Local Coverage Determination (LCD): Transcutaneous Electrical Nerve Stimulators (TENS) (L33802)

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Contractor Information

Contractor Name	Contract Type	Contract Number	Jurisdiction	State(s)
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 North Carolina New Mexico Oklahoma Puerto Rico South Carolina Tennessee Texas Virginia Virgin Islands West Virginia
Noridian Healthcare Solutions, LLC	DME MAC	16013 - DME MAC J-A		Connecticut District of Columbia Delaware Massachusetts Maryland Maine New Hampshire New Jersey New York - Entire State Pennsylvania Rhode Island Vermont
Noridian Healthcare Solutions, LLC	DME MAC	19003 - DME MAC J-D		Alaska American Samoa Arizona California - Entire State Guam Hawaii Iowa Idaho Kansas Missouri - Entire State Montana North Dakota Nebraska Nevada Oregon South Dakota

Contractor Name	Contract Type	Contract Number	Jurisdiction	State(s)
				Utah Washington Wyoming Northern Mariana Islands

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LCD Information

Document Information

LCD ID
L33802

Original ICD-9 LCD ID
L11506
L5031
L27031
L11495

LCD Title
Transcutaneous Electrical Nerve Stimulators (TENS)

Original Effective Date
For services performed on or after 10/01/2015

Revision Effective Date
For services performed on or after 01/01/2017

Revision Ending Date
N/A

Retirement Date
N/A

Notice Period Start Date
N/A

Notice Period End Date
N/A

CMS National Coverage Policy CMS Manual System, Pub. 100-03, Medicare National Coverage Determinations Manual, Chapter 1, Section 10.2, 160.7.1, 160.13, 160.27, 280.13

Coverage Guidance
Coverage Indications, Limitations, and/or Medical Necessity

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.

The purpose of a Local Coverage Determination (LCD) is to provide information regarding "reasonable and necessary" criteria based on Social Security Act § 1862(a)(1)(A) provisions.

In addition to the "reasonable and necessary" criteria contained in this LCD there are other payment rules, which are discussed in the following documents, that must also be met prior to Medicare reimbursement:

- The LCD-related Standard Documentation Requirements Article, located at the bottom of this policy under the Related Local Coverage Documents section.
- The LCD-related Policy Article, located at the bottom of this policy under the Related Local Coverage Documents section.
- Refer to the Supplier Manual for additional information on documentation requirements.
- Refer to the DME MAC web sites for additional bulletin articles and other publications related to this LCD.

For the items addressed in this LCD, the "reasonable and necessary" criteria, based on Social Security Act § 1862(a)(1)(A) provisions, are defined by the following coverage indications, limitations and/or medical necessity.

The physician ordering the TENS unit and related supplies must be the treating physician for the disease or condition justifying the need for the TENS unit.

A TENS is covered for the treatment of beneficiaries with chronic, intractable pain or acute post-operative pain when one of the following coverage criteria, I-III, are met.

I. Acute Post-operative Pain

TENS is covered for acute post-operative pain. Coverage is limited to 30 days (one month's rental) from the day of surgery. Payment will be made only as a rental.

A TENS unit will be denied as not reasonable and necessary for acute pain (less than three months duration) other than for post-operative pain.

II. Chronic Pain Other than Low Back Pain

TENS is covered for chronic, intractable pain other than chronic low back pain when all of the following criteria must be met:

- The presumed etiology of the pain must be a type that is accepted as responding to TENS therapy. Examples of conditions for which TENS therapy is not considered to be reasonable and necessary are (not all-inclusive):
  - headache
  - visceral abdominal pain
  - pelvic pain
  - temporomandibular joint (TMJ) pain
- The pain must have been present for at least three months
- Other appropriate treatment modalities must have been tried and failed

TENS therapy for chronic pain that does not meet these criteria will be denied as not reasonable and necessary.

III. Chronic Low Back Pain (CLBP)

TENS therapy for CLBP is only covered when all of the following criteria are met:

- The beneficiary has one of the diagnosis codes listed in the ICD-10 Codes that Support Medical Necessity section below.
- The beneficiary is enrolled in an approved clinical study that meets all of the requirements set out in NCD §160.27 (CMS Internet Only Manual 100-03, Chapter 1). Refer to the APPENDICES section for additional information about approved clinical studies.

TENS therapy for CLBP that does not meet these criteria will be denied as not reasonable and necessary.

General Requirements for chronic pain (II) and CLBP (III)

When used for the treatment of chronic, intractable pain described in section II, the TENS unit must be used by the beneficiary 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 the pain. For coverage of a purchase, the physician must determine that the beneficiary is likely to derive significant therapeutic benefit from continuous use of the unit over a long period of time.

A 4-lead TENS unit may be used with either 2 leads or 4 leads, depending on the characteristics of the beneficiary's pain. If it is ordered for use with 4 leads, the medical record must document why 2 leads are insufficient to meet the beneficiary's needs.

TENS used for CLBP as described in section III does not require a trial rental period or an assessment of effectiveness by the treating physician. Upon the beneficiary's enrollment into an approved study, the TENS is eligible for purchase.

Supplies

Separate allowance will be made for replacement supplies when they are reasonable and necessary and are used with a covered TENS. Usual maximum utilization is:

- 2 TENS leads - a maximum of one unit of A4595 per month
- 4 TENS leads - a maximum of two units of A4595 per month.

If the use of the TENS unit is less than daily, the frequency of billing for the TENS supply code should be reduced proportionally.

Replacement of lead wires (A4557) more often than every 12 months would rarely be reasonable and necessary.

