Electromagnetic Therapy for Wounds (for Indiana Only)

Policy Number: CS035IN.05
Effective Date: June 1, 2024

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Related Policies

- Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation (for Indiana Only)
- Electrical Stimulation for Wounds (for Indiana Only)

Application

This Medical Policy only applies to the state of Indiana.

Coverage Rationale

Electromagnetic Therapy for wounds is medically necessary in certain circumstances. For medical necessity clinical coverage criteria, refer to the InterQual® Medicare: Procedures, Wound Care.

Click here to view the InterQual® criteria.

Note: The wound treatment device (HCPCS code E0769) is medically necessary if the therapy is medically necessary per above InterQual® criteria.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

HCPCS Code	Description
E0769	Electrical stimulation or electromagnetic wound treatment device, not otherwise classified
*G0295	Electromagnetic therapy, to one or more areas, for wound care other than described in G0329 or for other uses
*G0329	Electromagnetic therapy, to one or more areas for chronic Stage III and Stage IV pressure ulcers, arterial ulcers, diabetic ulcers and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care as part of a therapy plan of care

Note: Codes labeled with an asterisk (*) are not managed for medical necessity review for the state of Indiana at the time this policy became effective. Refer to the most up to date prior authorization list for Indiana at Prior Authorization and Notification: UnitedHealthcare Community Plan of Indiana.

U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

The FDA has not approved any electromagnetic devices specifically for the treatment of chronic wounds. Use of these devices for wound healing is an off-label indication.

For additional information search Product Code ILX at:
https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm. (Accessed September 28, 2023)

Policy History/Revision Information

Date	Summary of Changes
06/01/2024	**Title Change** • Previously titled *Electrical Stimulation and Electromagnetic Therapy for Wounds (for Indiana Only)* **Related Policies** • Added reference link to the Medical Policy titled *Electrical Stimulation for Wounds (for Indiana Only)* **Coverage Rationale** • Removed content/language pertaining to electrical stimulation for treating wounds and ulcers; refer to the Medical Policy titled *Electrical Stimulation for Wounds (for Indiana Only)* • Added language to indicate the wound treatment device (HCPCS code E0769) is medically necessary if the therapy is medically necessary per listed] InterQual® criteria **Applicable Codes** • Removed HCPCS codes G0281 and G0282 • Removed notation indicating HCPCS code E0769 is not managed for medical necessity review for the state of Indiana at this time **Supporting Information** • Updated *FDA* section to reflect the most current information • Archived previous policy version CS035IN.04

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.