Program Memorandum Intermediaries/Carriers

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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CHANGE REQUEST 2314

SUBJECT: Coverage and Billing for Neuromuscular Electrical Stimulation (NMES)

This Program Memorandum (PM) summarizes coverage for neuromuscular electrical stimulation (NMES) to enhance walking in patients with spinal cord injuries (SCI) and describes provider billing instructions for this service. See §35-77 of the Coverage Issues Manual (CIM) for complete information regarding the policy.

Background

The NMES involves the use of a device which transmits an electrical impulse to activate muscle groups by way of electrodes. 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. The type of NMES that is used to enhance walking in 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 services performed **on or after April 1, 2003**, Medicare will cover NMES/FES to enhance walking for SCI patients who have completed a training program, which consists of at least 32 physical therapy sessions with the device over a period of 3 months.

NOTE: Contractors may establish local edits to ensure weekly sessions during the 3-month period.

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

1) persons with intact lower motor units (L1 and below) (both muscle and peripheral nerve);

2) 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;

3) persons that demonstrate brisk muscle contraction to NMES and have sensory perception of electrical stimulation sufficient for muscle contraction;

4) persons that possess high motivation, commitment and cognitive ability to use such devices for walking;

5) persons that can transfer independently and can demonstrate standing independently for at least 3 minutes;

6) persons that can demonstrate hand and finger function to manipulate controls;

7) persons with at least 6-month post recovery spinal cord injury and restorative surgery;

8) persons without hip and knee degenerative disease and no history of long bone fracture secondary to osteoporosis; and

9) persons who have demonstrated a willingness to use the device long-term.

NMES/FES to enhance walking for SCI patients will not be covered for SCI patients with any of the following:

1) presence of cardiac pacemakers or cardiac defibulators;
2) severe scoliosis or severe osteoporosis;
3) irreversible contracture;
4) autonomic dysreflexia; or
5) skin disease or cancer at area of stimulation.

See §35-77 of the CIM for further coverage limitations.

Intermediary Payment Requirements

The NMES/FES to enhance walking in SCI patients is covered by Medicare if provided in a hospital setting, either inpatient or outpatient and in a Comprehensive Outpatient Rehabilitation Facility (CORF) or Outpatient Rehabilitation Facility (ORF). The beneficiary must meet all of the conditions listed above to be eligible for this benefit."

Diagnosis code 344.1 must be present for payment to be made. However, while paraplegia of both lower limbs is a necessary condition for coverage, the nine criteria on the preceding page are also required. Intermediaries must deny payment for patients with any of the following diagnosis codes:

1) presence of cardiac pacemakers (V45.89 & V53.31) or cardiac defibulators (V45.00, V45.01, V45.02 & V45.09);
2) severe scoliosis or severe osteoporosis (733.00-733.09, 736.89, 736.9, 737.30 – 737.39, 737.40, 737.43, 738.4, 738.5 & 754.2);
3) irreversible contracture (736.00 – 736.09, 736.30 – 736.39, 736.6, 736.70 - 736.79, 736.81 & 736.89);
4) autonomic dysreflexia (337.3); or the following diagnosis:
5) skin diseases or cancer at area of stimulation.

Intermediary Billing Instructions

Applicable Bill Types

The applicable bill types are:

Inpatient acute care hospitals that are not critical access hospitals (CAHs), including Inpatient rehabilitation facilities (IRFs) TOB = 11x , 12x
Outpatient hospital services (OPPS) TOB = 13x
Outpatient rehabilitation facilities (ORFs) TOB = 74x
Comprehensive outpatient rehabilitation facilities (CORFs) TOB = 75x

Applicable Revenue Codes

Revenue code must = 0420.

Applicable HCPCS Code

Applicable HCPCS Code for TOB 12x, 13x, 74x & 75x

- **97116 -** gait training (include stair climbing).

NOTE: This is the only code to be billed. It must be used for one-on-one face-to-face service provided by the physician or therapist.

