Electrical Stimulation for Nausea, Vomiting and Motion Sickness (PrimaBella and ReliefBand) and Other Selected Indications

Policy

*Please see amendment for Pennsylvania Medicaid at the end of this CPB.

Aetna considers transcutaneous electrical acupoint stimulation (prescription version ReliefBand devices) medically necessary for the treatment of post-operative nausea and chemotherapy-induced nausea that is unresponsive to antiemetics and other conservative therapies.

Aetna considers transcutaneous electrical acupoint stimulation (prescription version PrimaBella or ReliefBand devices) medically necessary for the treatment of hyperemesis gravidarum that is unresponsive to other conservative medical therapy (e.g., change in diet, ginger capsules, vitamin B6).

Aetna considers transcutaneous electrical acupoint stimulation experimental and investigational for the following indications because its effectiveness for these indications (not an all-inclusive list) has not been established:
• Improvement of pregnancy rates in women undergoing in-vitro fertilization
• Prevention of motion sickness
• Treatment of chronic obstructive pulmonary disease
• Treatment of hemodialysis-associated fatigue
• Treatment of muscle spasticity following brain injury
• Treatment of post-hemorrhoidectomy-associated pain and anxiety
• Treatment of post-operative immune dysfunction in individuals with lung cancer
• Treatment of tinnitus

Aetna considers transcutaneous neuromodulation and auricular electrostimulation experimental and investigational for nausea, vomiting, motion sickness and other indications because of insufficient evidence of effectiveness.

Note: Aetna does not cover over-the-counter disposable ReliefBand devices, which are used for the treatment of motion sickness, because they do not meet Aetna’s definition of durable medical equipment.

Background
Transcutaneous electrical acupoint stimulation, also known as acustimulation, has been proposed as a method of treating severe nausea and vomiting that does not respond to other conservative treatments. A watch-like device is placed on the wrist and provides very mild electrical impulses to stimulate the median nerve (which is an acupuncture point thought to be effective for the treatment of nausea and vomiting). Examples of devices used for this treatment include, but may not be limited to, the PrimaBella and ReliefBand.

The ReliefBand (Neurowave Medical Technologies, Chicago, IL) is a watch-like device worn on the ventral side of the wrist. When activated, the device emits a low-level electrical current across 2 small electrodes on its underside, stimulating the median nerve (an acupuncture point). The ReliefBand offers 5 stimulation levels from the rotary dial that one can control to provide maximum comfort and relief. The non-invasive and drug-free ReliefBand is
available by prescription for the treatment of nausea and vomiting (NV) due to pregnancy (PrimaBella, Alaven Pharmaceutical LLC, Marietta, GA), chemotherapy-induced NV, post-operative nausea and vomiting (PONV), and over-the-counter for the treatment of motion sickness.

Studies have shown that the ReliefBand is effective in treating chemotherapy-induced NV and as effective as antiemetic medications in managing NV following surgery.

Lee and Done (1999) evaluated the effectiveness of non-pharmacologic techniques to prevent post-operative PONV by systematic review. These studies included acupuncture, electroacupuncture, transcutaneous electrical nerve stimulation, acupoint stimulation, and acupressure. The authors concluded that non-pharmacologic techniques were equivalent to commonly used antiemetic drugs in preventing vomiting after surgery. Non-pharmacologic techniques were more effective than placebo in preventing NV within 6 hours of surgery in adults, but there was no benefit in children.

