Transcutaneous Electrical Nerve Stimulation (TENS)

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Policy
Blue Cross and Blue Shield of Kansas City (Blue KC) may provide coverage for transcutaneous electrical stimulation (TENS) when it is determined to be medically necessary because the criteria shown below are met.

Please note that this is a type of electrical stimulation that is considered a benefit exclusion in many health plan contracts.

When Policy Topic is covered
A trial of transcutaneous electrical nerve stimulation (TENS) of at least 30 days may be considered medically necessary to establish efficacy for the management of refractory chronic pain (e.g., chronic musculoskeletal pain or neuropathic pain) that causes significant disruption of function when the following conditions have been met:

- The pain is unresponsive to at least 3 months of conservative medical therapy; AND
- The trial is monitored by a physician.

Continued use of transcutaneous electrical nerve stimulation (TENS) may be considered medically necessary for treatment of refractory chronic pain (e.g., chronic musculoskeletal or neuropathic pain) that causes significant disruption of function when the following conditions have been met:

- Efficacy has been demonstrated in an initial therapeutic trial (see considerations); AND
- Compliance has been demonstrated in the therapeutic trial with the device used on a regular basis (e.g., daily or near daily use) throughout the trial period.

When Policy Topic is not covered
TENS is considered investigational for the management of acute pain (e.g., postoperative or during labor and delivery).
The use of TENS for any other condition, including the treatment of dementia and prevention of migraine headaches, is considered *investigational*.

**Considerations**

TENS units may be covered for Ford and BPU members when prescribed by a physician. Electrical stimulation (97014 or 97032) provided in the office setting is a covered benefit for Ford and BPU members.

Refractory chronic pain is defined in this policy as pain that causes significant disruption of function and has not responded to at least 3 months of conservative therapy, including non-steroidal anti-inflammatory medications, ice, rest and/or physical therapy.

Documentation for the trial should include:

- Initial assessment/evaluation of the nature, duration, and perceived intensity of pain;
- The types and duration of prior treatments;
- Treatment plan including ongoing medications and proposed use of TENS unit including the frequency and duration of treatment.

Clinical summary of the trial to determine efficacy should include:

- Perceived intensity of pain with and without TENS (e.g., 2 point or 30% improvement in VAS);
- Ongoing medication requirements for pain relief (if any);
- Other modalities (if any) in use for pain control;
- Actual use of TENS on a daily basis (frequency and duration of application).

TENS devices may be delivered through a practitioner and require a prescription, or obtained without a prescription. It is possible that prescribed devices provide higher intensity stimulation than units sold directly to the public.

**Description of Procedure or Service**

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Transcutaneous electrical nerve stimulation (TENS) describes the application of electrical stimulation to the surface of the skin at the site of pain. TENS may be applied in a variety of settings (in the patient's home, a physician's office, or in an outpatient clinic).

The evidence for TENS in individuals who have chronic pain includes numerous randomized controlled trials (RCTs) and systematic reviews. Relevant outcomes are symptoms, functional outcomes, quality of life, and medication use. The overall strength of the evidence is weak. The best evidence exists for treatment of chronic, intractable pain. Available evidence indicates that TENS can improve chronic intractable pain in some patients, and there is support for its use in clinical guidelines by specialty societies. To best direct TENS toward patients who will benefit, a short-term trial of TENS is appropriate, with continuation only in patients who show an initial improvement. The evidence is sufficient to determine qualitatively that the technology results in a meaningful improvement in the net health outcome.

The evidence for TENS in individuals who have acute pain includes RCTs and systematic reviews. Relevant outcomes are symptoms and medication use. Overall, evidence for the use of TENS from high quality trials remains inconclusive for most indications. A Cochrane review of TENS for acute pain (eg, cervical laser treatment, venipuncture, screening flexible sigmoidoscopy, postpartum uterine contractions, rib fractures) found some evidence that TENS reduces pain intensity over and above that seen with placebo, but the high risk of bias made definitive conclusions impossible. For the treatment of pain after total knee arthroplasty, 1 large RCT found no benefit of TENS compared with sham TENS. For the prevention of migraine headaches, 1 small RCT reported a greater proportion of patients achieving at least 50% reduction in migraines with TENS than with sham placebo, and modest reductions in the number of total headache and migraine days. This manufacturer-sponsored trial needs corroboration before conclusions can be made about the efficacy of TENS for preventing migraine headaches. The evidence is insufficient to determine the effects of the technology on health outcomes.

Clinical input was generally in agreement that TENS is investigational for the management of acute pain and for other conditions such as dementia. Clinical input was, for the most part, in agreement that TENS is a generally accepted treatment modality and can be beneficial for the management of chronic pain in some patients. A trial period, similar to that in Medicare Coverage guidelines, was recommended by some.

