcomes, quality of life, medication use and treatment-related morbidity. IFS has been tested for a variety of gastrointestinal conditions, with a small number of trials completed for each condition. Trials results are mixed, with some reporting benefit and others not. This body of evidence is inconclusive on whether IFS is an efficacious treatment for gastrointestinal conditions. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have post stroke spasticity who receive IFS, the evidence includes RCTs. Relevant outcomes are symptoms, functional outcomes, quality of life, and treatment-related morbidity. The RCTs had small sample sizes and very short follow-up (immediately post treatment to 5 weeks). The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

#### **Practice Guidelines and Position Statements:**

##### **American College of Physicians and the American Pain Society**

Clinical practice guidelines from the American College of Physicians and the American Pain Society, published in 2009, concluded that there was insufficient evidence to recommend interferential stimulation for the treatment of low back pain. An update of these guidelines by the American College of Physicians (2017) confirmed the 2009 findings that there was insufficient evidence to determine the effectiveness of interferential current stimulation (IFS) for the treatment of low back pain.

##### **American College of Occupational and Environmental Medicine**

The American College of Occupational and Environmental Medicine published several relevant guidelines. For shoulder disorders, guidelines found the evidence on IFS to be insufficient and, depending on the specific disorder, either did not recommend IFS or were neutral on whether to recommend it. For low back disorders, guidelines found the evidence on IFS to be insufficient and did not recommend it. For knee disorders, guidelines recommended IFS for postoperative anterior cruciate ligament reconstruction, meniscectomy, and knee chondroplasty immediately postoperatively in the elderly. This was a level C recommendation.

##### **National Institute for Health and Care Excellence**

In 2016, the National Institute for Health and Care Excellence had a guideline (NG59) on assessment and management of low back pain and sciatica in people aged 16 and over. The guideline states “Do not offer interferential therapy for managing low back pain with or without sciatica”.

##### **U.S. Preventive Services Task Force Recommendations**

Not applicable

**KEY WORDS:**

Interferential current therapy (IF), interferential stimulation (IF), interferential stimulator, transcutaneous electrical nerve stimulation (TENS), sequential stimulator, RS-4i Sequential stimulator, Medstar™ 100, RS-4i®

**APPROVED BY GOVERNING BODIES:**

A number of IFS devices have been cleared for marketing by the U.S. Food and Drug Administration through the 510(k) process, including the Medstar™ 100 (MedNet Services) and the RS-4i® (RS Medical). IFS may be included in multimodal electrotherapy devices such as transcutaneous electrical nerve stimulation and functional electrostimulation.

**BENEFIT APPLICATION:**

Coverage is subject to member's specific benefits. Group-specific policy will supersede this policy when applicable.

**CURRENT CODING:****CPT Codes:**

97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)
97032	Application of modality or one or more areas; electrical stimulation (manual), each 15 minutes (attended)

**HCPCS Codes:**

G0283	Electrical stimulation (unattended, to 1 or more areas for indications other than wound care, as part of a therapy plan of care)
S8130	Interferential current stimulator, 2 channel
S8131	Interferential current stimulator, 4 channel

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## **POLICY HISTORY:**

Adopted for Blue Advantage, October 2005

Available for comment October 8-November 21, 2005

Medical Policy Group, November 2006

Medical Policy Group, November 2008

Medical Policy Group, November 2010

Medical Policy Group, December 2011

Medical Policy Group, March 2012

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Medical Policy Group, January 2014

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Medical Policy Group, July 2016

Medical Policy Group, September 2017

Medical Policy Group, December 2017

Medical Policy Group, June 2018

Medical Policy Group, December 2018: 2019 CPT Coding Update

Medical Policy Group, June 2019

Medical Policy Group, July 2020

Medical Policy Group, June 2021

Medical Policy Group, June 2022

Medical Policy Group, June 2023

Medical Policy Group, November 2023: Archived effective 11/1/2023.

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*This medical policy is not an authorization, certification, explanation of benefits, or a contract. Eligibility and benefits are determined on a case-by-case basis according to the terms of the member's plan in effect as of the date services are rendered. All medical policies are based on (i) research of current medical literature and (ii) review of common medical practices in the treatment and diagnosis of disease as of the date hereof. Physicians and other providers are solely responsible for all aspects of medical care and treatment, including the type, quality, and levels of care and treatment.*

*This policy is intended to be used for adjudication of claims (including pre-admission certification, pre-determinations, and pre-procedure review) in Blue Cross and Blue Shield's administration of plan contracts.*