In a single-center, randomized, double-blind, placebo- and sham-controlled study, White et al (2002) compared the effectiveness of the ReliefBand to ondansetron when utilized alone or in combination for preventing PONV following plastic surgery (n = 120). Patients were randomly assigned to 3 prophylactic antiemetic treatment regimens with routine low-dose droperidol prophylaxis: (i) ondansetron (n = 40): 4 mg intravenous (I.V.) ondansetron and a sham ReliefBand; (ii) acustimulation (n = 40): 2 ml I.V. saline and an active ReliefBand; and (iii) combination (n = 40): 4 mg I.V. ondansetron and an active ReliefBand. The incidences of PONV, as well as the need for "rescue" antiemetics, were determined at specific time intervals for up to 72 hours after surgery. The outcome variables assessed included recovery times, quality of recovery score, time to resumption of normal diet, and patient satisfaction with the prophylactic antiemetic therapy. Use of the ReliefBand in combination with ondansetron significantly reduced nausea (20 versus 50 %), vomiting (0 versus 20 %), and the need for rescue antiemetics (10 versus 37 %) compared with ondansetron alone at 24 hours after surgery.
Furthermore, the ability to resume a normal diet (74 versus 35 %) within 24 hours after surgery was significantly improved when the ReliefBand was used to supplement ondansetron (versus ondansetron alone). Finally, the quality of recovery (90 +/- 10 versus 70 +/- 20) and patient satisfaction (94 +/- 10 versus 75 +/- 22) scores were significantly higher in the combination group than the ondansetron group. There were no significant differences between the ReliefBand and ondansetron when administered as adjuvants to droperidol for antiemetic prophylaxis. The authors concluded that the ReliefBand compared favorably to ondansetron when used for prophylaxis against PONV.

In a randomized, double-blind, placebo- and sham-controlled study, Coloma et al (2002) compared the ReliefBand with ondansetron (Zofran) for the treatment of PONV after outpatient laparoscopic surgery (n = 268). All patients received antiemetic prophylaxis with metoclopramide, 10 mg I.V. or droperidol, 0.625 mg I.V. after induction of anesthesia. A total of 90 patients developed PONV in the recovery units and were randomized to 1 of 3 treatment groups: (i) the ondansetron group received 4 mg I.V. ondansetron and a sham ReliefBand; (ii) the acustimulation group received 2 ml I.V. saline and a ReliefBand; and (iii) the combination group received 4 mg I.V. ondansetron and a ReliefBand. A rescue antiemetic (10 mg I.V. metoclopramide) was administered only if the PONV symptoms persisted for 15 minutes or longer after initiating the treatment. A blinded observer recorded the recovery times, emetic symptoms, rescue antiemetics, maximum nausea scores, complete response to study treatment, and time to achieve discharge criteria. Post-discharge side effects, as well as patient satisfaction and quality of recovery scores, were assessed at 24 and 72 hours after surgery. The combination group had a significantly higher complete response rate than the acustimulation group (73 versus 40 %). In addition, fewer patients in the combination group experienced subsequent emetic events (8 compared to 18 in the acustimulation group). However, there were no significant differences between the 3 groups with respect to patient satisfaction and quality of recovery scores. The authors concluded that acustimulation with the ReliefBand can be used as an
alternative to ondansetron for the treatment of established PONV.

Habib and colleagues (2006) examined whether transcutaneous acupoint electrical stimulation with the ReliefBand can prevent NV during and after cesarean delivery under spinal anesthesia. These investigators randomized 94 patients undergoing cesarean delivery with spinal anesthesia to receive the ReliefBand at the P6 point (active group) or an active ReliefBand applied to the dorsum of the wrist (sham control group). The ReliefBand was applied 30 to 60 mins pre-operatively and left in place for 24 hours. There was no statistically significant difference between the active and sham control groups in the incidence of intra-operative/post-operative nausea (30 % versus 43 %/23 % versus 41 %), vomiting (13 % versus 9 %/26 % versus 37 %), need for rescue antiemetics (23 % versus 18 %/34 % versus 39 %), or complete response (55 % versus 57 %/51 % versus 34 %). There was also no difference between the 2 groups in nausea scores, number of vomiting episodes, or patient satisfaction with PONV management.

In a randomized controlled study (n = 105), White et al (2005) reported that acustimulation with the ReliefBand was most effective in reducing PONV and improving patients' satisfaction with their antiemetic therapy when it was administered after surgery.

However, a Cochrane review on acupuncture-point stimulation (needles, electrical stimulation, magnets, or acupressure) for chemotherapy-induced NV (Ezzo et al, 2006) reported that non-invasive electrostimulation appears unlikely to have a clinically relevant impact when patients are given state-of-the-art pharmacological antiemetic therapy.

