



Medicare Part C Medical Coverage Policy

Electrical Stimulators - TENS

Origination: June 30, 1988
Review Date: March 16, 2020
Next Review: March, 2022

******This policy applies to all Blue Medicare HMO, Blue Medicare PPO, Blue Medicare Rx members, and members of any third-party Medicare plans supported by Blue Cross NC through administrative or operational services. ******

DESCRIPTION OF PROCEDURE OR SERVICE

Transcutaneous electrical nerve stimulation (TENS) describes the application of electrical stimulation to the surface of the skin at the site of pain, and is used to relieve pain that is unresponsive to other standard pain therapies. Electrical stimulation is applied to nerves serving the painful limb or body region using one or more sets of two electrodes attached to the skin surface.

POLICY STATEMENT

Coverage will be provided for TENS when it is determined to be medically necessary because the medical criteria and guidelines shown below are met.

BENEFIT APPLICATION

Please refer to the member's individual Evidence of Coverage (EOC) for benefit determination. Coverage will be approved according to the EOC limitations, if the criteria are met.

Coverage decisions will be made in accordance with:

- The Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCDs);
- General coverage guidelines included in Original Medicare manuals unless superseded by operational policy letters or regulations; and
- Written coverage decisions of local Medicare carriers and intermediaries with jurisdiction for claims in the geographic area in which services are covered.

Benefit payments are subject to contractual obligations of the Plan. If there is a conflict between the general policy guidelines contained in the Medical Coverage Policy Manual and the terms of the member's particular Evidence of Coverage (EOC), the EOC always governs the determination of benefits.

INDICATION FOR COVERAGE:

Preauthorization by the Plan is required prior to the stimulator being dispensed by the vendor;

AND

A hard copy documented care plan indicating the stimulator use and expected outcome must be submitted by the physician;

AND

- I. Documentation of **one** of the following conditions and applicable criteria:
 1. **Acute post-operative pain** is limited to 30 days from the day of surgery. If additional days are necessary, individual consideration will be made based upon supportive documentation provided by the attending physician. TENS units used for acute post-operative pain will be approved for coverage on a rental basis only.
 2. **Chronic pain (Other than Low Back Pain):**
 - a. The presumed etiology of the pain must be accepted as responding to TENS therapy; **AND**
 - b. The pain must have been present for 3 months; **AND**
 - c. Other appropriate treatment modalities must have been tried and failed.
 3. **Chronic Low Back Pain (CLBP)** has to meet the following criteria:
 - a. An episode has persisted for 3 months or longer; **AND**
 - b. The back pain is not a manifestation of a clearly identified and generally recognizable primary disease entity, as metastatic cancers of the spine or Rheumatoid arthritis etc; **AND**
 - c. Is participating in a Medicare approved clinical study (Confirm trial number is Medicare approved at: www.clinicaltrials.gov); **AND**
 - d. The member has one of the diagnoses that is listed and must be referenced per LCD L33802

Special Note:

1. Severe and chronic pain is refractory to all other standard pain therapies, such as Physical Therapy, medications, pain clinic, etc. The TENS unit must be used by the patient on a trial basis for a minimum of one month (30 days), but not to exceed two months.
2. Conductive garment (E0731) used with a TENS unit may be covered if all the following conditions are met:

- a) It has been prescribed by a physician for use in delivering covered TENS treatments; **and**
- b) **One** of the medical indications outlined below is met:
 1. the member cannot manage without the conductive garment because:
 - i. there is such a large area or so many sites to be stimulated; **and**
 - ii. the stimulation would have to be delivered so frequently that it is not feasible to use conventional electrodes, adhesive tapes, and lead wires; **or**
 2. the member cannot manage without the conductive garment for the treatment of chronic intractable pain because the areas or sites to be stimulated are inaccessible with the use of conventional electrodes, adhesive tapes, and lead wires; **or**
 3. The member has a documented medical condition, such as skin problems, that preclude the application of conventional electrodes, adhesive tapes, and lead wires; **or**
 4. The member requires electrical stimulation beneath a cast to treat chronic intractable pain.

If criteria above are not met for E0731, it will be denied as not medically necessary.

WHEN COVERAGE WILL NOT BE APPROVED

1. When used for acute pain (less than 3 months) other than post-operative pain.
2. When used for the following conditions (not all-inclusive):
 - Headache
 - Visceral abdominal pain
 - Pelvic pain
 - Temporomandibular joint pain (TMJ)

SPECIAL NOTES:

For coverage of a purchase, the physician must determine that the member is likely to derive significant therapeutic benefit from continuous use of the unit over a long period of time.

BILLING/ CODING/PHYSICIAN DOCUMENTATION INFORMATION

This policy may apply to the following codes. Inclusion of a code in the section does not guarantee that it will be reimbursed.

Applicable codes: E0720, E0730, E0731, A4557, A4595

The Plan may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

GLOSSARY OF MEDICAL TERMS

1. **Acute Pain**- refers to pain that is resolved within three (3) months.
2. **Chronic Pain**- refers to pain that is a chief complaint for the member for greater than three (3) months.

SPECIAL NOTES

Terms of coverage:

1. **Acute pain**- coverage should not exceed two-month rental.
2. **Chronic pain**- initially rent for a one-month trial. Continued rental or purchase of the unit may be considered after the trial period if member compliance with the device is demonstrated, the member indicates decreased pain as evidenced by a 50% reduction in pain scale intensity, there is a decrease in pain medication use, and determination of long-term benefit are documented by the ordering physician.
3. **Purchase of a TENS unit** may be approved if the physician has reevaluated the patient at the end of the trial period for compliance with use, decreased pain, decreased medication and determined the patient is likely to derive significant therapeutic benefit from continuous use of the TENS over a long period of time.

References:

1. Medicare National Coverage Determination for Electrical Nerve Stimulators (TENS) _ (ID #160.27); Effective date: 06/08/12; Implementation Date 01/01/2013: Accessed via Internet site www.cms.gov; Viewed online , 03/16/2020
2. Medicare Local Coverage Determination for Electrical Nerve Stimulators (TENS) – CGS Administrators (L33802); Effective date: 10/01/2017: Accessed via www.cms.gov . 03/16/20

Policy Implementation/Update Information:

Revision Dates: January 8, 2002 and January 25, 2002; February 23, 2005

Revision Dates: November 30, 2006: Revised HCPCS codes to include E0730 & E0731 and delete E0749; Added rental only language for post-operative pain for clarification; Increased rental limit to two months instead of one; and Clarified measurements for pain control improvement.

Revision Date: September 2009: No changes proposed to the review criteria. Formatting and minor wording changes only

Revision Date: October 28, 2010: Removed items 1-7 under "When Coverage Will Not be Approved" since this language is a continuation of the medical coverage research from Hayes and not current with CMS policies. Conductive garment language added to remain current with CMS policies.

Revision Date: April 16, 2014; Policy was reviewed to mirror NCD/LCD changes regarding Chronic Lower Back Pain covered in a clinical trial only; No other changes. October 29, 2015 updated LCD due to ICD-10 update only.

Revision Date: June 15, 2016; Indications For Coverage-Item 3-d, Removed list of diagnoses 1-21 and added language to reference LCD for current diagnosis codes. Updated Code section.

Revision Date: March 21, 2018; Annual Review, No CMS Updates. Minor Revisions Only.

Revision Date: March 16, 2020; Annual Review, No CMS Updates. Minor Revisions Only.

Approval Dates:

Medical Coverage Policy Committee: March 16, 2020

Policy Owner: Carolyn Wisecarver, RN, BSN Medical Policy Coordinator