A conductive garment (E0731) used with a TENS unit is rarely reasonable and necessary, but is covered only if all of the following conditions are met:

- It has been prescribed by the treating physician for use in delivering covered TENS treatment

- One of the medical indications outlined below is met:

    - The beneficiary cannot manage without the conductive garment because
        - There is such a large area or so many sites to be stimulated and
        - The stimulation would have to be delivered so frequently that it is not feasible to use conventional electrodes, adhesive tapes, and lead wires
    - The beneficiary 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
    - The beneficiary has a documented medical condition, such as skin problems, that preclude the application of conventional electrodes, adhesive tapes, and lead wires
    - The beneficiary requires electrical stimulation beneath a cast to treat chronic intractable pain.

A conductive garment is not covered for use with a TENS device during the trial period unless:

- The beneficiary has a documented skin problem prior to the start of the trial period; and

- The TENS is reasonable and necessary for the beneficiary.

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

Reimbursement for supplies is contingent upon use with a covered TENS unit. Claims for TENS supplies provided when there is no covered TENS unit will be denied as not reasonable and necessary.

Effective for claims with dates of service on or after June 8, 2012 supplies provided for use with a previously covered TENS unit used for CLBP (not as part of an approved study) are not eligible for reimbursement. These supply claims will be denied as not reasonable and necessary.

GENERAL

A Detailed Written Order (DWO) (if applicable) must be received by the supplier before a claim is submitted. If the supplier bills for an item addressed in this policy without first receiving a completed DWO, the claim shall be denied as not reasonable and necessary.

For Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) base items that require a Written Order Prior to Delivery (WOPD), the supplier must also obtain a DWO before submitting a claim for any associated options, accessories, and/or supplies that are separately billed. In this scenario, if the supplier bills for associated options, accessories, and/or supplies without first receiving a completed DWO, the claim shall be denied as not reasonable and necessary.

A WOPD (if applicable) must be received by the supplier before a DMEPOS item is delivered to a beneficiary. If a supplier delivers a DMEPOS item without first receiving a completed WOPD, the claim shall be statutorily denied. Refer to the LCD-related Policy Article, located at the bottom of this policy under the Related Local Coverage Documents section.

An item/service is correctly coded when it meets all the coding guidelines listed in CMS HCPCS guidelines, LCDs, LCD-related Policy Articles, or DME MAC articles. Claims that do not meet coding guidelines shall be denied as not reasonable and necessary/incorrectly coded.

Proof of delivery (POD) is a Supplier Standard and DMEPOS suppliers are required to maintain POD documentation in their files. Proof of delivery documentation must be made available to the Medicare contractor upon request. All services that do not have appropriate proof of delivery from the supplier shall be denied as not reasonable and necessary.

REFILL REQUIREMENTS

For DMEPOS items and supplies provided on a recurring basis, billing must be based on prospective, not retrospective use. For DMEPOS products that are supplied as refills to the original order, suppliers must contact the beneficiary prior to dispensing the refill and not automatically ship on a pre-determined basis, even if authorized by the beneficiary. This shall be done to ensure that the refilled item remains reasonable and necessary, existing supplies are approaching exhaustion, and to confirm any changes or modifications to the order. Contact with the beneficiary or designee regarding refills must take place no sooner than 14 calendar days prior to the delivery/shipping date. For delivery of refills, the supplier must deliver the DMEPOS product no sooner than 10 calendar days prior to the end of usage for the current product. This is regardless of which delivery method is utilized.

For all DMEPOS items that are provided on a recurring basis, suppliers are required to have contact with the beneficiary or caregiver/designee prior to dispensing a new supply of items. Suppliers must not deliver refills without a refill request from a beneficiary. Items delivered without a valid, documented refill request will be denied as not reasonable and necessary.

Suppliers must not dispense a quantity of supplies exceeding a beneficiary's expected utilization. Suppliers must stay attuned to changed or atypical utilization patterns on the part of their clients. Suppliers must verify with the ordering physicians that any changed or atypical utilization is warranted. Regardless of utilization, a supplier must not dispense more than a three (3) - month quantity at a time.

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Coding Information

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 policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy 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 policy, 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 policy should be assumed to apply equally to all Revenue Codes.

N/A

CPT/HCPCS Codes

Group 1 Paragraph: The appearance of a code in this section does not necessarily indicate coverage.

HCPCS MODIFIERS:

EY - No physician or other licensed health care provider order for this item or service

GA - Waiver of liability statement issued as required by payer policy, individual case

GZ – Item or service expected to be denied as not reasonable and necessary

KX - Requirements specified in the medical policy have been met

Q0 (zero) - Investigational clinical service provided in a clinical research study that is in an approved clinical research study

HCPCS CODES:

EQUIPMENT

Group 1 Codes:

E0720	TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION (TENS) DEVICE, TWO LEAD, LOCALIZED STIMULATION
E0730	TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION (TENS) DEVICE, FOUR OR MORE LEADS, FOR MULTIPLE NERVE STIMULATION
E0731	FORM FITTING CONDUCTIVE GARMENT FOR DELIVERY OF TENS OR NMES (WITH CONDUCTIVE FIBERS SEPARATED FROM THE PATIENT'S SKIN BY LAYERS OF FABRIC)

Group 2 Paragraph: SUPPLIES

Group 2 Codes:

A4557 LEAD WIRES, (E.G., APNEA MONITOR), PER PAIR
A4595 ELECTRICAL STIMULATOR SUPPLIES, 2 LEAD, PER MONTH, (E.G., TENS, NMES)

ICD-10 Codes that Support Medical Necessity
Group 1 Paragraph: The presence of an ICD-10 code listed in this section is not sufficient by itself to assure coverage. Refer to the section on "Coverage Indications, Limitations and/or Medical Necessity" for other coverage criteria and payment information.

