Article - Transcutaneous Electrical Nerve Stimulators (TENS) - Policy Article (A52520)

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Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATES
CGS Administrators, LLC	DME MAC	17013 - DME MAC	J-B	Illinois Indiana Kentucky Michigan Minnesota Ohio Wisconsin
CGS Administrators, LLC	DME MAC	18003 - DME MAC	J-C	Alabama Arkansas Colorado Florida Georgia Louisiana Mississippi New Mexico North Carolina Oklahoma Puerto Rico South Carolina Tennessee Texas Virgin Islands Virginia West Virginia
Noridian Healthcare Solutions, LLC	DME MAC	16013 - DME MAC	J-A	Connecticut Delaware District of Columbia Maine Maryland Massachusetts New Hampshire New Jersey New York - Entire State Pennsylvania Rhode Island Vermont

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATES
Noridian Healthcare Solutions, LLC	DME MAC	19003 - DME MAC	J-D	Alaska American Samoa Arizona California - Entire State Guam Hawaii Idaho Iowa Kansas Missouri - Entire State Montana Nebraska Nevada North Dakota Northern Mariana Islands Oregon South Dakota Utah Washington Wyoming

Article Information

General Information

Article ID
A52520

Article Title
Transcutaneous Electrical Nerve Stimulators (TENS) - Policy Article

Article Type
Article

Original Effective Date
10/01/2015

Revision Effective Date
11/20/2021

Revision Ending Date

AMA CPT / ADA CDT / AHA NUBC Copyright Statement

N/A

Retirement Date

N/A

Article Guidance

Article Text

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES

For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements. Information provided in this policy article relates to determinations other than those based on Social Security Act §1862(a)(1)(A) provisions (i.e. "reasonable and necessary").

Transcutaneous electrical nerve stimulation (TENS) equipment is covered under the Durable Medical Equipment benefit (Social Security Act §1861(s)(6)). In order for a beneficiary's equipment to be eligible for reimbursement the reasonable and necessary (R&N) requirements set out in the related Local Coverage Determination must be met. In addition, there are specific statutory payment policy requirements, discussed below, that also must be met.

During the rental of a TENS unit, supplies for the unit are included in the rental allowance; there is no additional allowance for items such as electrodes, lead wires, and batteries. If a TENS unit (E0720 or E0730) is purchased, the allowance is all-inclusive of items such as lead wires and one month's supply of items such as electrodes, conductive paste or gel (if needed), and batteries.

Refer to the COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY section of the LCD for additional information about coverage criteria and associated documentation.

REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO Final Rule 1713 (84 Fed. Reg Vol 217)

Final Rule 1713 (84 Fed. Reg Vol 217) requires a face-to-face encounter and a Written Order Prior to Delivery (WOPD) for specified HCPCS codes. CMS and the DME MACs provide a list of the specified codes, which is periodically updated. The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.

Claims for the specified items subject to Final Rule 1713 (84 Fed. Reg Vol 217) that do not meet the face-to-face encounter and WOPD requirements specified in the LCD-related Standard Documentation Requirements Article (A55426) will be denied as not reasonable and necessary.

If a supplier delivers an item prior to receipt of a WOPD, it will be denied as not reasonable and necessary. If the WOPD is not obtained prior to delivery, payment will not be made for that item even if a WOPD is subsequently obtained by the supplier. If a similar item is subsequently provided by an unrelated supplier who has obtained a WOPD, it will be eligible for coverage.

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS

In addition to policy specific documentation requirements, there are general documentation requirements that are applicable to all DMEPOS policies. These general requirements are located in the DOCUMENTATION REQUIREMENTS section of the LCD.

Refer to the LCD-related Standard Documentation Requirements article, located at the bottom of this Policy Article under the Related Local Coverage Documents section for additional information regarding GENERAL DOCUMENTATION REQUIREMENTS and the POLICY SPECIFIC DOCUMENTATION REQUIREMENTS discussed below.

For all claims for TENS and related supplies there must be information in the medical record demonstrating that the coverage criteria are met.