PrimaBella™ (Alaven Pharmaceutical LLC, Marietta, GA) is a neuromodulatory device that utilizes the same technology as the ReliefBand. It is intended for use in the treatment of NV due to pregnancy.

Slotnick (2001) evaluated the safety and effectiveness of P-6 acustimulation for the relief of NV associated with early
pregnancy in 41 patients. Pre-treatment nausea severity, post-treatment nausea relief and device effectiveness were patient-rated using a 1 to 5 scale. All neonates were evaluated for congenital abnormalities. Pre-treatment nausea severity scores for treated patients averaged 4.2, with most severe and debilitating nausea rated 5. Post-treatment device effectiveness averaged 4.2, with significant or complete relief rated 5. Device ease of use averaged 4.3, with very easy to use rated 5. No congenital abnormalities were found. The authors concluded that because current pharmacologic treatments for nausea in early pregnancy are not consistent, efficacious or without unwanted side effects or increased teratogenic risks, acustimulation of P-6 in pregnancy may prove to be a significant therapeutic alternative to current pharmacologic treatments for nausea in early pregnancy.

The American College of Obstetrics and Gynecology (ACOG, 2004) recommend a step-wise approach to alleviating NV in pregnancy, beginning with prevention at the time of conception. Two studies found that women who take a multi-vitamin at the time of conception were less likely to need medical attention for vomiting. While there is little published evidence regarding the efficacy of dietary changes for prevention or treatment of NV of pregnancy, a small study showed that protein meals were more likely to relieve NV of pregnancy than carbohydrate and fatty meals. Other conservative treatments recommended by ACOG included ginger capsules and electrical stimulation or acupressure at the P6 (or Neguian) point on the inside of the wrist. Women with more complicated NV of pregnancy may need pharmacologic therapy. While many conventional antiemetics have been used for NV of pregnancy, it is important to note that no drug has been approved by the FDA for the treatment of NV in pregnancy since Benedictine (an antiemetic no longer available in the U.S. but still widely used in Europe).

In the largest controlled clinical study of the Relief Band for motion sickness published to date (n = 77), Miller and Muth (2004) examined whether acupressure and acustimulation can prevent motion sickness, taking into consideration whether or not the acupressure and acustimulation are administered properly.
These investigators found that neither band (the Acuband or the ReliefBand) nor placebo prevented the development of motion sickness, regardless of whether the bands were used correctly or incorrectly.

Zheng et al (2014) noted that the latest meta-analysis demonstrated that acupuncture improves pregnancy rates among women undergoing in-vitro fertilization-embryo transfer (IVF-ET), and surface acupoint stimulation, such as transcutaneous electrical acupoint stimulation (TEAS), may have the same or better potential. To explore the effect of TEAS on the clinical pregnancy rate (CPR) and live-birth rate (LBR) compared with real acupuncture and controls in women undergoing IVF, a multi-center, randomized controlled trial will be conducted. The inclusion criteria are the following: infertile women less than 40 years of age undergoing a fresh IVF or intra-cytoplasmic sperm injection cycle, and the study will be restricted to women with the potential for a lower success rate as defined by 2 or more previous unsuccessful ETs (fresh or frozen). Those who have severe illnesses possibly precluding IVF or pregnancy, have FSH levels greater than 20 IU/L, received donor eggs, had been previously randomized for this study or had undergone acupuncture (in any modality) as infertility treatment will be excluded. The subjects will be randomly assigned to the TEAS group (IVF + TEAS), the electro-acupuncture (EA) group (IVF + EA), or the control group (only IVF). A total sample size of 2,220 women is needed to detect differences in CPR among the 3 groups. Transcutaneous electrical acupoint stimulation or EA treatments will start once every 2 or 3 days from day 3 of menstruation in the ovarian stimulation cycle until the day of ET. The parameters of TEAS or EA will be the following: a frequency of 2/100 Hz, a moderate electrical current of 3 to 5 mA for TEAS and 0.8 to 1.0 mA for EA. The primary outcome is CPR; secondary outcomes are LBR, the number of oocytes aspirated and the total gonadotropin dose used in the stimulation cycle. The authors concluded that this study will provide significant evidence for using a new method (TEAS) in IVF.