For TENS (E0720, E0730) used for CLBP when the approved clinical study (criterion III) requirements are met.

Group 1 Codes:

ICD-10 Codes	Description
M40.36	Flatback syndrome, lumbar region
M40.37	Flatback syndrome, lumbosacral region
M40.46	Postural lordosis, lumbar region
M40.47	Postural lordosis, lumbosacral region
M40.56	Lordosis, unspecified, lumbar region
M40.57	Lordosis, unspecified, lumbosacral region
M41.26	Other idiopathic scoliosis, lumbar region
M41.27	Other idiopathic scoliosis, lumbosacral region
M41.56	Other secondary scoliosis, lumbar region
M41.57	Other secondary scoliosis, lumbosacral region
M42.16	Adult osteochondrosis of spine, lumbar region
M42.17	Adult osteochondrosis of spine, lumbosacral region
M43.06	Spondylolysis, lumbar region
M43.07	Spondylolysis, lumbosacral region
M43.16	Spondylolisthesis, lumbar region
M43.17	Spondylolisthesis, lumbosacral region
M43.26	Fusion of spine, lumbar region
M43.27	Fusion of spine, lumbosacral region
M43.5X6	Other recurrent vertebral dislocation, lumbar region
M43.5X7	Other recurrent vertebral dislocation, lumbosacral region
M43.8X6	Other specified deforming dorsopathies, lumbar region
M43.8X7	Other specified deforming dorsopathies, lumbosacral region
M47.16	Other spondylosis with myelopathy, lumbar region
M47.26	Other spondylosis with radiculopathy, lumbar region
M47.27	Other spondylosis with radiculopathy, lumbosacral region
M47.816	Spondylosis without myelopathy or radiculopathy, lumbar region
M47.817	Spondylosis without myelopathy or radiculopathy, lumbosacral region
M47.896	Other spondylosis, lumbar region
M47.897	Other spondylosis, lumbosacral region
M48.06	Spinal stenosis, lumbar region
M48.07	Spinal stenosis, lumbosacral region
M48.16	Ankylosing hyperostosis [Forestier], lumbar region
M48.17	Ankylosing hyperostosis [Forestier], lumbosacral region
M48.26	Kissing spine, lumbar region
M48.27	Kissing spine, lumbosacral region
M48.36	Traumatic spondylopathy, lumbar region
M48.37	Traumatic spondylopathy, lumbosacral region
M48.8X6	Other specified spondylopathies, lumbar region
M48.8X7	Other specified spondylopathies, lumbosacral region
M51.06	Intervertebral disc disorders with myelopathy, lumbar region
M51.16	Intervertebral disc disorders with radiculopathy, lumbar region
M51.17	Intervertebral disc disorders with radiculopathy, lumbosacral region
M51.26	Other intervertebral disc displacement, lumbar region

ICD-10 Codes	Description
M51.27	Other intervertebral disc displacement, lumbosacral region
M51.36	Other intervertebral disc degeneration, lumbar region
M51.37	Other intervertebral disc degeneration, lumbosacral region
M51.46	Schmorl's nodes, lumbar region
M51.47	Schmorl's nodes, lumbosacral region
M51.86	Other intervertebral disc disorders, lumbar region
M51.87	Other intervertebral disc disorders, lumbosacral region
M53.2X6	Spinal instabilities, lumbar region
M53.2X7	Spinal instabilities, lumbosacral region
M53.86	Other specified dorsopathies, lumbar region
M53.87	Other specified dorsopathies, lumbosacral region
M54.16	Radiculopathy, lumbar region
M54.17	Radiculopathy, lumbosacral region
M54.30	Sciatica, unspecified side
M54.31	Sciatica, right side
M54.32	Sciatica, left side
M54.40	Lumbago with sciatica, unspecified side
M54.41	Lumbago with sciatica, right side
M54.42	Lumbago with sciatica, left side
M54.5	Low back pain
S32.000A	Wedge compression fracture of unspecified lumbar vertebra, initial encounter for closed fracture
S32.000B	Wedge compression fracture of unspecified lumbar vertebra, initial encounter for open fracture
S32.000D	Wedge compression fracture of unspecified lumbar vertebra, subsequent encounter for fracture with routine healing
S32.000G	Wedge compression fracture of unspecified lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.000K	Wedge compression fracture of unspecified lumbar vertebra, subsequent encounter for fracture with nonunion
S32.000S	Wedge compression fracture of unspecified lumbar vertebra, sequela
S32.001A	Stable burst fracture of unspecified lumbar vertebra, initial encounter for closed fracture
S32.001B	Stable burst fracture of unspecified lumbar vertebra, initial encounter for open fracture
S32.001D	Stable burst fracture of unspecified lumbar vertebra, subsequent encounter for fracture with routine healing
S32.001G	Stable burst fracture of unspecified lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.001K	Stable burst fracture of unspecified lumbar vertebra, subsequent encounter for fracture with nonunion
S32.001S	Stable burst fracture of unspecified lumbar vertebra, sequela
S32.002A	Unstable burst fracture of unspecified lumbar vertebra, initial encounter for closed fracture
S32.002B	Unstable burst fracture of unspecified lumbar vertebra, initial encounter for open fracture
S32.002D	Unstable burst fracture of unspecified lumbar vertebra, subsequent encounter for fracture with routine healing
S32.002G	Unstable burst fracture of unspecified lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.002K	Unstable burst fracture of unspecified lumbar vertebra, subsequent encounter for fracture with nonunion
S32.002S	Unstable burst fracture of unspecified lumbar vertebra, sequela
S32.008A	Other fracture of unspecified lumbar vertebra, initial encounter for closed fracture
S32.008B	Other fracture of unspecified lumbar vertebra, initial encounter for open fracture
S32.008D	Other fracture of unspecified lumbar vertebra, subsequent encounter for fracture with routine healing
S32.008G	Other fracture of unspecified lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.008K	Other fracture of unspecified lumbar vertebra, subsequent encounter for fracture with nonunion
S32.008S	Other fracture of unspecified lumbar vertebra, sequela
S32.009A	Unspecified fracture of unspecified lumbar vertebra, initial encounter for closed fracture
S32.009B	Unspecified fracture of unspecified lumbar vertebra, initial encounter for open fracture
S32.009D	Unspecified fracture of unspecified lumbar vertebra, subsequent encounter for fracture with routine healing