For acute post-operative pain covered under criterion I of the related LCD, there must be information about:

- The date of surgery
- The nature of the surgery
- The location and severity of the pain

For chronic pain covered under criterion II of the related LCD, there must be information in the medical record describing:

- The location of the pain
- The severity of the pain
- The duration of time the beneficiary has had the pain
- The presumed etiology of the pain
- Prior treatment and results of that treatment
- Reevaluation of the beneficiary at the end of the trial period, must indicate
    - How often the beneficiary used the TENS unit
    - The typical duration of use each time
    - The results (effectiveness of therapy)

Each claim for code E0731 must be accompanied by the brand, name and model number of the conductive garment.

CERTIFICATE OF MEDICAL NECESSITY (CMN)

For TENS provided under criteria I and II in the Coverage Indications, Limitations, and/or Medical Necessity of the related LCD, a Certificate of Medical Necessity (CMN), which has been completed, signed, and dated by the treating practitioner, must be kept on file by the supplier and made available upon request. The CMN may act as a substitute for the Standard Written Order (SWO) if it contains the same information as required in a SWO. The CMN for TENS is CMS Form 848. In addition to the information that the treating practitioner enters in Section B, the supplier can use the space in Section C for a written confirmation of other details of the order or the treating practitioner can enter the other details directly.

A new CMN is not required just because the supplier changes assignment status on the submitted claim.

A CMN is not needed for a TENS rental.

MODIFIERS

GA, GZ AND KX MODIFIERS:

Suppliers must add a KX modifier to codes E0720, E0730, and E0731 only if all of the criteria in the COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY section of the related LCD have been met.

For the situation where a KX modifier is required, if all of the criteria in the COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY section of the related LCD have not been met, the GA or GZ modifier must be added to these codes. When there is an expectation of a reasonable and necessary denial, suppliers must enter the GA modifier on the claim line if they have obtained a properly executed Advance Beneficiary Notice (ABN) or the GZ modifier if they have not obtained a valid ABN.

Claim lines billed for E0720, E0730, and E0731 without a GA, GZ or KX modifier as specified above will be rejected as missing information.

CODING GUIDELINES

A transcutaneous electrical nerve stimulator (TENS) (E0720, E0730) is a device that utilizes electrical current delivered through electrodes placed on the surface of the skin to decrease the patient's perception of pain by inhibiting the transmission of afferent pain nerve impulses and/or stimulating the release of endorphins. A TENS unit must be distinguished from other electrical stimulators (e.g., neuromuscular stimulators) which are used to directly stimulate muscles and/or motor nerves.

A TENS supply allowance (A4595), is an all-inclusive code and includes items such as electrodes (any type), conductive paste or gel (if needed, depending on the type of electrode), tape or other adhesive (if needed, depending on the type of electrode), adhesive remover, skin preparation materials, batteries (9 volt or AA, single use or rechargeable), and a battery charger (if rechargeable batteries are used).

Codes A4556 (Electrodes, [e.g., apnea monitor], per pair), A4558 (Conductive paste or gel), and A4630 (Replacement batteries, medically necessary TENS owned by patient) are not valid for claim submission to the DME MAC. A4595 should be used instead.

For code A4557, one unit of service is for lead wires going to two electrodes. If all the lead wires of a 4 lead TENS unit needed to be replaced, billing would be for two units of service.

There should be no billing and there will be no separate allowance for replacement electrodes (A4556), conductive paste or gel (A4558), replacement batteries (A4630), or a battery charger used with a TENS unit.

Other supplies, including but not limited to the following, will not be separately allowed: adapters (snap, banana, alligator, tab, button, clip), belt clips, adhesive remover, additional connecting cable for lead wires, carrying pouches, or covers.

Suppliers should contact the Pricing, Data Analysis and Coding (PDAC) Contractor for guidance on the correct coding of these items.

Coding Information

CPT/HCPCS Codes

N/A

ICD-10-CM Codes that Support Medical Necessity

N/A

ICD-10-CM Codes that DO NOT Support Medical Necessity

Group 1 Paragraph:

Group 1 Codes:

N/A

ICD-10-PCS Codes

N/A

Additional ICD-10 Information

N/A

Bill Type Codes

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the article does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the article should be assumed to apply equally to all claims.

N/A

Revenue Codes

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the article, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the article should be assumed to apply equally to all Revenue Codes.

