MEDICAL POLICY

POLICY TITLE	INTERFERENTIAL CURRENT STIMULATION
POLICY NUMBER	MP-6.047

Original Issue Date (Created):	**3/1/2012**
Most Recent Review Date (Revised):	**6/10/2020**
Effective Date:	**9/1/2020**

I. POLICY

Interferential current stimulation is considered **investigational** as there is insufficient evidence to support a conclusion concerning the health outcomes or benefits associated with this procedure.

Cross-references:

MP-2.064 Biofeedback and Neurofeedback Therapy
MP-6.020 Transcutaneous Electrical Nerve Stimulation
MP-6.050 Percutaneous Electrical Nerve Stimulation (PENS) and Percutaneous Neuromodulation Therapy (PNT)

II. PRODUCT VARIATIONS

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This policy is only applicable to certain programs and products administered by Capital BlueCross please see additional information below, and subject to benefit variations as discussed in Section VI below.

FEP PPO- Refer to FEP Medical Policy Manual MP-1.01.24 Interferential Stimulation for Treatment of Pain. The FEP Medical Policy manual can be found at: https://www.fepblue.org/benefit-plans/medical-policies-and-utilization-management-guidelines/medical-policies

III. DESCRIPTION/BACKGROUND

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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.

IFS 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 the tissues more effectively and 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.

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REGULATORY STATUS

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.

IV. RATIONALE

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Summary of Evidence

For individuals who have musculoskeletal conditions who receive IFS, the evidence includes RCTs and meta-analyses. Relevant outcomes are symptoms, functional outcomes, quality of life, medication use, and treatment-related morbidity. Placebo-controlled randomized trial(s) have found that IFS, when used to treat musculoskeletal pain and impaired function(s), does not significantly improve outcomes; additionally, a meta-analysis of placebo-controlled trials did not find a significant benefit of IFS for decreasing pain or improving function. The evidence is insufficient to determine the effects of the technology on health outcomes.

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. The results of the trials 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 the effects of the technology on health outcomes.

For individuals who have post stroke spasticity who receive IFS, the evidence includes an RCT. Relevant outcomes are symptoms, functional outcomes, quality of life, and treatment-related morbidity. The RCT had a small sample size and very short follow-up (immediately posttreatment). The evidence is insufficient to determine the effects of the technology on health outcomes.

V. DEFINITIONS

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510 (K) is a premarketing submission made to FDA to demonstrate that the device to be marketed is as safe and effective, that is, substantially equivalent (SE), to a legally marketed device that is not subject to premarket approval (PMA). Applicants must compare their 510(k) device to one or more similar devices currently on the U.S. market and make and support their substantial equivalency claims.

VI. BENEFIT VARIATIONS

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The existence of this medical policy does not mean that this service is a covered benefit under the member's health benefit plan. Benefit determinations should be based in all cases on the applicable health benefit plan language. Medical policies do not constitute a description of

benefits. A member's health benefit plan governs which services are covered, which are excluded, which are subject to benefit limits and which require preauthorization. There are different benefit plan designs in each product administered by Capital BlueCross. Members and providers should consult the member's health benefit plan for information or contact Capital BlueCross for benefit information.

VII. DISCLAIMER

Capital BlueCross's medical policies are developed to assist in administering a member's benefits, do not constitute medical advice and are subject to change. Treating providers are solely responsible for medical advice and treatment of members. Members should discuss any medical policy related to their coverage or condition with their provider and consult their benefit information to determine if the service is covered. If there is a discrepancy between this medical policy and a member's benefit information, the benefit information will govern. If a provider or a member has a question concerning the application of this medical policy to a specific member's plan of benefits, please contact Capital BlueCross' Provider Services or Member Services. Capital BlueCross considers the information contained in this medical policy to be proprietary and it may only be disseminated as permitted by law.

VIII. CODING INFORMATION

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Note: This list of codes may not be all-inclusive, and codes are subject to change at any time. The identification of a code in this section does not denote coverage as coverage is determined by the terms of member benefit information. In addition, not all covered services are eligible for separate reimbursement.

Interferential Stimulation for the treatment of pain is investigational; therefore, the following codes are not covered when billed for interferential stimulation for treatment of pain:

CPT Codes®								
97014	97032							

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HCPCS Code	Description
G0283	Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan
S8130	Interferential current stimulator, 2 channel
S8131	Interferential current stimulator, 4 channel

IX. REFERENCES

TOP

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Other Sources:

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X. POLICY HISTORY

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MP-6.047	**CAC 10/25/2011 Adopted BCBSA**. New Policy, information regarding interferential stimulation removed from Electrical Stimulation policy and created in this separate policy.
	CAC 10/30/12 Consensus. References updated. No change to policy statements. Codes reviewed 10/22/12
	CAC 11/26/13 Consensus review. References updated. "For the treatment of pain" removed from the policy statement however remains investigational. Rationale added. Policy title revised to "Interferential Current Stimulation".
	CAC 11/25/14 Consensus. References and rationale updated. No change to policy statements. Coded Reviewed 11/05/2014

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	CAC 11/24/15 Consensus review. No change to policy statements. Rationale and references updated. Coding reviewed**.**
	CAC 9/27/16 Consensus. No change to policy statements. References and rationale updated. Variation reformatted. Coding reviewed.
	CAC 11/28/17 Consensus. No change to policy statements. References and rationale reviewed. Coding reviewed.
	7/20/18 Consensus review. No change to the policy statement. Background and references updated. Rationale revised.
	1/1/19 Administrative update. Removed deleted CPT codes
	4/22/19 Consensus review. No change to the policy statement. References updated.
	06/10/2020 Consensus Review. No change to policy statements. References reviewed.

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