ICD-10 Codes	Description
S32.009G	Unspecified fracture of unspecified lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.009K	Unspecified fracture of unspecified lumbar vertebra, subsequent encounter for fracture with nonunion
S32.009S	Unspecified fracture of unspecified lumbar vertebra, sequela
S32.010A	Wedge compression fracture of first lumbar vertebra, initial encounter for closed fracture
S32.010B	Wedge compression fracture of first lumbar vertebra, initial encounter for open fracture
S32.010D	Wedge compression fracture of first lumbar vertebra, subsequent encounter for fracture with routine healing
S32.010G	Wedge compression fracture of first lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.010K	Wedge compression fracture of first lumbar vertebra, subsequent encounter for fracture with nonunion
S32.010S	Wedge compression fracture of first lumbar vertebra, sequela
S32.011A	Stable burst fracture of first lumbar vertebra, initial encounter for closed fracture
S32.011B	Stable burst fracture of first lumbar vertebra, initial encounter for open fracture
S32.011D	Stable burst fracture of first lumbar vertebra, subsequent encounter for fracture with routine healing
S32.011G	Stable burst fracture of first lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.011K	Stable burst fracture of first lumbar vertebra, subsequent encounter for fracture with nonunion
S32.011S	Stable burst fracture of first lumbar vertebra, sequela
S32.012A	Unstable burst fracture of first lumbar vertebra, initial encounter for closed fracture
S32.012B	Unstable burst fracture of first lumbar vertebra, initial encounter for open fracture
S32.012D	Unstable burst fracture of first lumbar vertebra, subsequent encounter for fracture with routine healing
S32.012G	Unstable burst fracture of first lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.012K	Unstable burst fracture of first lumbar vertebra, subsequent encounter for fracture with nonunion
S32.012S	Unstable burst fracture of first lumbar vertebra, sequela
S32.018A	Other fracture of first lumbar vertebra, initial encounter for closed fracture
S32.018B	Other fracture of first lumbar vertebra, initial encounter for open fracture
S32.018D	Other fracture of first lumbar vertebra, subsequent encounter for fracture with routine healing
S32.018G	Other fracture of first lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.018K	Other fracture of first lumbar vertebra, subsequent encounter for fracture with nonunion
S32.018S	Other fracture of first lumbar vertebra, sequela
S32.019A	Unspecified fracture of first lumbar vertebra, initial encounter for closed fracture
S32.019B	Unspecified fracture of first lumbar vertebra, initial encounter for open fracture
S32.019D	Unspecified fracture of first lumbar vertebra, subsequent encounter for fracture with routine healing
S32.019G	Unspecified fracture of first lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.019K	Unspecified fracture of first lumbar vertebra, subsequent encounter for fracture with nonunion
S32.019S	Unspecified fracture of first lumbar vertebra, sequela
S32.020A	Wedge compression fracture of second lumbar vertebra, initial encounter for closed fracture
S32.020B	Wedge compression fracture of second lumbar vertebra, initial encounter for open fracture
S32.020D	Wedge compression fracture of second lumbar vertebra, subsequent encounter for fracture with routine healing
S32.020G	Wedge compression fracture of second lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.020K	Wedge compression fracture of second lumbar vertebra, subsequent encounter for fracture with nonunion
S32.020S	Wedge compression fracture of second lumbar vertebra, sequela
S32.021A	Stable burst fracture of second lumbar vertebra, initial encounter for closed fracture
S32.021B	Stable burst fracture of second lumbar vertebra, initial encounter for open fracture
S32.021D	Stable burst fracture of second lumbar vertebra, subsequent encounter for fracture with routine healing
S32.021G	Stable burst fracture of second lumbar vertebra, subsequent encounter for fracture with delayed healing

