TENS Units

Face-to-Face Documentation Requirements

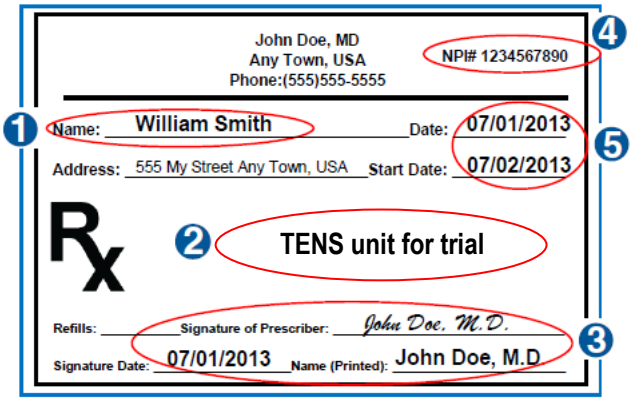
For Any New Order On Or After July 1, 2013

- The patient's medical record must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity of the items ordered.
- A ***Practitioner*** must have a Face-to-Face Evaluation with the beneficiary prior to the written DME order and document the Face-to-Face Evaluation in the patient's medical record. A ***Practitioner*** is:
  - Medical Doctor
  - Doctor of Osteopathic Medicine
  - Doctor of Podiatric Medicine
  - Physician Assistant
  - Nurse Practitioner
  - Clinical Nurse Specialist
- Every item subject to Face-to-Face requirements is also subject to mandatory Specific Written Orders **prior** to delivery. A complete Specific Written Order must be received before the item may be delivered to the patient.
- The Face-to-Face Evaluation must be signed by the Prescribing Practitioner
- Medicare beneficiaries discharged from a hospital do not need to receive a separate Face-to-Face Evaluation, so long as the Prescribing Practitioner who performed the Face-to-Face encounter in the hospital issues the DME order within six months after the patient's discharge from the hospital.
- The Face-to-Face Evaluation must occur during the six months prior to the written order for each item.
- Every item subject to Face-to-Face requirements is also subject to mandatory Specific Written Orders **prior** to delivery. A complete Specific Written Order must be received before the item may be delivered to the patient.

A Written Order for the item must be received before the delivery of the item can take place. A Written Order prior to delivery has five (5) mandatory elements, also referred to as a Five Element Order (5EO).

1. Beneficiary's name
2. Item of DME ordered - this may be general – e.g., "hospital bed"– or may be more specific.
3. Signature of the prescribing practitioner and date signed
4. Prescribing practitioner's National Practitioner Identifier (NPI)
5. The date of the order

A date stamp or equivalent must be used to document the date that the order was received.



Additional requirements, if applicable:

- Dosage or concentration
- Route of administration
- Frequency of use
- Duration of infusion
- Quantity to be dispensed
- Number of refills

Documentation in Medical Records Required by CMS

Documentation Requirements

- ☐ Duration of patient's condition
- ☐ Clinical course
- ☐ Prognosis
- ☐ Nature and extent of functional limitations
- ☐ Other therapeutic interventions and results

Key Items to Address

- ☐ Why does the patient require the item?
- ☐ Do the physical examination findings support the need for the item?
- ☐ Signs and symptoms that indicate the need for the item
- ☐ Diagnoses that are responsible for these signs and symptoms
- ☐ Other diagnoses that may relate to the need for the item

TENS Units

Face-to-Face Documentation Requirements

HCPCS Codes included:

E0720, E0730, E0731

Coverage Criteria

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 unit is covered for the treatment of patients with chronic, intractable pain or acute post-operative pain when one of the following criteria are met and documented in the patient's medical record:

- **Acute Post-Operative Pain**
  - -Coverage is limited to 30 days from the day of surgery. Payment will be made only as a rental.
- **Chronic Pain Other Than Lower Back Pain**
  - **All of the following criteria must be met and documented in the patient's medical record:**
  - -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 (3) months
  - -Other appropriate treatment modalities must have been tried and failed.
- **Chronic Low Back Pain (CLBP)**
  - -TENS therapy for CLBP is only covered when all of the following criteria are met and documented in the patient's medical record:
  - **-The patient has one of the listed diagnoses:**

-Lumbosacral root lesions, not elsewhere classified
-Sacroilitis, not elsewhere classified
-Lumbosacral spondylosis without myelopathy
-Thoracic or lumbar spondylosis with myelopathy-lumbar region
-Lumbar intervertebral disc without myelopathy
-Lumbosacral intervertebral disc
-Intervertebral disc disorder myelopathy - lumbar region
-Post laminectomy syndrome—lumbar region
-Other and unspecified disc disorders, lumbar region
-Spinal stenosis, lumbar region without neurogenic claudication
-Spinal stenosis, lumbar region with neurogenic claudication
-Lumbago
-Sciatica
-Thoracic or lumbosacral neuritis or radiculitis, unspecified, radicular syndrome of lower extremities
-Acquired spondylolysthesis
-Non-allopathic lesions NEC (not elsewhere classified—lumbar region
-Spondylosis, lumbosacral region
-Spondylolysthesis
-Fracture of vertebral column without mention of spinal cord injury, lumbar, closed
-Sprains and strains of sacroiliac region—lumbosacral (joint) (ligament)
-Sprains and strains of sacroiliac ligament
-Sprains and strains of other and unspecified parts of back, lumbar
-Injury to nerve roots and spinal plexus, lumbar root

-The patient is enrolled in an approved clinical study that meets all of the requirements set forth by Medicare.

