POLICY SUMMARY

Overview
TENS and/or NMES can ordinarily be delivered to patients through the use of conventional electrodes, adhesive tapes and lead wires. There may be times, however, where it might be medically necessary for certain patients receiving TENS or NMES treatment to use, as an alternative to conventional electrodes, adhesive tapes and lead wires, a form-fitting conductive garment (i.e., a garment with conductive fibers which are separated from the patients' skin by layers of fabric).

Guidelines
A form-fitting conductive garment (and medically necessary related supplies) may be covered under the program only when:

- It has received permission or approval for marketing by the Food and Drug Administration;
- It has been prescribed by a physician for use in delivering covered TENS or NMES treatment; and
- One of the medical indications outlined below is met:
  - The patient cannot manage without the conductive garment because there is such a large area or so many sites to be stimulated that it is not feasible to use conventional electrodes, adhesive tapes and lead wires;
  - The patient 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 patient has a documented medical condition such as skin problems that preclude the application of conventional electrodes, adhesive tapes and lead wires;
  - The patient requires electrical stimulation beneath a cast either to treat disuse atrophy, where the nerve supply to the muscle is intact, or to treat chronic intractable pain; or
  - The patient has a medical need for rehabilitation strengthening (pursuant to a written plan of rehabilitation) following an injury where the nerve supply to the muscle is intact.
A conductive garment is not covered for use with a TENS device during the trial period specified in §160.3 unless:
- The patient has a documented skin problem prior to the start of the trial period; and
- The carrier’s medical consultants are satisfied that use of such an item is medically necessary for the patient. (See conditions for coverage of the use of TENS in the diagnosis and treatment of chronic intractable pain in §§160.3, 160.13, and 160.27 and the use of NMES in the treatment of disuse atrophy in §150.4).

**Cross Reference:** Also see NCDs on NMES in the Treatment of Disuse Atrophy (§150.4), Assessing Patients Suitability for ENS (§160.7), NMES (§160.12), and TENS (§280.13).

### APPLICABLE CODES

The following list(s) of codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4556</td>
<td>Electrodes (e.g., apnea monitor), per pair (bundled/excluded code except for HH, DME)</td>
</tr>
<tr>
<td>A4557</td>
<td>Lead wires (e.g., apnea monitor), per pair (bundled/excluded code except for HH, DME)</td>
</tr>
<tr>
<td>A4558</td>
<td>Conductive gel or paste, for use with electrical device (e.g., TENS, NMES), per oz (Bundled/Excluded code except for HH and DME)</td>
</tr>
<tr>
<td>A4595</td>
<td>Electrical stimulator supplies, 2 lead, per month, (e.g., TENS, NMES)</td>
</tr>
<tr>
<td>A4630</td>
<td>Replacement batteries, medically necessary, transcutaneous electrical stimulator, owned by patient</td>
</tr>
<tr>
<td>E0731</td>
<td>Form-fitting conductive garment for delivery of TENS or NMES (with conductive fibers separated from the patient's skin by layers of fabric)</td>
</tr>
</tbody>
</table>

**ICD-10 Diagnosis Codes**

See related NCD and LCD for ICD-10 coding guidelines.

### QUESTIONS AND ANSWERS

<table>
<thead>
<tr>
<th>Q: Is a detailed written (DWO) required?</th>
</tr>
</thead>
<tbody>
<tr>
<td>A:</td>
</tr>
<tr>
<td>1. A detailed written order (DWO) is required before billing. Someone other than the ordering physician may produce the DWO. However, the ordering physician must review the content and sign and date the document. It must contain:</td>
</tr>
<tr>
<td>• Beneficiary's name</td>
</tr>
<tr>
<td>• Physician's name</td>
</tr>
<tr>
<td>• Date of the order and the start date, if start date is different from the date of the order</td>
</tr>
<tr>
<td>• Detailed description of the item(s) (see below for specific requirements for selected items)</td>
</tr>
<tr>
<td>• Physician signature and signature date</td>
</tr>
</tbody>
</table>

### PURPOSE

The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers’ submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:
- Medicare coding or billing requirements, and/or
- Medical necessity coverage guidelines; including documentation requirements.