ICD-10 Codes	Description
S32.021K	Stable burst fracture of second lumbar vertebra, subsequent encounter for fracture with nonunion
S32.021S	Stable burst fracture of second lumbar vertebra, sequela
S32.022A	Unstable burst fracture of second lumbar vertebra, initial encounter for closed fracture
S32.022B	Unstable burst fracture of second lumbar vertebra, initial encounter for open fracture
S32.022D	Unstable burst fracture of second lumbar vertebra, subsequent encounter for fracture with routine healing
S32.022G	Unstable burst fracture of second lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.022K	Unstable burst fracture of second lumbar vertebra, subsequent encounter for fracture with nonunion
S32.022S	Unstable burst fracture of second lumbar vertebra, sequela
S32.028A	Other fracture of second lumbar vertebra, initial encounter for closed fracture
S32.028B	Other fracture of second lumbar vertebra, initial encounter for open fracture
S32.028D	Other fracture of second lumbar vertebra, subsequent encounter for fracture with routine healing
S32.028G	Other fracture of second lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.028K	Other fracture of second lumbar vertebra, subsequent encounter for fracture with nonunion
S32.028S	Other fracture of second lumbar vertebra, sequela
S32.029A	Unspecified fracture of second lumbar vertebra, initial encounter for closed fracture
S32.029B	Unspecified fracture of second lumbar vertebra, initial encounter for open fracture
S32.029D	Unspecified fracture of second lumbar vertebra, subsequent encounter for fracture with routine healing
S32.029G	Unspecified fracture of second lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.029K	Unspecified fracture of second lumbar vertebra, subsequent encounter for fracture with nonunion
S32.029S	Unspecified fracture of second lumbar vertebra, sequela
S32.030A	Wedge compression fracture of third lumbar vertebra, initial encounter for closed fracture
S32.030B	Wedge compression fracture of third lumbar vertebra, initial encounter for open fracture
S32.030D	Wedge compression fracture of third lumbar vertebra, subsequent encounter for fracture with routine healing
S32.030G	Wedge compression fracture of third lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.030K	Wedge compression fracture of third lumbar vertebra, subsequent encounter for fracture with nonunion
S32.030S	Wedge compression fracture of third lumbar vertebra, sequela
S32.031A	Stable burst fracture of third lumbar vertebra, initial encounter for closed fracture
S32.031B	Stable burst fracture of third lumbar vertebra, initial encounter for open fracture
S32.031D	Stable burst fracture of third lumbar vertebra, subsequent encounter for fracture with routine healing
S32.031G	Stable burst fracture of third lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.031K	Stable burst fracture of third lumbar vertebra, subsequent encounter for fracture with nonunion
S32.031S	Stable burst fracture of third lumbar vertebra, sequela
S32.032A	Unstable burst fracture of third lumbar vertebra, initial encounter for closed fracture
S32.032B	Unstable burst fracture of third lumbar vertebra, initial encounter for open fracture
S32.032D	Unstable burst fracture of third lumbar vertebra, subsequent encounter for fracture with routine healing
S32.032G	Unstable burst fracture of third lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.032K	Unstable burst fracture of third lumbar vertebra, subsequent encounter for fracture with nonunion
S32.032S	Unstable burst fracture of third lumbar vertebra, sequela
S32.038A	Other fracture of third lumbar vertebra, initial encounter for closed fracture
S32.038B	Other fracture of third lumbar vertebra, initial encounter for open fracture
S32.038D	Other fracture of third lumbar vertebra, subsequent encounter for fracture with routine healing
S32.038G	Other fracture of third lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.038K	Other fracture of third lumbar vertebra, subsequent encounter for fracture with nonunion
S32.038S	Other fracture of third lumbar vertebra, sequela
S32.039A	Unspecified fracture of third lumbar vertebra, initial encounter for closed fracture
S32.039B	Unspecified fracture of third lumbar vertebra, initial encounter for open fracture
S32.039D	

ICD-10 Codes	Description
	Unspecified fracture of third lumbar vertebra, subsequent encounter for fracture with routine healing
S32.039G	Unspecified fracture of third lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.039K	Unspecified fracture of third lumbar vertebra, subsequent encounter for fracture with nonunion
S32.039S	Unspecified fracture of third lumbar vertebra, sequela
S32.040A	Wedge compression fracture of fourth lumbar vertebra, initial encounter for closed fracture
S32.040B	Wedge compression fracture of fourth lumbar vertebra, initial encounter for open fracture
S32.040D	Wedge compression fracture of fourth lumbar vertebra, subsequent encounter for fracture with routine healing
S32.040G	Wedge compression fracture of fourth lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.040K	Wedge compression fracture of fourth lumbar vertebra, subsequent encounter for fracture with nonunion
S32.040S	Wedge compression fracture of fourth lumbar vertebra, sequela
S32.041A	Stable burst fracture of fourth lumbar vertebra, initial encounter for closed fracture
S32.041B	Stable burst fracture of fourth lumbar vertebra, initial encounter for open fracture
S32.041D	Stable burst fracture of fourth lumbar vertebra, subsequent encounter for fracture with routine healing
S32.041G	Stable burst fracture of fourth lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.041K	Stable burst fracture of fourth lumbar vertebra, subsequent encounter for fracture with nonunion
S32.041S	Stable burst fracture of fourth lumbar vertebra, sequela
S32.042A	Unstable burst fracture of fourth lumbar vertebra, initial encounter for closed fracture
S32.042B	Unstable burst fracture of fourth lumbar vertebra, initial encounter for open fracture
S32.042D	Unstable burst fracture of fourth lumbar vertebra, subsequent encounter for fracture with routine healing
S32.042G	Unstable burst fracture of fourth lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.042K	Unstable burst fracture of fourth lumbar vertebra, subsequent encounter for fracture with nonunion
S32.042S	Unstable burst fracture of fourth lumbar vertebra, sequela
S32.048A	Other fracture of fourth lumbar vertebra, initial encounter for closed fracture
S32.048B	Other fracture of fourth lumbar vertebra, initial encounter for open fracture
S32.048D	Other fracture of fourth lumbar vertebra, subsequent encounter for fracture with routine healing
S32.048G	Other fracture of fourth lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.048K	Other fracture of fourth lumbar vertebra, subsequent encounter for fracture with nonunion
S32.048S	Other fracture of fourth lumbar vertebra, sequela
S32.049A	Unspecified fracture of fourth lumbar vertebra, initial encounter for closed fracture
S32.049B	Unspecified fracture of fourth lumbar vertebra, initial encounter for open fracture
S32.049D	Unspecified fracture of fourth lumbar vertebra, subsequent encounter for fracture with routine healing
S32.049G	Unspecified fracture of fourth lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.049K	Unspecified fracture of fourth lumbar vertebra, subsequent encounter for fracture with nonunion
S32.049S	Unspecified fracture of fourth lumbar vertebra, sequela
S32.050A	Wedge compression fracture of fifth lumbar vertebra, initial encounter for closed fracture
S32.050B	Wedge compression fracture of fifth lumbar vertebra, initial encounter for open fracture
S32.050D	Wedge compression fracture of fifth lumbar vertebra, subsequent encounter for fracture with routine healing
S32.050G	Wedge compression fracture of fifth lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.050K	Wedge compression fracture of fifth lumbar vertebra, subsequent encounter for fracture with nonunion
S32.050S	Wedge compression fracture of fifth lumbar vertebra, sequela
S32.051A	Stable burst fracture of fifth lumbar vertebra, initial encounter for closed fracture
S32.051B	Stable burst fracture of fifth lumbar vertebra, initial encounter for open fracture
S32.051D	Stable burst fracture of fifth lumbar vertebra, subsequent encounter for fracture with routine healing