total of 60 patients with muscle spasticity after brain injury were randomized to the following 3 groups: 100, 2, and 0 Hz (sham) TEAS. The acupoints Hegu (LI4) -- Yuji (LU10) and Zusanli (ST36) -- Chengshan (BL57) on the injured side were stimulated at 0, 2, or 100 Hz; 5 times per week for 4 weeks. Patients were followed-up for 1 and 2 months after the treatments. The effects of the treatments on muscle spasticity at the wrist, thumb, the other 4 fingers, elbow, shoulder, knee, and ankle were evaluated by the Modified Ashworth Scale, and the effects on disability were assessed by the Disability Assessment Scale. The walking capability was evaluated by the Holden functional ambulation classification score. The overall performance was assessed by the Global Assessment Scale score and the improved Barthel Index. The safety of the treatments administered was also monitored. The wrist spasticity was significantly reduced from baseline at weeks 2, 3, and 4 of treatment and at the 1- and 2-month follow-up visits in the 100 Hz group (p < 0.01). Compared with 2 Hz or sham TEAS, 100 Hz TEAS decreased wrist spasticity at weeks 2, 3, and 4 of treatment and 1 month after treatment (p < 0.001). The other end-points were not affected by the treatments. No treatment-emergent adverse events were reported during treatments and follow-up visits. The authors concluded that TEAS appears to be a safe and effective therapy to relieve muscle spasticity after brain injury, although large-scale studies are needed to further verify the findings.

Transdermal Neuromodulation:

Transdermal neuromodulation is a variation of transcutaneous electrical acupoint stimulation. It is proposed as treatment for chemotherapy-induced nausea and vomiting. An example of a device used for this treatment is the Nomete, a watch-like device that generates a programmed pulse to stimulate the median nerve on the underside of the wrist.

Auricular Electrostimulation:

Auricular electrostimulation (also referred to as auricular electroacupuncture or pulsed stimulation) is the application of electrical impulses/stimulation to acupuncture points on the ear.
It is theorized that stimulation of the corresponding acupuncture points will relieve pain in various locations in the body. Examples of this type of device include, but may not be limited to, the P-Stim and NIPP device which are disposable, pre-programmed units worn behind the ear and connected to acupuncture needles.

**Treatment of Chronic Obstructive Pulmonary Disease:**

In a prospective, single-blind, randomized, placebo-controlled study, Liu and associates (2015) evaluated the clinical effect of transcutaneous electrical nerve stimulation over acupoints (acu-TENS) on patients with stable chronic obstructive pulmonary disease (COPD). A total of 50 patients with stable COPD enrolled in the study. Patients were randomly assigned to 1 of 2 groups: (i) the acu-TENS group (n = 25), who underwent acu-TENS over acupoints of bilateral EX-B-1 (Dingchuan), BL-13 (Feishu), BL-23 (Shenshu), ST-36 (Zusanli), and (ii) the placebo acu-TENS control group (n = 25), who had the same electrode placement but no electrical output. Treatments were performed for 40-min sessions every 2 days for 4 weeks. Lung function (forced expiratory volume in 1 second, percentage predicted (FEV(1)% predicted); forced vital capacity, percentage predicted (FVC% predicted), 6-minute walk distance (6MWD) and oxygen saturation (SpO(2)), COPD assessment test (CAT), and Dyspnea Visual Analogue Scale (DVAS) were assessed before and after the intervention. Compared to control group, FEV(1)% predicted was improved and CAT score was decreased significantly in the acu-TENS group after treatment (p < 0.05). The DVAS score decreased significantly in the acu-TENS group (p = 0.039), with a slight but insignificant improve in 6MWD, SpO(2), and FVC% predicted after treatment. The authors concluded that the Acu-TENS over acupoints of bilateral EX-B-1 (Dingchuan), BL-13 (Feishu), BL-23 (Shenshu), and ST-36 (Zusanli) improved FEV(1)% predicted and reduced DVAS and CAT scores on patients with stable COPD. They stated that this may be a novel treatment strategy in COPD.

