MEDICAL POLICY

POLICY TITLE	INTERFERENTIAL CURRENT STIMULATION
POLICY NUMBER	MP 6.047

CLINICAL BENEFIT	☐ MINIMIZE SAFETY RISK OR CONCERN. ☒ MINIMIZE HARMFUL OR INEFFECTIVE INTERVENTIONS. ☐ ASSURE APPROPRIATE LEVEL OF CARE. ☐ ASSURE APPROPRIATE DURATION OF SERVICE FOR INTERVENTIONS. ☐ ASSURE THAT RECOMMENDED MEDICAL PREREQUISITES HAVE BEEN MET. ☐ ASSURE APPROPRIATE SITE OF TREATMENT OR SERVICE.
Effective Date:	**10/1/2024**

I. POLICY

Interferential current stimulation is considered **investigational** as there is insufficient evidence to support a general 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 VARIATION

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

FEP PPO – Refer to FEP Medical Policy Manual. 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.

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 the tissues more effectively, with less

unwanted stimulation of cutaneous nerves and 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.

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). Interferential current stimulation 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 randomized controlled trials (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. Meta-analyses for IFS in musculoskeletal conditions have generally found IFS to be no more effective than other therapies. One network meta-analysis did find improvement with IFS compared with control, but the analysis is limited by indirect comparisons. 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. Interferential current stimulation 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 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 a small sample sizes and very short follow-up (immediately posttreatment to 5 weeks). The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

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 Blue Cross. Members and providers should consult the member's health benefit plan for information or contact Capital Blue Cross for benefit information.

VII. DISCLAIMER

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Capital Blue Cross' 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 Blue Cross' Provider Services or Member Services. Capital Blue Cross 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.

Investigational; therefore, not covered.

Procedure Codes								
97014	97032	G0283	S8130	S8131				

IX. REFERENCES

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11. *Moore JS, Gibson PR, Burgell RE. Randomised clinical trial: transabdominal interferential electrical stimulation vs sham stimulation in women with functional constipation. Aliment Pharmacol Ther. Apr 2020; 51(8): 760-769. PMID 32128859*
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15. *Eslamian F, Farhoudi M, Jahanjoo F, et al. Electrical interferential current stimulation versus electrical acupuncture in management of hemiplegic shoulder pain and disability following ischemic stroke-a randomized clinical trial. Arch Physiother. 2020; 10: 2. PMID 31938571*
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21. *Blue Cross Blue Shield Association Medical Policy Reference Manual. 1.01.24, Interferential Current Stimulation. July, 2024*

X. POLICY HISTORY

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MP 6.047	**06/10/2020 Consensus Review.** No change to policy statements. References reviewed.
	04/29/2021 Consensus Review. No change to policy statement. References updated. No changes to coding.
	07/12/2022 Consensus Review. No change to policy statement. Rationale and FEP language updated. References added.
	08/01/2023 Consensus Review. No change to policy statement. Background updated.
	01/19/2024 Administrative Update. Clinical benefit added.
	07/10/2024 Consensus Review. No change to policy statement. References added.

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