ICD-10 Codes	Description
S32.051G	Stable burst fracture of fifth lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.051K	Stable burst fracture of fifth lumbar vertebra, subsequent encounter for fracture with nonunion
S32.051S	Stable burst fracture of fifth lumbar vertebra, sequela
S32.052A	Unstable burst fracture of fifth lumbar vertebra, initial encounter for closed fracture
S32.052B	Unstable burst fracture of fifth lumbar vertebra, initial encounter for open fracture
S32.052D	Unstable burst fracture of fifth lumbar vertebra, subsequent encounter for fracture with routine healing
S32.052G	Unstable burst fracture of fifth lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.052K	Unstable burst fracture of fifth lumbar vertebra, subsequent encounter for fracture with nonunion
S32.052S	Unstable burst fracture of fifth lumbar vertebra, sequela
S32.058A	Other fracture of fifth lumbar vertebra, initial encounter for closed fracture
S32.058B	Other fracture of fifth lumbar vertebra, initial encounter for open fracture
S32.058D	Other fracture of fifth lumbar vertebra, subsequent encounter for fracture with routine healing
S32.058G	Other fracture of fifth lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.058K	Other fracture of fifth lumbar vertebra, subsequent encounter for fracture with nonunion
S32.058S	Other fracture of fifth lumbar vertebra, sequela
S32.059A	Unspecified fracture of fifth lumbar vertebra, initial encounter for closed fracture
S32.059B	Unspecified fracture of fifth lumbar vertebra, initial encounter for open fracture
S32.059D	Unspecified fracture of fifth lumbar vertebra, subsequent encounter for fracture with routine healing
S32.059G	Unspecified fracture of fifth lumbar vertebra, subsequent encounter for fracture with delayed healing
S32.059K	Unspecified fracture of fifth lumbar vertebra, subsequent encounter for fracture with nonunion
S32.059S	Unspecified fracture of fifth lumbar vertebra, sequela
S33.0XXA	Traumatic rupture of lumbar intervertebral disc, initial encounter
S33.0XXD	Traumatic rupture of lumbar intervertebral disc, subsequent encounter
S33.0XXS	Traumatic rupture of lumbar intervertebral disc, sequela
S33.100A	Subluxation of unspecified lumbar vertebra, initial encounter
S33.100D	Subluxation of unspecified lumbar vertebra, subsequent encounter
S33.100S	Subluxation of unspecified lumbar vertebra, sequela
S33.101A	Dislocation of unspecified lumbar vertebra, initial encounter
S33.101D	Dislocation of unspecified lumbar vertebra, subsequent encounter
S33.101S	Dislocation of unspecified lumbar vertebra, sequela
S33.110A	Subluxation of L1/L2 lumbar vertebra, initial encounter
S33.110D	Subluxation of L1/L2 lumbar vertebra, subsequent encounter
S33.110S	Subluxation of L1/L2 lumbar vertebra, sequela
S33.111A	Dislocation of L1/L2 lumbar vertebra, initial encounter
S33.111D	Dislocation of L1/L2 lumbar vertebra, subsequent encounter
S33.111S	Dislocation of L1/L2 lumbar vertebra, sequela
S33.120A	Subluxation of L2/L3 lumbar vertebra, initial encounter
S33.120D	Subluxation of L2/L3 lumbar vertebra, subsequent encounter
S33.120S	Subluxation of L2/L3 lumbar vertebra, sequela
S33.121A	Dislocation of L2/L3 lumbar vertebra, initial encounter
S33.121D	Dislocation of L2/L3 lumbar vertebra, subsequent encounter
S33.121S	Dislocation of L2/L3 lumbar vertebra, sequela
S33.130A	Subluxation of L3/L4 lumbar vertebra, initial encounter
S33.130D	Subluxation of L3/L4 lumbar vertebra, subsequent encounter
S33.130S	Subluxation of L3/L4 lumbar vertebra, sequela
S33.131A	Dislocation of L3/L4 lumbar vertebra, initial encounter
S33.131D	Dislocation of L3/L4 lumbar vertebra, subsequent encounter
S33.131S	Dislocation of L3/L4 lumbar vertebra, sequela
S33.140A	Subluxation of L4/L5 lumbar vertebra, initial encounter
S33.140D	Subluxation of L4/L5 lumbar vertebra, subsequent encounter
S33.140S	Subluxation of L4/L5 lumbar vertebra, sequela
S33.141A	Dislocation of L4/L5 lumbar vertebra, initial encounter
S33.141D	Dislocation of L4/L5 lumbar vertebra, subsequent encounter