**Treatment of Post-Operative Immune Dysfunction in Individuals with Lung Cancer:**
Wu and colleagues (2016) noted that an imbalance in the various T lymphocytes, including T-helper (Th)1, Th2 and Th17 cells, and regulatory T (Treg) cells, has been associated with immune dysfunction, and may occur following thoracotomy of patients with lung cancer. The use of transcutaneous acupoint electrical stimulation (TAES) has previously been demonstrated to exert immune-regulatory effects; therefore, the present study aimed to examine if TAES was able to attenuate post-operative immune suppression in patients with lung cancer. Thoracic surgical patients with lung cancer (n = 27) underwent TAES (frequency, 2/100 Hz; intensity, 4 to 12 mA) at the bilateral large intestine 4, pericardium 6, small intestine 3 and San Jiao 6 acupuncture points for 30 mins, prior to incision, and at 20, 44, 68, 92 and 116 hrs following thoracotomy. The number of Th1, Th2, Th17 and Treg cells, and the protein and mRNA expression levels of related cytokines were measured by flow cytometry, ELISA and polymerase chain reaction, respectively. The balance of Th1, Th2, Th17 and Treg cells in the peripheral blood of patients with lung cancer was disrupted following thoracotomy; TAES administration increased the percentage of Th1 and Th17 cells, the protein expression levels of interleukin (IL)-2 and interferon-γ, the mRNA expression levels of T-bet and RAR-related orphan receptor-γt, and decreased the percentage of Th2 cells, IL-10 protein expression levels, and GATA binding protein 3 mRNA expression levels. The results of the present study demonstrated that TAES was able to partially attenuate the post-operative immune depression of patients with lung cancer, by regulating the balance of Th1, Th2, Th17 and Treg cells, and the expression levels of related cytokines and transcription factors; therefore, TAES may be considered to be a promising strategy for treating post-operative immune dysfunction in patients with lung cancer.

Hu and colleagues (2017) examined the effect of percutaneous electrical stimulation on chemotherapy-induced bone marrow suppression in patients with lung cancer. From December 2014 to August 2015, a total of 191 non-small cell lung cancer (NSCLC) patients with chemotherapy naive were randomly divided into control group, medication group, and TEAS group. Patients with the control group received routine nursing care, the medication group was treated by oral administration of prophylactic agents,
and TEAS group received electrical stimulation of acupoints including Dazhui (DU14), Geshu (BL17), Zusanli (ST36), Sanyinjiao (SP6), and Hegu (LI4). The primary end-point was the blood routine indexes and secondary end-point was the degree of comfort. The white blood cell in the TEAS group was significantly higher than the control group on day 8 and day 14 (p < 0.05). The platelet count in the TEAS group was significantly higher than control group on day 5, day 8 and day 11 (p < 0.05). The comfort score in the TEAS group was significantly higher than control group on day 8 (p < 0.05). The authors concluded that TEAS could prevent chemotherapy-induced bone marrow suppression in patients with NSCLC and ensure a smooth continuation of chemotherapy. Moreover, they stated that a larger, multi-center study is needed to confirm the effects of TEAS.

Treatment of Tinnitus:

Li and co-workers (2015) noted that subjective tinnitus is a phantom sensation experienced in the absence of any source of sound. Its mechanism remains unclear, and no approved drugs are available. Vagus nerve stimulation (VNS) is an exciting new method to treat tinnitus, but direct electrical stimulation of the cervical vagus has disadvantages. This randomized controlled clinical trial aims to overcome these limitations by stimulating the auricular branch of vagus nerve (ABVN) on the outer ear. Since the ABVN is the only peripheral branch of the vagus nerve distributed on the ear’s surface, it should be possible to achieve analogous efficacy to VNS by activating the central vagal pathways. However, researches have indicated that the curative effect lies in a combination of auditory and vagal nerve stimulation. Moreover, from traditional Chinese theory, auricular acupoints used to treat tinnitus are mainly in the regions supplied by the ABVN. Whether stimulation at the auricular acupoints is due to unintentional stimulation of vagal afferent fibers also needs evidence. A total of 120 subjects with subjective tinnitus are randomized equally into 4 groups: (i) electrical stimulation at auricular acupoints (CO10, CO11, CO12, and TF4) innervated by the ABVN; (ii) electrical stimulation at auricular acupoints (CO10, CO11, CO12, and TF4) innervated by ABVN pairing tones; (iii) electrical stimulation at auricular acupoints innervated by non-
ABVN pairing tones; and (iv) electrical acupuncture. Patients will be treated for 30 minutes every other day for 8 weeks. The primary outcome measure is the Tinnitus Handicap Inventory.

