Priority Health	BILLING POLICY No. 117
UPPER LIMB STIMULATION FOR THE TREATMENT OF TREMORS	
Date of origin: July 11, 2025	**Review dates: 7/2026**

MEDICAL POLICY

- Peripheral Nerve Stimulation (#91634)

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the provider. In addition, the provider should consult any specific documentation requirements that are necessary of any applicable defined guidelines.

Coding guidelines

HCPCS code E0734: External upper limb tremor stimulator of the peripheral nerves of the wrist

HCPCS code A4542 is separately billed at initial issue of the external upper limb tremor stimulator of the peripheral nerves of the wrist.

- A4542 is billed on the initial claim with E0734
- A4542 is billed every 90 days after the initial claim

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. The modifier list below may not be an all-inclusive list. Get more information on modifier us in our Provider Manual.

GA, GZ, KX, LT and RT modifiers

Claim lines billed without a KX, GA, or GZ modifier will be rejected as missing information.

An external upper limb tremor stimulator of the peripheral nerves of the wrist (E0734) and associated supplies (A4542) are limb-specific (i.e., right or left upper extremity).

The RT (right) and LT (left) modifiers must be used when billing codes E0734 and A4542.

When bilateral (left and right) upper limb tremor stimulators or supplies are billed on the same date of service, bill each item on separate claim lines using the RT and LT modifiers and 1 unit of service (UOS) on each claim line.

Do not use the RT/LT modifier on the same claim line with 2 UOS.

Claim lines billed without the RT and/or LT modifiers, or with RTLT on the same claim line and 2 UOS, will be rejected as incorrect coding.

Place of service
Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Get more information in our Provider Manual.

Reimbursement rates
Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. See our fee schedules (login required).

DISCLAIMER
CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made

July 30, 2026	Reviewed, no changes