ICD-10 Codes	Description
S33.141S	Dislocation of L4/L5 lumbar vertebra, sequela
S33.5XXA	Sprain of ligaments of lumbar spine, initial encounter
S33.5XXD	Sprain of ligaments of lumbar spine, subsequent encounter
S33.5XXS	Sprain of ligaments of lumbar spine, sequela
S33.6XXA	Sprain of sacroiliac joint, initial encounter
S33.6XXD	Sprain of sacroiliac joint, subsequent encounter
S33.6XXS	Sprain of sacroiliac joint, sequela
S34.21XA	Injury of nerve root of lumbar spine, initial encounter
S34.21XD	Injury of nerve root of lumbar spine, subsequent encounter
S34.21XS	Injury of nerve root of lumbar spine, sequela
S34.22XA	Injury of nerve root of sacral spine, initial encounter
S34.22XD	Injury of nerve root of sacral spine, subsequent encounter
S34.22XS	Injury of nerve root of sacral spine, sequela
S39.002A	Unspecified injury of muscle, fascia and tendon of lower back, initial encounter
S39.002D	Unspecified injury of muscle, fascia and tendon of lower back, subsequent encounter
S39.002S	Unspecified injury of muscle, fascia and tendon of lower back, sequela
S39.012A	Strain of muscle, fascia and tendon of lower back, initial encounter
S39.012D	Strain of muscle, fascia and tendon of lower back, subsequent encounter
S39.012S	Strain of muscle, fascia and tendon of lower back, sequela
S39.022A	Laceration of muscle, fascia and tendon of lower back, initial encounter
S39.022D	Laceration of muscle, fascia and tendon of lower back, subsequent encounter
S39.022S	Laceration of muscle, fascia and tendon of lower back, sequela
S39.092A	Other injury of muscle, fascia and tendon of lower back, initial encounter
S39.092D	Other injury of muscle, fascia and tendon of lower back, subsequent encounter
S39.092S	Other injury of muscle, fascia and tendon of lower back, sequela
Z00.6	Encounter for examination for normal comparison and control in clinical research program

ICD-10 Codes that DO NOT Support Medical Necessity
Group 1 Paragraph: For TENS used for CLBP as part of an approved study, all codes not specified.

For all other TENS uses, not specified.

Group 1 Codes: N/A

ICD-10 Additional Information

For other uses of TENS (acute post-operative pain (criterion I), chronic pain other than CLBP(criterion II), there are no specified diagnosis codes.
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General Information

Associated Information
DOCUMENTATION REQUIREMENTS

Section 1833(e) of the Social Security Act precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider". It is expected that the beneficiary's medical records will reflect the need for the care provided. The beneficiary's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be available upon request.

GENERAL DOCUMENTATION REQUIREMENTS

In order to justify payment for DMEPOS items, suppliers must meet the following requirements:

- Prescription (orders)
- Medical Record Information (including continued need/use if applicable)
- Correct Coding
- Proof of Delivery

Refer to the LCD-related Standard Documentation Requirements article, located at the bottom of this policy under the Related Local Coverage Documents section for additional information regarding these requirements.

Refer to the Supplier Manual for additional information on documentation requirements.

Refer to the DME MAC web sites for additional bulletin articles and other publications related to this LCD.

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS

Items covered in this LCD have additional policy-specific requirements that must be met prior to Medicare reimbursement.

Refer to the LCD-related Policy article, located at the bottom of this policy under the Related Local Coverage Documents section for additional information.

Miscellaneous

Appendices

TENS used to treat CLBP is provided under limited coverage. Reimbursement is only available for beneficiaries who are enrolled in an approved clinical trial. CMS maintains a list of policies that require study participation as a condition of coverage on the CMS web site. For each policy the approved studies are listed and a link provided to the study on the clinicaltrials.gov web site. The clinicaltrials.gov identifier number required on each claim is listed on this site.

Utilization Guidelines

Refer to Coverage Indications, Limitations, and/or Medical Necessity

Sources of Information and Basis for Decision

Reserved for future use. Back to Top

Revision History Information

Revision History Date	Revision History Number	Revision History Explanation	Reason(s) for Change
01/01/2017	R4	**Revision Effective Date: 01/01/2017** COVERAGE INDICATIONS, INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Removed: Standard Documentation Language Added: New reference language and directions to Standard Documentation Requirements Added: General Requirements Revised: Refill Requirements DOCUMENTATION REQUIREMENTS: Removed: Standard Documentation Language Added: General Documentation Requirements	• Provider Education/Guidance

Revision History Date	Revision History Number	Revision History Explanation	Reason(s) for Change
		Added: New reference language and directions to Standard Documentation Requirements POLICY SPECIFIC DOCUMENTATION REQUIREMENTS: Removed: Standard Documentation Language Added: Direction to Standard Documentation Requirements Removed: Supplier Manual reference under Miscellaneous Removed: PIM reference under Appendices RELATED LOCAL COVERAGE DOCUMENTS: Added: LCD-related Standard Documentation Requirements article	
07/01/2016	R3	Effective July 1, 2016 oversight for DME MAC LCDs 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 LCDs.	• Change in Assigned States or Affiliated Contract Numbers
10/01/2015	R2	Revision Effective Date: 10/31/2014 COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility DOCUMENTATION REQUIREMENTS: Revised: Standard Documentation Language for WOPD to make consistent with ACA requirements Revised: Standard Documentation Language to add who can enter date of delivery date on the POD Added: Instructions for Equipment Retained from a Prior Payer Added: Repair/Replacement section	• Provider Education/Guidance
10/01/2015	R1	**Revision Effective Date: 10/01/2015** ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY: ICD-10 diagnosis codes updated based on ICD-10 Conversion/Coding Infrastructure Revisions/ICD-9 Updates to National Coverage Determinations (NCDs) Maintenance CR	• Revisions Due To ICD -10-CM Code Changes

