COMPLETE GUIDE TO
MEDICARE COVERAGE ISSUES

A REFERENCE TO COVERED AND NONCOVERED SERVICES
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**Summary of Changes to the November 2013 Complete Guide to Medicare Coverage Issues.**

The following table contains a complete summary of the information added to the Complete Guide to Medicare Coverage Issues for this update.

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<td>• A decision that continuing the requirement for certification for bariatric surgery facilities would not improve health outcomes for Medicare beneficiaries. Therefore, CMS proposes to remove this certification requirement.</td>
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**Revised Procedure for National Coverage Determinations**

In a notice published in the August 7, 2013 issue of the Federal Register, the Centers for Medicare and Medicaid Services (CMS) establishes a revised procedure for initiating, determining, and reevaluation of national coverage determinations (NCDs). The agency has also formulated a process to accelerate the removal of some current NCDs that are no longer necessary which allows local contractors to make decisions regarding coverage for the service or supply. However, current rules and regulations pertaining to the administrative review of NCDs will remain the same.

The agency acknowledges the necessity of reviewing policies and processes in the effort to remain transparent and efficient. It is important for the agency to remain cognizant of changes in the industry and for policies to be reflective of the current progress being made in medicine and related technology. To this end, the agency has announced the development of a procedure by which NCDs that have not been reviewed in the preceding 10 years will be reevaluated and a decision made to determine if the NCD should remain active as a national policy. Under the new process, the decision regarding coverage of a service or supply would be made by the local contractors, although the agency feels the use of items or services
addressed in the old NCD would be only on a limited basis. The agency feels the process of culling NCDs will result in:

- Removal of NCDs for items or services no longer containing clinically relevant information or seldom used by beneficiaries
- Allow for access to other technologies

As the scientific community continues to pursue research in certain areas, the evidence base we previously reviewed may have evolved to support other policy conclusions. Alternatively, in some circumstances, removing an NCD has the effect of striking national noncoverage and may permit access to technologies that may be valuable for some limited uses.

The process will involve publishing of a list of NCDs flagged for removal on the web site with the rationale for the removal. This will be followed by a 30 day public comment period. All of the comments and rationale received during this process will be used by the agency to determine their decision to keep or remove the NCD. Reconsideration of the NCD will go through the current process and a tracking sheet will be posted on the web site. When the decision is finalized, comments will be summarized and the rationale for the decision will be clarified. This shortened process is expected to reduce the time of the current nine month to one year reconsideration process considerably.

Longstanding NCDs may be removed for any of the following reasons:

- The agency feels local contractor discretion would enhance the needs of Medicare and Medicare beneficiaries
- The technology is generally recognized as outdated
- A service or item is no longer considered to be experimental
- The NCD has been superseded by more recent Medicare policy
- The policy fails to meet the definition of an “NCD” as defined in sections 1862(l) or 1869(f) of the Social Security Act

Source: Federal Register August 7, 2013

All ICD-10 LCDs and associated ICD-10 Articles are to be published on the Medicare coverage database (MCD) no later than April 10, 2014. All other LCDs and articles (e.g., does not contain ICD-10 information, or articles not attached to an LCD) shall be published on the MCD no later than September 4, 2014. All LCDs and Articles will receive a new LCD/Article ID number (e.g., LCD ID 1234 will become LCD ID 4567). The new LCD/Article ID number could have an impact on Medicare Administrative Contractors (MACs) local systems; such as changing their Medicare Summary Notice (MSN) to capture the new LCD/Article ID number. CMS has determined that although new LCD numbers will be assigned to the ICD-10 LCD policies, the policies shall not be considered new policies. CMS considers this type of update to be a coding revision that does not change the intent of coverage/non-coverage within an LCD. Therefore, if a MAC only translates ICD-9 codes to the appropriate ICD-10 code, the policy does not need to be vetted through their Carrier Advisory Committee or be sent through the public Comment and process notice. However, if a MAC decides to revise more than just the ICD-10 code(s), they shall follow the normal LCD development process outlined in Pub. 100-08, Chapter 13.

