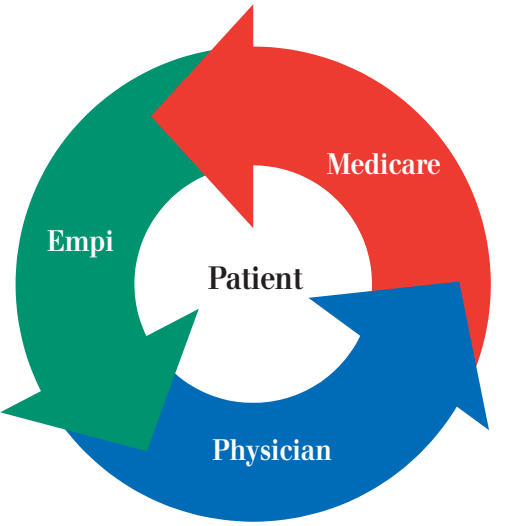
# Medicare Guidelines for TENS



# Medicare Guidelines for TENS

## Introduction

Medicare has very specific guidelines covering the use of Transcutaneous Electrical Nerve Stimulation (TENS) in treating pain conditions. Empi desires to work with referring physicians to ensure full compliance so that patients can benefit from TENS treatment when it is medically necessary and shown to be effective for a given patient.

## What is Empi's role as a supplier?

Empi processes the paperwork needed to secure reimbursement and files the claim with Medicare on behalf of the patient. **Each original certificate of medical necessity (CMN) and the original prescription for TENS must be on file at Empi.**

Clinicians and patients have toll-free telephone access to Medicare Service Specialists.

## What are the requirements of the prescribing physician?

The requirements are detailed in the Medicare MED-MANUAL. Relevant excerpts on coverage and payment rules follow.

## Coverage and payment rules

"A Transcutaneous Electrical Nerve Stimulator (TENS) is covered for the treatment of patients with chronic, intractable pain or acute post operative pain who meet the coverage rules listed below.

"When a TENS unit is used for acute post-operative pain, the medical necessity is usually limited to 30 days rental from the day of surgery. A payment for more than one month is determined by individual consideration based on supportive documentation provided by the attending physician. Payment will be made only as a rental. A TENS unit will be denied as not medically necessary for acute pain (less than three months) duration other than post-operative pain.

"For chronic pain, the medical record must document the location of the pain, the duration of time the patient has had the pain, and the presumed etiology of the pain. The pain must have been present for at least three months. Other appropriate treatment modalities must have been tried and failed, and the medical record must document what treatment modalities have been used (including the names and dosages of medication), the length of time each type of treatment used, and the results.

"The presumed etiology of pain must be a type accepted as responding to TENS therapy. Examples of conditions for which a TENS unit are not considered to be medically necessary are headache, visceral abdominal pain, pelvic pain, and TMJ pain." [1]

## Why two CMNs may be required for TENS?

When a Medicare patient is using the TENS device for chronic pain, a trial period (rental) is required. The first CMN is needed for the trial.

A second CMN is required prior to approval of the purchase of a TENS device. The prescribing physician must reevaluate the patient at the end of the trial period (30-60 days) and document that the device is medically necessary.

## What is required in the trial CMN?

"When used for the treatment of chronic, intractable pain, 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. The trial period will be paid as a rental. The trial period must be monitored by the physician to determine the effectiveness of the TENS unit in modulating pain." [1]

Physician (or non-physician clinician, or physician employee, if reviewed and signed by prescribing physician) must complete the following questions in Section B and sign and date the CMN: Length of Need, ICD-9 Codes, and Questions 1-6 and 12. A reevaluation with the prescribing physician is required following a one month (30 days minimum) to two month (60 days maximum) trial period.

## What is required in the purchase CMN?

"For coverage of a TENS purchase, the physician must determine that the patient is likely to derive significant therapeutic benefit from the continuous use of the unit

over a long period of time. The physician's records must document a reevaluation of the patient at the end of the trial period, must indicate how often the patient used the TENS unit, the typical duration of use each time, and the results." [1]

Physician (or non-physician clinician, or physician employee, if reviewed and signed by prescribing physician) must complete the following questions in Section B and sign and date the CMN: Length of Need, ICD-9 Codes, and Questions 3-12.