UnitedHealthcare follows Medicare guidelines such as LCDs, NCDs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the References section below to view the Medicare source materials used to develop this resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.
REFERENCES

CMS National Coverage Determinations (NCDs)
NCD 160.13 Supplies Used in the Delivery of Transcutaneous Electrical Nerve Stimulation (TENS) and Neuromuscular Electrical Stimulation (NMES)
Reference NCDs:
NCD 10.2 Transcutaneous Electrical Nerve Stimulation (TENS) for Acute Post-Operative Pain
NCD 150.5 Diathermy Treatment
NCD 160.2 Treatment of Motor Function Disoders with Electric Nerve Stimulation
NCD 160.7 Electrical Nerve Stimulators
NCD 160.7.1 Assessing Patient's Suitability for Electrical Nerve Stimulation Therapy
NCD 160.12 Neuromuscular Electrical Stimulation (NMES)
NCD 160.15 Electrotherapy for Treatment of Facial Nerve Paralysis (Bell's Palsy)
NCD 160.19 Phrenic Nerve Stimulator
NCD 160.27 Transcutaneous Electrical Nerve Stimulation (TENS) for Chronic Low Back Pain (CLBP)
NCD 280.13 Transcutaneous Electrical Nerve Stimulators (TENS)

CMS Local Coverage Determinations (LCDs)
Refer to the related NCD for specific LCDs.

CMS Articles
Refer to the related NCDs for specific Articles.

CMS Benefit Policy Manual
Chapter 15; § 110 Durable Medical Equipment - General

CMS Claims Processing Manual
Chapter 20; § 30.1.2 Transcutaneous Electrical Nerve Stimulator (TENS)

MLN Matters
Article MM7836, Transcutaneous Electrical Nerve Stimulation (TENS) for Chronic Low Back Pain (CLBP)

Related Medicare Advantage Policy Guidelines
Assessing Patient's Suitability for Electrical Nerve Stimulation Therapy (NCD 160.7.1)
Diathermy Treatment (NCD 150.5)
Electrical Nerve Stimulators (NCD 160.7)
Electrotherapy for Treatment of Facial Nerve Paralysis (Bell's Palsy) (NCD 160.15)
Neuromuscular Electrical Stimulation (NMES) (NCD 160.12)
Phrenic Nerve Stimulator (NCD 160.19)
Transcutaneous Electrical Nerve Stimulation (TENS) for Acute Post-Operative Pain (NCD 10.2)
Transcutaneous Electrical Nerve Stimulation (TENS) for Chronic Low Back Pain (CLBP) (NCD 160.27)
Treatment of Motor Function Disorders with Electric Nerve Stimulation (NCD 160.2)

UnitedHealthcare Commercial Policies
Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation

GUIDELINE HISTORY/REVISION INFORMATION

Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

<table>
<thead>
<tr>
<th>Date</th>
<th>Action/Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/01/2019</td>
<td>• Reorganized policy template; relocated Terms and Conditions and Purpose section</td>
</tr>
<tr>
<td>08/08/2018</td>
<td>• Annual review; no changes</td>
</tr>
</tbody>
</table>

TERMS AND CONDITIONS

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document* and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services...
Supplies Used in the Delivery of Transcutaneous Electrical Nerve Stimulation (TENS) and
Neuromuscular Electrical Stimulation (NMES) (NCD 160.13)

Medicare Advantage Policy Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of publication, and is provided on an "AS IS" basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage Policy Guidelines use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

Medicare Advantage Policy Guidelines are the property of UnitedHealthcare. Unauthorized copying, use and distribution of this information are strictly prohibited.

*For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the Administrative Guide.