Source: Transmittal 1293, September 6, 2013 Medicare One-Time Notification. Pub. 100-20

**Changes to Coding Ultrasound for Transesophageal Doppler Monitoring**

Since 2007 a National Coverage Determination (Pub. 100-3, 220.5) has been in place stating that esophageal Doppler monitoring of cardiac output for ventilated patients in the ICU and operative patients with the need for intra-operative fluid optimization was reasonable and necessary for claims with dates of service on and after May 17, 2007. This procedure was reported with unlisted CPT code 76999, Unlisted ultrasound procedure (e.g., diagnostic, interventional) for claims prior to January 1, 2013. Effective January 1, 2013, report HCPCS Level II code, G9157 Transesophageal Doppler measurement of cardiac output (including probe placement, image acquisition, and interpretation per course of treatment) for monitoring purposes. G9157 is a diagnostic procedure indicated for ventilated patients in the ICU and operative patients with a need for intra-operative fluid optimization and is only covered when furnished in an inpatient hospital place of service.

The services under code G9157 include the insertion, placement, and repositioning of the esophageal Doppler probe in addition to the assessment(s) with report, image acquisition(s), and interpretation(s) per course of treatment.

This service is only covered in a hospital setting, and payment is included under the existing Inpatient Prospective Payment System. This code is not reportable under OPPS. Professional services are covered only if provided in an inpatient hospital place of service (POS 21). This code includes the physician work entailed in the insertion, placement, and repositioning of the esophageal Doppler probe as well as the assessment(s) with report, image acquisition(s), and interpretation(s) per course of treatment. This code may be reported only once per treatment course.


**Enrollment Moratoria to Combat Fraud**

Armed with the authority established by the Affordable Care Act, the Centers for Medicare and Medicaid Services (CMS) is targeting high-fraud areas with a temporary moratoria on the enrollment of new home health provider and ambulance supplier enrollments in Medicare, Medicaid and the Children’s Health Insurance Program (CHIP) effective July 30, 2013. Like other programs in place to fight fraud, the purpose of the moratoria is to safeguard taxpayer dollars, as well as to make sure patients have the access to care they need. Existing providers and suppliers can continue to deliver and bill for services normally, as the moratoria impact new provider and supplier applications in these areas only.

The temporary enrollment moratoria is applicable only to newly-enrolling home health agencies in specific counties in the Miami and Chicago area and ground ambulance suppliers in the Houston area as noted in the following list:

- Miami: Miami-Dade and Monroe
- Chicago: Cook, DuPage, Kane, Lake, McHenry and Will
- Houston: Brazoria, Chambers, Fort Bend, Galveston, Harris, Liberty, Montgomery and Waller

The decision to enact the moratoria in these areas was based on many fraud risk factors including a disproportionate number of providers and suppliers relative to beneficiaries, a rapid increase in enrollment applications from providers and suppliers, and extremely high utilization. In addition, a large number of health care fraud cases have been prosecuted in these specific areas. CMS has the choice of lifting the moratoria earlier or extending it for another six months.

Source: Federal Register, July 26, 2013

**Oncologic PET Scans Using New, Proprietary Radiopharmaceuticals**

CMS opened a reconsideration of Pub. 100-03, the National Coverage Determinations Manual, (NCD) section 220.6, to review the coverage of positron emission tomography (PET) on July 11, 2012. This important diagnostic imaging
procedure is used for the evaluation of normal tissue in addition to tissue that is
diseased due to conditions such as cancer, ischemic heart disease, and some
neurologic disorders. To perform the test, the patient is injected with a
radiopharmaceutical that releases positrons as it decays. PET technology uses a
positron camera (tomograph) to measure the rate of decay of the
radiopharmaceutical, which imparts biochemical information on the metabolism
of the tissue being studied.

In the NCD, FDG (2-deoxy-2-[F-18]fluoro-D-glucose (fluorodeoxyglucose)),
NaF-18 (fluorine-18 labeled sodium fluoride), ammonia-N-13, and rubidium-82
(Rb-82) are recognized as the only nationally covered radiopharmaceuticals (e.g.,
radioisotopes or tracers) for use in PET. All remaining uses of PET are nationally
noncovered. CMS reconsidered section 220.6 of the NCD manual regarding these
remaining noncovered uses of PET.