[1] MED-MANUAL, MED-GUIDE, MEDICAL POLICY SUBJECT: Transcutaneous Electrical Nerve Stimulators (TENS), COPYRIGHT 1998, CCH Incorporated.

## What is required on the prescription?

The prescription must be written on the physician's personalized pad and include the following information:

- Patient's name
- Description of item
- Physician's signature
- Date the physician signed the prescription

As with a CMN, signature and date stamps are not allowed. The date of the prescription must be on or before the issuance date of the TENS device.

## Accurate completion of the CMN is critical to successful coverage.

**TRIAL** and **PURCHASE**. Complete colored items directly on the form. The CMN must be signed and dated by prescribing physician in original ink. Medicare does not allow signature stamps or date stamps. If the CMN is altered the prescribing physician must circle or put a slash (/) through the error, sign in full and date the correction. Correction fluid is not allowed.

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0679

**CERTIFICATE OF MEDICAL NECESSITY**

**DMERC 06.02B**

TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR (TENS)

SECTION A Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___

| PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER | SUPPLIER NAME ADDRESS, TELEPHONE and NSC NUMBER |
|---|---|
| (__ __ __) __ __ __ - __ __ __ __ HIC #_____ | (__ __ __) __ __ __ - __ __ __ __ NSC #_____ |
| PLACE OF SERVICE_____<br>NAME and ADDRESS of FACULTY if appropriate<br>(See Reverse) | HCPCS CODE<br>_____<br>_____<br>_____<br>_____ |
| | PT DOB ___/___/___; Sex____(M/F); HT.____(in.); WT.____(lbs.) |
| | PHYSICIAN NAME, ADDRESS (Printed or Typed)<br><br>PHYSICIAN'S UPIN:_____<br>PHYSICIAN'S TELEPHONE #: (__ __ __) __ __ __ - __ __ __ __ |

SECTION B Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.

EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99 = LIFETIME)

| ANSWERS | ANSWER QUESTIONS 1-6 FOR RENTAL OF TENS, AND 3-12 FOR PURCHASE OF TENS.<br>(Circle Y for Yes, N for No, or D for Does Not Apply, Unless Otherwise Noted) |
|---|---|
| Y N D | 1. Does the patient have acute post-operative pain? |
| ___/___/___ | 2. What is the date of surgery resulting if acute post-operative pain? |
| Y N D | 3. Does the patient have chronic, intractable pain? |
| (___ months) | 4. How long has the patient had intractable pain? (Enter number of months, 1 - 99.) |
| 1 2 3 4 5 | 5. Is the TENS unit being prescribed by any of the following conditions? (Circle appropriate number)<br>1 - Headache 2 - Visceral abdominal pain 3 - Pelvic pain<br>4 - Tempomandibular joint (TMJ) pain 5 - None of the above |
| Y N D | 6. Is there documentation in the medical record of multiple medications and/or other therapies that have been tried and failed. |
| | |
| Began/Ended<br>___/___/___<br>___/___/___ | 8. What are the dates that trial of TENS unit gena and ended? |
| ___/___/___ | 9. What is the date you reevaluated the patient at the end of the trial period? |
| 1 2 3 | 10. How often has the patient been using the TENS? (Circle appropriate number)<br>1 = Daily 2 = 3 to 6 days per week 3 = 2 or less days per week |
| | 11. Do you and the patient agree that there has been a significant improvement in the pain and that long term use of a TENS is warranted? |
| 2 4 | 12. Number of TENS leads (i.e., separate electrodes) routinely needed and used by the patient at any one time.<br>(Circle appropriate number) 2 = 2 leads 4 = 4 leads |

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME:_____ TITLE:_____ EMPLOYER:_____

SECTION C Narrative Description Of Equipment And Cost

(1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule Allowance for each item, accessory, and option.
*(See Instructions On Back)*

SECTION D Physician Attestation and Signature/Date

I certify that I am the physician identified in Section A of this form. I have received Sections A, B and C and the Certificate of Medical Necessity (including changes for times ordered). Any statement on my letterhead attached therein, has been received and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE ___/___/___ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)