The secondary outcome measure combines a visual analog scale (VAS) to measure tinnitus disturbance and loudness with the Hospital Anxiety and Depression Scale. Assessment is planned at baseline (before treatment) and in the 4th and 8th week, with further follow-up visits after termination of the treatment at the 12th week. Any adverse events will be promptly documented. The authors stated that completion of this trial will help to confirm whether ABVN or the combination of ABVN and sound stimulus plays a more important role in treating tinnitus. Moreover, the result of this clinical trial will enhance our understanding of specific auricular acupoints.

**Hemodialysis-Associated Fatigue:**

In a randomized control trial (RCT), Hadadian and associates (2016) evaluated the effects of TEAS on fatigue among end-stage renal disease (ESRD) patients receiving hemodialysis treatment. This study was conducted over a 5-month period in 2009. A total of 56 patients who had undergone hemodialysis and meeting the inclusion criteria, were divided into 2 groups by simple random sampling: (i) TEAS (n = 28) and (ii) TEAS-Sham (n = 28). Data were gathered through the Brief Fatigue Inventory (BFI), entered into SPSS-16 software and analyzed by descriptive and inferential statistics. Out of 56, 38 patients (67.9 %) were men and 45 (80.4 %) were married. The mean and standard deviation (SD) of age were 52.29 ± 15.26 years. The inferential tests showed no differences in the clinical and the demographic characteristics of patients among 2 groups (p > 0.05). The mean rank of fatigue score in TEAS and TEAS-Sham groups was 30.68 and 26.32, respectively (p = 0.317) at the first of study. The results of the Mann-Whitney U-test indicated that there were significant differences between the TEAS and Sham groups after intervention (p = 0.002). The authors concluded that these findings revealed that application of the TEAS on these acupoints produced a better recovery rate of fatigue in TEAS group than Sham group after a course of 10 session intervention. Furthermore, they stated that additional studies are needed to consolidate a standardized
method and maximize the effectiveness of TEAS. They noted that future research should include the identification of the most effective acupoints and the mechanism behind it. In addition, other variables such as optimal electrode size, electrical power and frequency, waveform, stimulation duration should be examined.

This study had 2 major drawbacks: (i) Although, the results showed that the effects of TEAS on the improvement of fatigue in hemodialysis patients, the sample was drawn from 2 dialysis centers in Ahvaz, southwest of Iran. Generalizability of these findings to other samples of dialysis patients from other geographical areas in Iran cannot be ensured, (ii) non-registry in Iranian Registry of Clinical Trials (IRCT), because this project was conducted in 2009, and in that time, the registration was optional for the universities, so, this research has not been enrolled in the IRCT.

Post-Hemorrhoidectomy-Associated Pain and Anxiety:

In a randomized-controlled trial (RCT) with 5 repeated measures, Yeh and colleagues (2017) examined the effects of TAES intervention on post-operative pain, anxiety, and heart rate variability (HRV) in patients who received a hemorrhoidectomy. The TAES group (n = 39) received 4 20-min sessions of electrical stimulation at chengshan (BL57) and erbai (EX-UE2) after hemorrhoidectomy, whereas the control group (n = 41) did not. Data were collected using VAS, State Anxiety Inventory (STAI), and HRV physiological signal monitor; TAES resulted in a significant group difference in pain scores, anxiety levels, and some HRV parameters. The authors concluded that these findings indicated that TAES could aid in reducing pain and anxiety associated with hemorrhoidectomy. The main drawback of this study was its relatively small sample size (n = 39 for the TAES group).

