| Priority Health | BILLING POLICY<br>No. 158 |
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| **Transcutaneous Electrical Joint Stimulation Devices (TEJSD)** | |
| **Date of origin: October 2025** | **Review dates:** |

## DEFINITION

This policy outlines billing and payment requirements associated with Transcutaneous Electrical Joint Stimulation Devices (TEJSD).

A transcutaneous electrical joint stimulation device (TEJSD) coded (E0762) is a noninvasive device that delivers electrical stimulation intended to reduce the level of pain and symptoms associated with arthritis in a joint. TEJSD may have variation in the parameters of the current, how the current is applied, etc.

## MEDICAL POLICY

Stimulation Therapy and Devices- Medical Policy No.91468-R28

## For Medicare

For indications that do not meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Click here for additional details on PSOD.

## 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 specifics

A transcutaneous electrical joint stimulation device (TEJSD) coded (E0762) is a noninvasive device that is designed to deliver electrical impulses to a joint, aiming to alleviate pain and reduce symptoms linked to arthritis. TEJSD may have variation in the parameters of the current such as how the current is applied.

- A TEJSD coded E0762 is different from other electrical stimulators such as neuromuscular stimulators, functional electrical stimulators and transcutaneous electrical nerve stimulators, which also have specific HCPCS codes and are used to directly stimulate muscles and/or nerves. These devices have different mechanisms and clinical purposes, and must be coded accordingly.
- TEJSD is sometimes provided in combination with an orthosis brace. When these two devices are provided together, the TEJSD and brace are always coded separately, using the specific HCPCS codes assigned to each individual product. Braces with integrated components such as electrodes, lead wires, or storage for a Transcutaneous Electrical Joint Stimulation Device
- (TEJSD) are not considered accessories or supplies to the TEJSD. Instead, they are classified as orthotic braces and must be billed using the appropriate HCPCS code that describes the brace itself, regardless of the embedded technology. This ensures proper categorization under DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies) guidelines and avoids misclassification that could lead to claim denials or audits.

## Billing Specifics

- When electronic components are added to a brace, the item is no longer classified as a brace. Instead, it is considered Durable Medical Equipment (DME) if it satisfies the criteria for DME coverage. If it does not meet those requirements, it will be denied.
- Code A4465 is designated solely for the replacement of wraps or straps that secure electrodes in place when used with Transcutaneous Electrical Joint Stimulation Devices (TEJSD). Applying this code to replace wraps or straps associated with a brace constitutes incorrect coding.
- Code A4595 represents a monthly supply allowance that covers all essential items required for the prescribed use of the device. This includes any type of electrodes, conductive paste or gel, tape or other adhesives, adhesive remover, skin preparation materials, batteries (whether single-use or rechargeable), and a battery charger when rechargeable batteries are used. A single unit of service encompasses all necessary supplies for one month of use. Separate billing for individual supplies is considered unbundling.
- Codes A4556 (Electrodes, per pair) and A4558 (Conductive paste or gel), are not valid for claim submission to the DME MAC. Code A4595 should be used instead.
- For code A4557, one unit of service is for lead wires going to two electrodes.
- Other supplies, including but not limited to the following, are not separately allowed: adapters (snap, banana, alligator, tab, button, clip), belt clips, adhesive remover, additional connecting cable for lead wires, carrying pouches, or covers.

## 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. Please see our provider manual page for modifier use here.

## 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. Click here for additional information.

The DME benefit limits DME items to those used in the member's home. Provision of TEJSD to members in a Place of Service or facility considered to be other than home will be denied. This pertains to a TEJSD incorporated into or used with any type of brace.

## Reimbursement rates

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

# REFERENCES

Transcutaneous Electrical Joint Stimulation Devices (TEJSD)- Policy Article A52713

Transcutaneous Electrical Joint Stimulation Devices (TEJSD) L34821

# 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.

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## CHANGE / REVIEW HISTORY

| Date | Revisions made |
|---|---|
| 12/16/2025 | New policy effective 12/16/25 |