Effective for dates of service on or after March 7, 2013, CMS has determined that,
unless there is a specific NCD to the contrary, local Medicare Administrative
Contractors (MACs) may determine coverage (or noncoverage) within their
respective jurisdictions for PET using new, proprietary radiopharmaceuticals for
their FDA-approved labeled indications for oncologic imaging only. This includes
those radiopharmaceuticals that may be approved by FDA in the future.

CMS is clear about the intent of the NCD and underscores the following aspects of
it:

- Changing the `restrictive` language of prior PET decisions is not adequate on its
  own to extend Medicare coverage to new PET radiopharmaceuticals
- The scope of this revision is applicable to FDA-approved indications for
  oncologic uses of PET tracers only
- The revision to the NCD does not include any use of PET for screening

Sources: Transmittal 2750, 8/2/2013, Medicare Claims Processing Manual
transmittal 156, 8/2/2013, Medicare Coverage Determinations Manual

OPPS Changes effective October 1, 2013

- CPT vaccine code 90685 Influenza virus vaccine, quadrivalent, split virus,
  preservative free, when administered to children 6-35 months of age, for
  intramuscular use, is retroactively covered effective June 7, 2013, with an OPSI
  of L.
- Skin substitutes, HCPCS Level II codes Q4135, Mediskin, per square centimeter,
  and Q4136, EZ-derm, per square centimeter, have been approved as
  non-pass-through drugs and biologicals with an OPSI of K effective October 1,
  2013. Codes Q4135 and Q4136 have also been added to the list of skin
  substitutes that must be reported with CPT codes 15271–15278 for
  reimbursement. If one of these CPT codes is not present, the codes are treated
  as incidental
- There are two new pass-through drugs, biologicals and radiopharmaceuticals.
  Effective October 1, 2013, report C1204 for the diagnostic radiopharmaceutical
  Technetium Tc 99m tilmanocept, trade name Lymphoseek, up to 0.5
  millicuries. It is used for sentinel node mapping, the localization of lymph nodes
  that drain the primary tumor site, using a hand-held gamma counter in
  patients with breast cancer and melanoma.
- Effective October 1, 2013, for OPPS, report C9132 for Kcentra, which is a
  four-factor prothrombin complex composed of coagulation factors II, VII, IX,
  and X and antithrombotic proteins C and S. It is administered as an intravenous
  infusion to those patients with an acquired coagulation factor deficiency due to
  warfarin and who are experiencing an acute major bleed. For IPPS
  new-technology add-on payment, payment will be triggered by a new
  ICD-9-CM procedure code has been assigned for Kcentra infusion: 00.96,
  Infusion of 4-factor prothrombin complex concentrate, effective October 1,
  2013.

- For OPPS, there is one new pass-through device approved for October 1, 2013,
  C1841, Retinal prosthesis, includes all internal and external components. There
  is no OPPS offset associated with the device. For IPPS, a new-technology
  add-on payment was approved under IPPS for the Argus II Retinal Prosthesis
  System. The system is an implantable medical device that is intended to
  provide electrical stimulation of the retina to create visual perception in
  patients who are profoundly blind due to retinitis pigmentosa (RP). The device
  has three primary components: an epiretinal prosthesis that is fully implanted
  on and in the eye that is a receiver and processor; external components
  consisting of glasses on which is mounted a small lightweight video camera
  and transmitting coil and a video processing unit worn by the user; and a
  “fitting” system for the clinician that is periodically used to perform diagnostic
  tests and to custom-program the external unit for use by the patient. New
  ICD-9-CM procedure codes have been assigned effective October 1, 2013: 14.81
  is for the implantation of this prosthesis; 14.82 is for the removal of this
  prosthesis; and 14.83 is for the revision or replacement of this device.
- Effective October 1, 2013, a new-technology add-on payment was approved for
  the Zilver PTX Drug Eluting Peripheral Stent. The Zilver PTX is indicated in
  the treatment of peripheral artery disease (PAD) for above-the-knee
  femoropopliteal arteries, superficial femoral arteries. Add-on payments will
  be identified by ICD-9—CM procedure code 00.60.