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Associated Documents

Attachments CMS848-TENS (PDF - 72 KB)

Related Local Coverage Documents Article(s) A55426 - Standard Documentation Requirements for All Claims Submitted to DME MACs A52520 - Transcutaneous Electrical Nerve Stimulators (TENS) - Policy Article

Related National Coverage Documents N/A

Public Version(s) Updated on 05/10/2017 with effective dates 01/01/2017 - N/A Updated on 06/07/2016 with effective dates 07/01/2016 - 12/31/2016 Updated on 05/14/2015 with effective dates 10/01/2015 - 06/30/2016 Updated on 09/11/2014 with effective dates 10/01/2015 - N/A Updated on 04/04/2014 with effective dates 10/01/2015 - N/A Back to Top

Keywords

N/A Read the **LCD Disclaimer** Back to Top

END OF LOCAL COVERAGE DETERMINATION

Per the Code of Federal Regulations, 42 C.F.R § 426. 325, only those portions of the currently effective Local Coverage Determination (LCD) that are based on section 1862(a)(1)(A) of the Social Security Act, may be challenged through an acceptable complaint as described in 42 C.F.R § 426.400. Also, per 42 C.F.R § 426.325 items that are not reviewable, and therefore cannot be challenged, include the Policy Article. Please note the distinction of the documents when reviewing the materials.

Local Coverage Article:
Transcutaneous Electrical Nerve Stimulators (TENS) - Policy Article (A52520)

Links in PDF documents are not guaranteed to work. To follow a web link, please use the MCD Website.

Contractor Information

Contractor Name	Contract Type	Contract Number	Jurisdiction	State(s)
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 North Carolina New Mexico Oklahoma Puerto Rico South Carolina Tennessee Texas Virginia Virgin Islands West Virginia
Noridian Healthcare Solutions, LLC	DME MAC	16013 - DME MAC	J-A	Connecticut District of Columbia Delaware Massachusetts Maryland Maine New Hampshire New Jersey New York - Entire State Pennsylvania Rhode Island Vermont
Noridian Healthcare Solutions, LLC	DME MAC	19003 - DME MAC	J-D	Alaska American Samoa Arizona California - Entire State Guam Hawaii Iowa Idaho Kansas Missouri - Entire State Montana North Dakota Nebraska Nevada

Contractor Name	Contract Type	Contract Number	Jurisdiction	State(s)
				Oregon South Dakota Utah Washington Wyoming Northern Mariana Islands

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Article Information

General Information

Article ID
A52520

Original ICD-9 Article ID
A37219
A37064
A47130
A37074

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

Original Article Effective Date
10/01/2015

Revision Effective Date
01/01/2017

Revision Ending Date
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 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 electrodes, lead wires, batteries, etc. If a TENS unit (E0720 or E0730) is purchased, the allowance includes lead wires and one month's supply of 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 42 CFR 410.38(g)

42 CFR 410.38(g) requires a face-to-face evaluation and a specific written order prior to delivery for specified HCPCS codes. CMS provides a list of the specified codes, which is periodically updated, located here.

Claims for the specified items subject to 42 CFR 410.38(g) that do not meet the requirements specified in the LCD-related Standard Documentation Requirements Article will be denied as statutorily noncovered – failed to meet statutory requirements.

If the supplier delivers the item prior to receipt of a written order, it will be denied as statutorily noncovered. If the written order is not obtained prior to delivery, payment will not be made for that item even if a written order is subsequently obtained. If a similar item is subsequently provided by an unrelated supplier who has obtained a written order prior to delivery, 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)

For CLBP covered under criterion III of the related LCD, there must be information in the medical record describing:

- participation in an approved study
- the qualifying diagnosis

For CLBP, each claim must include:

- The diagnosis describing the CLBP
- The "clinicaltrials.gov" identifier number must be included in the narrative field on each claim. Refer to the Appendices section of the related LCD for additional information.

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, II, and III 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 physician, must be kept on file by the supplier and made available upon request. The CMN may act as a substitute for the detailed written order if it contains the same information as required in a detailed written order. The CMN for TENS is CMS Form 848 (DME form 06.03B). In addition to the information that the physician 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 physician 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

KX, GA, GZ AND Q0 (zero) 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.

In addition to the completion of a CMN and use of the KX, GA, and GZ modifiers, suppliers must add a Q0 (zero) modifier to codes E0720 and E0730 used for CLBP only if all of the criteria described in section III of the COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY section of the related LCD have been met.

If all of the criteria described in section III of the COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY section of the related LCD have not been met, the Q0 (zero) must not be used.

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) includes 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. Back to Top

Coding Information

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

CPT/HCPCS Codes N/A

ICD-10 Codes that are Covered N/A
ICD-10 Codes that are Not Covered N/A
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Revision History Information

Revision History Date	Revision History Number	Revision History Explanation
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
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

Back to Top **Related Local Coverage Document(s)** Article(s) A55426 - Standard Documentation Requirements for All Claims Submitted to DME MACs LCD(s) L33802 - Transcutaneous Electrical Nerve Stimulators (TENS)

Related National Coverage Document(s) N/A

Statutory Requirements URL(s) N/A

Rules and Regulations URL(s) N/A

CMS Manual Explanations URL(s) N/A

Other URL(s) N/A

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Keywords

N/A Read the **Article Disclaimer** Back to Top