TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION (TENS) FOR CHRONIC LOW BACK PAIN (CLBP) (NCD 160.27)

Guideline Number: MPG315.06

Overview
The TENS is a type of electrical nerve stimulator that is employed to treat chronic intractable pain. This stimulator is attached to the surface of the patient's skin over the peripheral nerve to be stimulated. It may be applied in a variety of settings (a physician's office, in the patient's home, or in an outpatient clinic).

For the purposes of this decision, chronic low back pain (CLBP) is defined as:

- An episode of low back pain that has persisted for three months or longer; and
- Is not a manifestation of a clearly defined and generally recognizable primary disease entity. For example, there are cancers that, through metastatic spread to the spine or pelvis, may elicit pain in the lower back as a symptom; and certain systemic diseases such as rheumatoid arthritis and multiple sclerosis manifest many debilitating symptoms of which low back pain is not the primary focus.

Guidelines
Nationally Non-Covered Indications
TENS is not reasonable and necessary for the treatment of CLBP under section 1862(a) (1)(A) of the Act. As of June 2015 The Centers for Medicare & Medicaid Services (CMS) coverage for Transcutaneous Electrical Nerve Stimulation (TENS) for CLBP under Coverage with Evidence Development (CED) has expired.

Other
See §160.13 for an explanation of coverage of medically necessary supplies for the effective use of TENS. See §160.7.1 for an explanation of coverage for assessing patients suitability for electrical nerve stimulation therapy. See §10.2 for an explanation of coverage of transcutaneous electrical nerve stimulation (TENS) for acute post-operative pain. Please note, §280.13Transcutaneous Electrical Nerve Stimulators (TENS) NCD has been removed from the NCD manual and incorporated into NCD 160.27.
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 and DME)</td>
</tr>
<tr>
<td>A4557</td>
<td>Lead wires (e.g., apnea monitor), per pair (Bundled/excluded code except for HH and 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>E0720</td>
<td>Transcutaneous electrical nerve stimulation (TENS) device, 2 lead, localized stimulation</td>
</tr>
<tr>
<td>E0730</td>
<td>Transcutaneous electrical nerve stimulation (TENS) device, 4 or more leads, for multiple nerve stimulation</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>

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 160.27 Transcutaneous Electrical Nerve Stimulation (TENS) for Chronic Low Back Pain (CLBP)
Reference NCDs: NCD 10.2 Transcutaneous Electrical Nerve Stimulation (TENS) for Acute Post-Operative Pain; NCD 160.7.1 Assessing Patient's Suitability for Electrical Nerve Stimulation Therapy.

CMS Local Coverage Determinations (LCDs)

<table>
<thead>
<tr>
<th>LCD</th>
<th>CGS: AL, AR, CO, ID, IL, FL, GA, KY, LA, MI, MN, MS, NC, NM, OH, OK, PR, SC, TN, TX, VA, VI, WI, WV</th>
<th>NORIDIAN: AK, AS, AZ, CA, CT, DC, DE, GU, HI, IA, ID, KS, MA, MD, ME, MO, MP, MT, ND, NE, NH, NJ, NV, NY, OR, PA, RI, SD, UT, VT, WA, WY</th>
</tr>
</thead>
<tbody>
<tr>
<td>L3802 (Transcutaneous Electrical Nerve Stimulators (TENS))</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**CMS Articles**

<table>
<thead>
<tr>
<th>Article</th>
<th>DME</th>
</tr>
</thead>
</table>
| A52520 (Transcutaneous Electrical Nerve Stimulators (TENS) - Policy Article - Effective October 2015) | CGS: AL, AR, CO, ID, IL, FL, GA, KY, LA, MI, MN, MS, NC, NM, OH, OK, PR, SC, TN, TX, VA, VI, WI, WV  
Noridian: AK, AS, AZ, CA, CT, DC, DE, GU, HI, IA, ID, KS, MA, MD, ME, MO, MP, MT, ND, NE, NH, NJ, NV, NY, OR, PA, RI, SD, UT, VT, WA, WV |

**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)*

**Others**

See NCD 160.13 for an explanation of coverage of medically necessary supplies for the effective use of TENS.
See NCD 160.7.1 for an explanation of coverage for assessing patient’s suitability for electrical nerve stimulation therapy.
See NCD 10.2 for an explanation of coverage of transcutaneous electrical nerve stimulation (TENS) for acute post-operative pain.

**Note:** NCD 280.13 Transcutaneous Electrical Nerve Stimulators (TENS) NCD has been removed from the NCD manual and incorporated into NCD 160.27.

**GUIDE LINE 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>06/12/2019</td>
<td>Updated language; CMS includes language in the NCD that has since expired</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 are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes the Medicare Advantage Policy Guidelines.

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.