Part B deductible and coinsurance apply.

Carrier Billing Instructions

Applicable HCPCS Codes

Applicable HCPCS Code

- **97116 -** gait training (include stair climbing).

NOTE: This is the only code to be billed. It must be used for one-on-one face-to-face service provided by the physician or therapist.

Diagnosis code 344.1 must be present for payment to be made. However, while paraplegia of both lower limbs is a necessary condition for coverage, the nine criteria on the preceding page are also required. Carriers must deny payment for patients with any of the following diagnosis codes:

1) presence of cardiac pacemakers (V45.89 & V53.31) or cardiac defibulators (V45.00, V45.01, V45.02 & V45.09);
2) severe scoliosis or severe osteoporosis (733.00-733.09, 736.89, 736.9, 737.30 – 737.39, 7 37.40, 737.43, 738.4, 738.5 & 754.2);
3) irreversible contracture (736.00 – 736.09, 736.30 – 736.39, 736.6, 736.70 - 736.79, 736.81 & 736.89);
4) autonomic dysreflexia (337.3) or the following diagnosis:
5) skin disease or cancer at area of stimulation.

Durable Medical Equipment Regional Carrier (DMERC) Billing Instructions

Durable medical equipment, prosthetics, orthotics, and supplies suppliers must use the following code when billing for the NMES device:

K0600 (Type of Service = 1): Functional neuromuscular stimulator, transcutaneous stimulation of muscles of ambulation with computer control, used for walking by spinal cord injured, entire system, after completion of training program

Suppliers must not use HCPCS code K0600 until April 1, 2003. DMERCs must return as unprocessable claims for code K0600 that they receive prior to 4/01/03, using ANSI code 16 and remark code M51.

The Common Working File, DMERC standard system and the DMERC local systems must recognize this HCPCS code.

Claims Requirements for Intermediaries and Carriers

Follow the general instructions for preparing claims as indicated in the electronic claims specifications contained at www.cms.hhs.gov/providers/edi/default.asp, and as discussed in Medicare Carriers Manual (MCM) Part 3, section 3023.6A or the addenda to Medicare Intermediary Manual (MIM) Part 3, section 3600 and as reported in the Health Insurance Portability and Accountability ACT (HIPAA) electronic transactions Program Memoranda issued by CMS. Instructions for the limited number of claims submitted on paper are located in MCM Part 4 section 2010 or MIM Part 3 section 3604."

Payment Requirements

Payment and pricing information for Part B services will be on the Rehabilitation Therapy Fee Schedule (RTFS). Pay for this service on the basis of the RTFS. Part B deductible and coinsurance

apply. Payment for inpatient hospital is included in the DRG. Claims from physicians or other practitioners where assignment was not taken are subject to the Medicare limiting charge (refer to MCM Part 3, chapter VII, §7555 for more information).

General Claims Processing Instructions

Remittance Advice Notice

Use appropriate existing remittance advice reason and remark codes at the line level to express the specific reason if you deny payment. If denying services as furnished before April 1, 2003, use existing ANSI X 12-835 claim adjustment reason code 26 "Expenses incurred prior to coverage" at the line level.

Medicare Summary Notice (MSN) Messages

Use the following MSN messages where appropriate:

If a claim for this service is being denied because the service was performed prior to April 1, 2003, use the MSN message:

"This service was not covered by Medicare at the time you received it." (MSN Message 21.11)

The Spanish version of the MSN message should read:

"Este servicio no estaba cubierto por Medicare cuando usted lo recibio`." (MSN Message 21.11)

Provider Notification

Contractors should notify providers of this new national coverage on their Web sites, in regularly published bulletins and in routinely scheduled training sessions.

The *effective date* for this PM is April 1, 2003.

The *implementation date* for this PM is April 1, 2003.

These instructions should be implemented within your current operating budget.

This PM may be discarded after April 1, 2004.

If you have any questions, contact the appropriate regional office. Providers and other interested parties should contact the appropriate carrier or intermediary.