Sources: Transmittal 2775, 8/23/2013, Medicare Claims Processing Manual

Presumed Medical Necessity

Effective October 1, 2013, CMS will apply a time-based presumption of medical
necessity for hospital inpatient services that is based on the patient’s length of stay.
An individual becomes an inpatient of a hospital, including a critical access hospital
(CAH), when formally admitted in an order for inpatient admission by a physician
or other qualified practitioner. The order is required for payment of hospital
inpatient services under Medicare Part A. CMS will presume that Medicare Part A
(inpatient) payment is generally appropriate when the physician expects the
patient will require care that crosses two midnights and the admission is based
upon that expectation. The hospital inpatient admission is deemed reasonable and
necessary for payment under Part A.

If the physician expects the patient to require care of less than two midnights,
payment under Medicare Part A is generally inappropriate. A presumption would
apply that hospital services spanning less than two midnights should have been
provided on an outpatient basis, unless the medical record clearly documents that
the physician’s order and expectation is that the patient would require care
spanning more than two midnights or the patient is receiving a service or
procedure designated by CMS as inpatient-only.

All time after the initiation of care at the hospital is counted in applying the
two-midnight benchmark. However, routine policies apply for other
considerations. For example, an inpatient stay starts with a formal order of
inpatient admission.

If a hospital is found to be abusing this two-midnight presumption for
non-medically necessary inpatient hospital admissions and payment by
systematically delaying the provision of care to surpass the two-midnight time
frames, CMS review contractors would disregard the two-midnight presumption
when reviewing that hospital.


Advance Beneficiary Notices and Bundled
Services

CMS has clarified Advance Beneficiary Notice (ABN) guidelines for outpatient
services that are packaged, grouped, or bundled into a single unit for payment.
When the bundle contains questionable covered services as well as non-covered
services, an ABN cannot be used to shift liability to the patient in these instances. An ABN has to apply to all of a packaged, grouped or bundled service or none at all. Medicare adjudication may still result in all, part, or none of such services being paid, or being re-grouped into another type of payment.

If part of a packaged, grouped or bundled service is covered as medically necessary, the provider may bill all the services as covered.

If the entire set of services is certain to be noncovered or not medically necessary, then the service should be billed as noncovered.

If there is overall doubt as to the medical necessity of the services, such as when there does not seem to be medical necessity, then follow billing instructions for ABNs and demand billing.

Source: Transmittal 2783, Medicare Claims Processing Manual, Pub. 100-04, chap. 1, sec. 60.4.3

**Home Health Advance Beneficiary Notices**

Effective December 9, 2013, the Home Health Advance Beneficiary Notice (HHABN), Form CMS-R-296, is discontinued. The previously used Home Health Advance Beneficiary Notice (HHABN), Form CMS-R-296 (CR 7323), will be discontinued. Option Box 1 formatting of the HHABN for beneficiary liability notification will be replaced with the existing Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131. The HHABN formatted with Option Box 2 or Option Box 3 for change of care notifications are being replaced by the Home Health Change of Care Notice (HHCCN). Chapter 30, section 60 and its subsections are being revised in accordance with these notice changes.

Source: Transmittal 2781, 2782 Medicare Claims Processing Manual, Pub. 100-04, chap. 30, sec. 50-50.15.5
**NCD 160.7.1—Assessing Patients Suitability for Electrical Nerve Stimulation Therapy** *(formerly CIM 35-46)*

**64550, 64555, 64585–64595, E0720–E0731**

**Effective Date:** June 8, 2012  
**Implementation Date:** January 1, 2013  
**Benefit Category:** Incident to a Physician’s Professional Service  
Outpatient Hospital Services Incident to a Physician’s Services  
Outpatient Physical Therapy Services  
Physicians’ Services

### Indications and Limitations of Coverage

**LC** Electrical nerve stimulation is an accepted modality for assessing a patient’s suitability for ongoing treatment with a transcutaneous or an implanted nerve stimulator. Accordingly, program payment may be made for the following techniques when used to determine the potential therapeutic usefulness of an electrical nerve stimulator:

A. Transcutaneous Electrical Nerve Stimulation (TENS).—This technique involves attachment of a transcutaneous nerve stimulator to the surface of the skin over the peripheral nerve to be stimulated. It is used by the patient on a trial basis and its effectiveness in modulating pain is monitored by the physician, or physical therapist. Generally, the physician or physical therapist is able to determine whether the patient is likely to derive a significant therapeutic benefit from continuous use of a transcutaneous stimulator within a trial period of 1 month; in a few cases this determination may take longer to make. Document the medical necessity for such services which are furnished beyond the first month. (See NCD 160.13 for an explanation of coverage of medically necessary supplies for the effective use of TENS).