N/A

Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
11/20/2021	R8	**Revision History Effective Date: 11/20/2021** MODIFIERS: Removed: Q0 (zero) modifier from sub-header *05/26/2022: At this time the 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.*
11/20/2021	R7	**Revision History Effective Date: 11/20/2021** REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217): Removed: "The link will be located here once it is available." Added: "The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here." with a hyperlink to the list *04/14/2022: At this time the 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.*
11/20/2021	R6	R**evision History Effective Date: 11/20/2021** NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Revised: Language regarding supply allowances during the rental period for clarification POLICY SPECIFIC DOCUMENTATION REQUIREMENTS: Removed: Medical records statement for Criterion III as coverage expired June 7, 2015 for CLBP under NCD 160.27 MODIFIERS: Removed: Q0 modifier statements regarding Criterion III as coverage expired June 7, 2015 for CLBP under NCD 160.27 ICD-10-CM CODES THAT SUPPORT MEDICAL NECESSITY: Removed: ICD-10-CM codes used for CLBP as coverage expired June 7, 2015 for CLBP under NCD 160.27 ICD-10-CM CODES THAT DO NOT SUPPORT MEDICAL NECESSITY: Removed: Statement under paragraph 1 regarding CLBP and all codes not specified *10/07/2021: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not*

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
		a local coverage determination.
01/01/2020	R5	**Revision History Effective Date: 01/01/2020** NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Removed: REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO 42 CFR 410.38(g) section REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 Fed. Reg Vol 217): Added: Section and related information based on Final Rule 1713 CERTIFICATE OF MEDICAL NECESSITY (CMN): Revised: "physician" to "practitioner" Revised: "physician" to "treating practitioner" Removed: CMN form version number "(DME form 06.03B)" Revised: "detailed written order" to "Standard Written Order (SWO)" Revised: "detailed written order" to "SWO" ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY: Revised: Section header "ICD-10 Codes that are Covered" updated to "ICD-10 Codes that Support Medical Necessity" ICD-10 CODES THAT DO NOT SUPPORT MEDICAL NECESSITY: Revised: Section header "ICD-10 Codes that are Not Covered" updated to "ICD-10 Codes that DO NOT Support Medical Necessity" *02/27/2020: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.*
01/01/2019	R4	**Revision History Effective Date: 01/01/2019** ICD-10 CODES THAT ARE COVERED: Added: All diagnosis codes formerly listed in the LCD ICD-10 CODES THAT ARE NOT COVERED: Added: Notation excluding all ICD-10 codes not specified above for TENS used for CLBP. TENS for all other uses not specified *02/21/2019: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.*
01/01/2017	R3	**Revision Effective Date: 01/01/2017** NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added: 42 CFR 410.38(g) POLICY SPECIFIC DOCUMENTATION REQUIREMENTS: Added: Coverage criteria information, CMN and Modifier requirements RELATED LOCAL COVERAGE DOCUMENTS: Added: LCD-related Standard Documentation Requirements Language Article

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
07/01/2016	R2	Effective July 1, 2016 oversight for DME MAC Articles is the responsibility of CGS Administrators, LLC 18003 and 17013 and Noridian Healthcare Solutions, LLC 19003 and 16013. No other changes have been made to the Articles.
10/01/2015	R1	Revision Effective Date: 10/31/2014 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Removed: "When required by state law" from ACA new prescription requirements Revised: Face-to-Face Requirements for treating practitioner

Associated Documents

Related Local Coverage Documents

Articles

A55426 - Standard Documentation Requirements for All Claims Submitted to DME MACs

LCDs

L33802 - Transcutaneous Electrical Nerve Stimulators (TENS)

Related National Coverage Documents

N/A

Statutory Requirements URLs

N/A

Rules and Regulations URLs

N/A

CMS Manual Explanations URLs

N/A

Other URLs

N/A

Public Versions

UPDATED ON	EFFECTIVE DATES	STATUS
05/20/2022	11/20/2021 - N/A	Currently in Effect (This Version)
04/07/2022	11/20/2021 - N/A	Superseded
10/01/2021	11/20/2021 - N/A	Superseded
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Some older versions have been archived. Please visit the MCD Archive Site to retrieve them.		

Keywords

N/A