

## MEDICAL POLICY

|                      |                                           |
|----------------------|-------------------------------------------|
| <b>POLICY TITLE</b>  | <b>INTERFERENTIAL CURRENT STIMULATION</b> |
| <b>POLICY NUMBER</b> | <b>MP 6.047</b>                           |

|                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|-------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>CLINICAL BENEFIT</b> | <input type="checkbox"/> MINIMIZE SAFETY RISK OR CONCERN.<br><input checked="" type="checkbox"/> MINIMIZE HARMFUL OR INEFFECTIVE INTERVENTIONS.<br><input type="checkbox"/> ASSURE APPROPRIATE LEVEL OF CARE.<br><input type="checkbox"/> ASSURE APPROPRIATE DURATION OF SERVICE FOR INTERVENTIONS.<br><input type="checkbox"/> ASSURE THAT RECOMMENDED MEDICAL PREREQUISITES HAVE BEEN MET.<br><input type="checkbox"/> ASSURE APPROPRIATE SITE OF TREATMENT OR SERVICE. |
| <b>Effective date:</b>  | <b>8/1/2026</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |

### 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 as a Treatment of Chronic Pain**

**MP 6.020 Transcutaneous Electrical Nerve Stimulation and Transcutaneous Afferent Patterned Stimulation**

**MP 6.050 Percutaneous Electrical Nerve Stimulation (PENS) and Percutaneous Neuromodulation Therapy (PNT)**

### PRODUCT VARIATION

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

**FEP PPO** - Refer to FEP medical policy manual. The FEP medical policy manual can be found at: [fepblue.org/benefit-plans/medical-policies-and-utilization-management-guidelines/medical-policies](http://fepblue.org/benefit-plans/medical-policies-and-utilization-management-guidelines/medical-policies).

### DESCRIPTION/BACKGROUND

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

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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.

### RATIONALE

#### 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.

### DEFINITIONS

**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.

### DISCLAIMER

*Capital Blue Cross' medical policies are used to determine coverage for specific medical technologies, procedures, equipment, and services. These medical policies do not constitute*

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medical advice and are subject to change as permitted by law or applicable clinical evidence from independent treatment guidelines. Treating providers are solely responsible for medical advice and treatment of members. These policies are not a guarantee of coverage or payment. Payment of claims is subject to a determination regarding the member's benefit program and eligibility on the date of service, and a determination that the services are medically necessary and appropriate. Final processing of a claim is based upon the terms of contract that applies to the members' benefit program, including benefit limitations and exclusions. If a provider or a member has a question concerning this medical policy, please contact Capital Blue Cross' Provider Services or Member Services.

### CODING INFORMATION

**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 |  |  |  |

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### POLICY HISTORY

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| MP 6.047 | <b>06/10/2020 Consensus Review.</b> No change to policy statements. References reviewed.                                 |
|          | <b>04/29/2021 Consensus Review.</b> No change to policy statement. References updated. No changes to coding.             |
|          | <b>07/12/2022 Consensus Review.</b> No change to policy statement. Rationale and FEP language updated. References added. |
|          | <b>08/01/2023 Consensus Review.</b> No change to policy statement. Background updated.                                   |
|          | <b>01/19/2024 Administrative Update.</b> Clinical benefit added.                                                         |
|          | <b>07/10/2024 Consensus Review.</b> No change to policy statement. References added.                                     |
|          | <b>07/14/2025 Consensus Review.</b> No change to policy statement. Cross Referenced policies updated. References added.  |
|          | <b>04/21/2026 Consensus Review.</b> No change to policy statement. Cross Referenced policies updated.                    |

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