If TENS significantly alleviates pain, it may be considered as primary treatment; if it produces no relief or greater discomfort than the original pain electrical nerve stimulation therapy is ruled out. However, where TENS produces incomplete relief, further evaluation with percutaneous electrical nerve stimulation may be considered to determine whether an implanted peripheral nerve stimulator would provide significant relief from pain.

Usually, the physician or physical therapist providing the services will furnish the equipment necessary for assessment. Where the physician or physical therapist advises the patient to rent the TENS from a supplier during the trial period rather than supplying it himself/herself, program payment may be made for rental of the TENS as well as for the services of the physician or physical therapist who is evaluating its use. However, the combined program payment which is made for the physician’s or physical therapist’s services and the rental of the stimulator from a supplier should not exceed the amount which would be payable for the total service, including the stimulator, furnished by the physician or physical therapist alone.

B. Percutaneous Electrical Nerve Stimulation (PENS).—This diagnostic procedure which involves stimulation of peripheral nerves by a needle electrode inserted through the skin is performed only in a physician's office, clinic, or hospital outpatient department. Therefore, it is covered only when performed by a physician or incident to physician's service. If pain is effectively controlled by percutaneous stimulation, implantation of electrodes is warranted.

As in the case of TENS (described in subsection A), generally the physician should be able to determine whether the patient is likely to derive a significant therapeutic benefit from continuing use of an implanted nerve stimulator within a trial period of 1 month. In a few cases, this determination may take longer to make. The medical necessity for such diagnostic services which are furnished beyond the first month must be documented.

**NOTE:** Electrical nerve stimulators do not prevent pain but only alleviate pain as it occurs. A patient can be taught how to employ the stimulator, and once this is done, can use it safely and effectively without direct physician supervision. Consequently, it is inappropriate for a patient to visit his/her physician, physical therapist, or an outpatient clinic on a continuing basis for treatment of pain with electrical nerve stimulation. Once it is determined that electrical nerve stimulation should be continued as therapy and the patient has been trained to use the stimulator, it is expected that a stimulator will be implanted or the patient will employ the TENS on a continual basis in his/her home. Electrical nerve stimulation treatments furnished by a physician in his/her office, by a physical therapist or outpatient clinic are excluded from coverage by sec. 1862(a)(1) of the Act. (See NCD 160.7 for an explanation of coverage of the therapeutic use of implanted peripheral nerve stimulators under the prosthetic devices benefit. See NCD 160.27 for an explanation of coverage of the therapeutic use of TENS under the durable medical equipment benefit).

### Revision History

(TN 26)

09/1988—Added cross-reference omitted from previous transmittal. Effective date NA. (TN 33)

07/1995—Determined that TENS is covered under durable medical equipment benefit rather than prosthetic device benefit. Effective date 08/07/1995. (TN 78)


### NCD 160.8—Electroencephalographic Monitoring During Surgical Procedures Involving the Cerebral Vasculature  
*(formerly CIM 35-57)*

**35301, 37565, 37600, 37605–37606, 95955**

**Effective Date:** June 19, 2006  
**Implementation Date:** June 19, 2006  
**Benefit Category:** Diagnostic Tests (other)  
Physicians’ Services

### Indications and Limitations of Coverage

Electroencephalographic (EEG) monitoring is a safe and reliable technique for the assessment of gross cerebral blood flow during general anesthesia and is covered under Medicare. Very characteristic changes in the EEG occur when cerebral perfusion is inadequate for cerebral function. EEG monitoring as an indirect measure of cerebral perfusion requires the expertise of an electroencephalographer, a neurologist trained in EEG, or an advanced EEG technician for its proper interpretation.

