HAP CareSource™

MEDICAL POLICY STATEMENT Michigan Medicaid	
Policy Name & Number	**Date Effective**
Peripheral Nerve Stimulators for Treatment of Pain-MI MCD-MM-1522	05/01/2026
Policy Type	
MEDICAL	

Medical Policy Statements are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased, or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage or Certificate of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other plan policies and procedures.

Medical Policy Statements do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage or Certificate of Coverage) for the service(s) referenced in the Medical Policy Statement. Except as otherwise required by law, if there is a conflict between the Medical Policy Statement and the plan contract, then the plan contract will be the controlling document used to make the determination.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject

Peripheral Nerve Stimulators for the Treatment of Pain

B. Background

The role of peripheral nerves as sources of pain and avenues of treatment when conservative therapy has failed is being more extensively explored than in previous years. Neuromodulation of peripheral nerves to treat refractory pain is one such area of interest. The neuromodulation of peripheral nerves to reduce pain is commonly known as peripheral nerve stimulation (PNS), peripheral nerve field stimulation (PNFS), and percutaneous-eletrical nerve field stimulation (PENFS). It has been developed as a minimally invasive pain management modality intended to manage acute and chronic pain.

The proposed mechanism of action, referred to as the gate control theory, involves a method by which stimulation of large-diameter sensory neurons reduce transmission of painful stimuli from small nociceptive fibers to the brain. The stimulation system is placed adjacent to the nerve, a process commonly known as remote selective targeting. The lead is connected to a small, wearable stimulator. Depending on the device, the wearer may be able to adjust the level of stimulation using Bluetooth technology.

C. Definitions

- **Acute Pain** – Pain lasting 4 weeks or less.
- **Chronic Pain** – A distressing feeling often caused by intense or damaging stimuli lasting more than 3 months, considered beyond normal healing time.
- **Sub-Acute Pain** – Pain lasting between 4 and 12 weeks.

D. Policy

I. Any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which HAP CareSource determines in its sole discretion to be experimental or investigational is not covered by HAP CareSource.

II. Peripheral nerve stimulators are considered experimental and investigational and are unproven for all indications for the reduction of acute, sub-acute, and chronic pain.

III. Peripheral nerve stimulators are not covered. This includes but is not limited to:
   A. IB-Stim (NeurAxis)
   B. Moventis PNS
   C. Nalu Neurostimulation System
   D. Nerivio
   E. SPRINT PNS System
   F. StimQ PNS System
   G. StimRouter Neuromodulation System

E. Conditions of Coverage

N/A

F. Related Policies/Rules

Medical Necessity Determinations
Experimental and/or Investigational Item or Service

G. Review/Revision History

	DATE	ACTION
Date Issued	09/13/2023	New policy. Approved at Committee
Date Revised	03/13/2024 06/05/2024 05/07/2025 01/28/2026	Review, no changes. Approved at Committee Revised Background, added D. III. A. Approved at Committee Annual review, references updated. Approved at Committee Annual review, added Nerivio to D. III. Approved at Committee
Date Effective	05/01/2026	
Date Archived		

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