Furthermore, an UpToDate review on “Surgical treatment of hemorrhoidal disease” (Rivadeneira and Steele, 2017) does not mention transcutaneous electrical acupoint stimulation as a management tool.
### CPT Codes / HCPCS Codes / ICD-10 Codes

*Information in the [brackets] below has been added for clarification purposes. Codes requiring a 7th character are represented by "+":*

#### CPT codes not covered for indications listed in the CPB:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>97813</td>
<td>Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with patient</td>
</tr>
<tr>
<td>+97814</td>
<td>with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)</td>
</tr>
</tbody>
</table>

#### Other CPT codes related to the CPB:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>97014</td>
<td>Application of a modality to one or more areas; electrical stimulation (unattended)</td>
</tr>
<tr>
<td>97032</td>
<td>Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes</td>
</tr>
</tbody>
</table>

#### HCPCS codes covered if selection criteria are met:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>E0765</td>
<td>FDA approved nerve stimulator, with replaceable batteries, for treatment of nausea and vomiting</td>
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</tbody>
</table>

#### HCPCS codes not covered for indications listed in the CPB:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>S8930</td>
<td>Electrical stimulation of auricular acupuncture points; each 15 minutes of personal one-on-one contact with the patient</td>
</tr>
</tbody>
</table>

#### Other HCPCS codes related to the CPB:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>G0283</td>
<td>Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care</td>
</tr>
</tbody>
</table>

#### ICD-10 codes covered if selection criteria are met:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>K91.0</td>
<td>Vomiting following gastrointestinal surgery</td>
</tr>
<tr>
<td>O21.0 - O21.9</td>
<td>Excessive vomiting in pregnancy</td>
</tr>
<tr>
<td>R11.0 - R11.2</td>
<td>Nausea and vomiting</td>
</tr>
</tbody>
</table>
T45.1X5+  Adverse effect of antineoplastic and
immunosuppressive drugs [post-operative nausea and
chemotherapy-induced nausea]

ICD-10 codes not covered for indications listed in the CPB:

C34.00 - Malignant neoplasm of bronchus and lung
C34.92
D02.20 - Carcinoma in situ of bronchus and lung
D02.22
H93.11 - Tinnitus
H93.19
H93.A1 - Pulstile tinnitus
H93.A9
J44.0 - J44.9 Other chronic obstructive pulmonary disease
M62.40 - Contracture of muscle
M62.49
N46.01 - Male infertility
N46.9
N97.0 - Female infertility
N97.9
S02.0XX+ - Fracture of skull and facial bones
S02.92X+
S06.0X0+ - Intracranial injury
06.9X9+
T75.3XX+ Motion sickness
Z31.83 Encounter for assisted reproductive fertility procedure
cycle
Z31.89 Encounter for other procreative management

The above policy is based on the following references:

1. Ho CM, Hseu SS, Tsai SK, Lee TY. Effect of P-6 acupressure
   on prevention of nausea and vomiting after epidural
   morphine for post-cesarean section pain relief. Acta
2. Fan CF, Tanhui E, Joshi S, et al. Acupressure treatment for


13. University of Texas at Austin, School of Nursing, Family Nurse Practitioner Program. Evaluation and management of nausea and vomiting in early pregnancy (less than or equal
to 20 weeks gestation). Austin, TX: University of Texas at Austin, School of Nursing; May 2002.


34. Xu M, Zhou SJ, Jiang CC, et al. The effects of P6 electrical acustimulation on postoperative nausea and vomiting in


43. Hadadian F, Sohrabi N, Farokhpayam M, et al. The effects of transcutaneous electrical acupoint stimulation (TEAS) on


AETNA BETTER HEALTH® OF PENNSYLVANIA

Amendment to
Aetna Clinical Policy Bulletin Number: 0676 Electrical Stimulation for Nausea, Vomiting and Motion Sickness (PrimaBella and ReliefBand) and Other Selected Indications

There are no amendments for Medicaid.