The EEG monitoring may be covered routinely in carotid endarterectomies and in other neurological procedures where cerebral perfusion could be reduced. Such other procedures might include aneurysm surgery where hypotensive anesthesia is used or other cerebral vascular procedures where cerebral blood flow may be interrupted.
Neuromuscular electrical stimulation (NMES) involves the use of a device that transmits an electrical impulse to activate muscle groups by way of electrodes. There are two broad categories of NMES. One type of device stimulates the muscle when the patient is in a resting state to treat muscle atrophy. The second type is used to enhance functional activity of neurologically impaired patients.

### Indications and Limitations of Coverage

**Use for Walking in Patients with Spinal Cord Injury (SCI)**

The type of NMES that is used to enhance the ability to walk of SCI patients is commonly referred to as functional electrical stimulation (FES). These devices are surface units that use electrical impulses to activate paralyzed or weak muscles in precise sequence. **Coverage** for the use of NMES/FES is limited to SCI patients, for walking, who have completed a training program, which consists of at least 32 physical therapy sessions with the device over a period of 3 months. The trial period of physical therapy will enable the physician treating the patient for his or her spinal cord injury to properly evaluate the person’s ability to use these devices frequently and for the long term. Physical therapy sessions are only covered in the inpatient hospital, outpatient hospital, comprehensive outpatient rehabilitation facilities, and outpatient rehabilitation facilities. The physical therapy necessary to perform this training must be directly performed by the physical therapist as part of a one-on-one training program; this service cannot be done unattended.

The goal of physical therapy must be to train SCI patients on the use of NMES/FES devices to achieve walking, not to reverse or retard muscle atrophy.

**Benefit Category:** Physicians’ Services

**Effective Date:** October 1, 2006

**Implementation Date:** October 1, 2006

**Item/Service Description**

The value of EEG monitoring during open heart surgery and in the immediate post-operative period is debatable because there are little published data based on well designed studies regarding its clinical effectiveness. The procedure is not frequently used and does not enjoy widespread acceptance of benefit.

### Indications and Limitations of Coverage

**Coverage** of NMES to treat muscle atrophy is limited to the treatment of patients with disuse atrophy where the nerve supply to the muscle is intact, including brain, spinal cord and peripheral nerves and other non-neurological reasons for disuse atrophy. Examples include casting or splitting of a limb, contracture due to scarring of soft tissue as in burn lesions, and hip replacement surgery (until orthotic training begins). (See NCD 160.13 for an explanation of coverage of medically necessary supplies for the effective use of NMES).

**Benefit Category:** Diagnostic Tests (other)

**Effective Date:** January 15, 1980

**Item/Service Description**

These tests measure brain responses to repetitive visual, click or other stimuli.

### Indications and Limitations of Coverage

**Coverage** for NMES/FES for walking will be limited to SCI patients with all of the following characteristics:

- Persons with intact lower motor units (L1 and below) (both muscle and peripheral nerve);
- Persons with muscle and joint stability for weight bearing at upper and lower extremities that can demonstrate balance and control to maintain an upright support posture independently;
- Persons that demonstrate brisk muscle contraction to NMES and have sensory perception of electrical stimulation sufficient for muscle contraction;
- Persons that possess high motivation, commitment and cognitive ability to use such devices for walking;
- Persons that can transfer independently and can demonstrate independent standing tolerance for at least 3 minutes;
- Persons that can demonstrate independent and demonstrate independent standing tolerance for at least 3 minutes;
- Persons that can demonstrate hand and finger function to manipulate controls;
- Persons with at least 6-month post recovery spinal cord injury and restorative surgery;
- Persons without hip and knee degenerative disease and no history of long bone fracture secondary to osteoporosis; and
- Persons who have demonstrated a willingness to use the device long-term.

**Benefit Category:** Physicians’ Services

**Effective Date:** October 1, 2006

**Implementation Date:** October 1, 2006

**Item/Service Description**

Neuromuscular electrical stimulation (NMES) involves the use of a device that transmits an electrical impulse to activate muscle groups by way of electrodes. There are two broad categories of NMES. One type of device stimulates the muscle when the patient is in a resting state to treat muscle atrophy. The second type is used to enhance functional activity of neurologically impaired patients.
The only settings where therapists with the sufficient skills to provide these services are employed, are inpatient hospitals, outpatient hospitals, comprehensive outpatient rehabilitation facilities and outpatient rehabilitation facilities. The physical therapy necessary to perform this training must be part of a one-on-one training program.

Additional therapy after the purchase of the DME would be limited by our general policies on coverage of skilled physical therapy.

**Revision History**


05/2006—Added cross-reference to section 220. Effective date 10/01/2006. (TN 55) (CR4014)

**Cross-reference**

Also reference the Medicare Benefit Policy Manual, Chapter 15, “Covered Medical and Other Health Services,” §220 and §230, and Medicare Claims Processing Manual, Chapter 5, “Part B Outpatient Rehabilitation and CORF Services,” §10.1

**NCD 160.13—Supplies Used in the Delivery of Transcutaneous Electrical Nerve Stimulation (TENS) and Neuromuscular Electrical Stimulation (NMES)**

(Formerly CIM 45-25)

A4595, A4630, E0731

**Effective Date:** June 8, 2012

**Implementation Date:** January 7, 2013

**Benefit Category:** Incident to a Physician’s Professional Service

**Item/Service Description**

Transcutaneous Electrical Nerve Stimulation (TENS) and/or Neuromuscular Electrical Stimulation (NMES) can ordinarily be delivered to patients through the use of conventional electrodes, adhesive tapes and lead wires. There may be times, however, where it might be medically necessary for certain patients receiving TENS or NMES treatment to use, as an alternative to conventional electrodes, adhesive tapes and lead wires, a form-fitting conductive garment (i.e., a garment with conductive fibers which are separated from the patients’ skin by layers of fabric).

**Indications and Limitations of Coverage**

A form-fitting conductive garment (and medically necessary related supplies) may be covered under the program only when:

1. It has received permission or approval for marketing by the Food and Drug Administration;
2. It has been prescribed by a physician for use in delivering covered TENS or NMES treatment; and
3. One of the medical indications outlined below is met:

- The patient cannot manage without the conductive garment because there is such a large area or so many sites to be stimulated and the stimulation would have to be delivered so frequently that it is not feasible to use conventional electrodes, adhesive tapes and lead wires;
- The patient cannot manage without the conductive garment for the treatment of chronic intractable pain because the areas or sites to be stimulated are inaccessible with the use of conventional electrodes, adhesive tapes and lead wires;
- The patient has a documented medical condition such as skin problems that preclude the application of conventional electrodes, adhesive tapes and lead wires;
- The patient requires electrical stimulation beneath a cast either to treat disuse atrophy, where the nerve supply to the muscle is intact, or to treat chronic intractable pain; or
- The patient has a medical need for rehabilitation strengthening (pursuant to a written plan of rehabilitation) following an injury where the nerve supply to the muscle is intact.

A conductive garment is not covered for use with a TENS device during the trial period specified in NCD 160.3 unless:

1. The patient has a documented skin problem prior to the start of the trial period; and
2. The carrier’s medical consultants are satisfied that use of such an item is medically necessary for the patient.

(See conditions for coverage of the use of TENS in the treatment of chronic intractable pain NCD 160.3, 160.13, and 160.27 and the use of NMES in the treatment of disuse atrophy 150.4).

**Cross-reference**

Also see NCDs on NMES in the Treatment of Disuse Atrophy ($150.4), Assessing Patients Suitability for ENS ($160.7), NMES ($160.12), and TENS ($280.13).

**Revision History**

06/1988—Established conditions under which such supplies may be covered. Effective date 07/14/1988. (TN 26)

07/1995—Determined that TENS is covered under durable medical equipment benefit rather than prosthetic device benefit. Effective date 08/07/1995. (TN 78)

**NCD 160.14—Invasive Intracranial Pressure Monitoring** (Formerly CIM 35-62)

61107, 61210, 62160

**Effective Date:** This is a longstanding national coverage determination. The effective date of this version has not been posted.

**Benefit Category:** Inpatient Hospital Services Physicians’ Services

**Item/Service Description**

Invasive intracranial pressure monitoring is a safe and effective therapeutic tool used to monitor intracranial pressure. It is usually used for patients suffering from head injuries, subarachnoid hemorrhage, intracerebral hemorrhage, Reye’s syndrome, or posthypoxic, metabolic, and viral encephalopathies. It is usually performed in specialized intensive care units for neurosurgical and neurologic patients.