**Background**

TENS has been used to treat chronic intractable pain, postsurgical pain, and pain associated with active or post-trauma injury unresponsive to other standard pain therapies. It has been proposed that TENS may provide pain relief through release of endorphins in addition to potential blockade of local pain pathways. TENS has also been used to treat dementia by altering neurotransmitter activity and increasing brain activity that is thought to reduce neural degeneration and stimulate regenerative processes. Percutaneous electrical nerve stimulation
(located in a separate policy) is similar to TENS but uses microneedles that penetrate the skin instead of surface electrodes. Interferential stimulation (located in a separate policy) uses a modulated waveform for deeper tissue stimulation and is believed to improve blood flow to the affected area.

**Regulatory Status**
TENS devices consist of an electrical pulse generator, usually battery operated, connected by wire to 2 or more electrodes, which are applied to the surface of the skin at the site of the pain. Since 1977, a large number of devices have received marketing clearance through the U.S. Food and Drug Administration (FDA) 510(k) process. Marketing clearance via the 510(k) process does not require data regarding clinical efficacy; these devices are considered substantially equivalent to predicate devices marketed in interstate commerce prior to May 1976, the enactment date of the Medical Device Amendments, or to devices that have been reclassified and do not require approval of a premarket approval application (PMA).

On March 11, 2014, FDA granted de novo 510(k) approval for marketing to Cefaly® (STX-med, Herstal, Belgium), which is a TENS device for the prophylactic treatment of migraine in patients 18 years of age or older. (1)

**Rationale**
This evidence review was created in 1996 and has been updated periodically using the MEDLINE database. The most recent literature update was performed through October 12, 2015.

This evidence review was originally based on a 1996 TEC Assessment on transcutaneous electrical nerve stimulation (TENS) for the treatment of chronic and postoperative pain, which concluded that the evidence did not clearly show that the effects of TENS exceeded placebo effects.(2) Over the intervening years, a large number of Cochrane reviews of TENS for a variety of pain conditions have been published, including the topics of osteoarthritis, rheumatoid arthritis, pancreatitis, myofascial trigger points, temporomandibular joint pain, cancer pain, neck pain, acute pain, phantom limb pain, labor pain, and chronic back pain.(3-23) In 2010, the American Academy of Neurology (AAN) published an evidence-based review of the efficacy of TENS in the treatment of pain in neurologic disorders, including low back pain and diabetic peripheral neuropathy.(24) The evidence on TENS for specific conditions is described next.

**Chronic Pain**

**Chronic Pain: Low Back Pain**
Cochrane reviews from 2005, updated in 2008, concluded that there is limited and inconsistent evidence for the use of TENS as an isolated treatment for low back pain.(10,11) For the treatment of chronic low back pain, 4 high-quality randomized controlled trials (RCTs) met the selection criteria (585 patients). There was conflicting evidence about whether TENS reduced back pain, and consistent
In 2010, AAN published an evidence-based review of the efficacy of TENS in the treatment of pain in neurologic disorders. The evidence on TENS for chronic low back pain of various etiologies (some neurologic) included 2 class I studies (prospective randomized trial with masked outcome assessment in a representative population) and 3 class II studies (randomized trial not meeting class I criteria or a prospective matched group cohort study in a representative population). The class I studies compared TENS with sham TENS for 4 or 6 weeks of treatment. Although both studies were adequately powered to find a 20% or greater difference in pain reduction by visual analog scale (VAS), after correction for multiple comparisons, no significant benefit was found for TENS compared with sham TENS. In 2 of the 3 class II studies, no significant differences were found between TENS and sham TENS. In the third class II study, benefit was found in 1 of 11 patients treated with conventional TENS, 4 of 11 treated with burst pattern TENS, and 8 of 11 treated with frequency-modulated TENS. Overall, evidence was conflicting. Because class I studies provide stronger evidence, AAN considered the evidence sufficient to conclude that TENS is ineffective for the treatment of chronic low back pain.

Subsequently, Keskin et al (2012) reported an RCT of TENS for pregnancy-related low back pain. Seventy-nine patients were randomized to 6 TENS sessions over 3 weeks, a home exercise program, acetaminophen, or a no-treatment control. In the control group, pain intensity increased in 57% of participants. Pain decreased in 95% of participants in the exercise group and in all participants in the acetaminophen and TENS groups. VAS improved by a median of 4 points with TENS and by 1 point in the exercise and acetaminophen groups. In the control group, VAS worsened by 1 point. Roland-Morris Disability Questionnaire scores indicated a significantly greater improvement in function in the TENS group (-8.5) compared with the control (+1), exercise (-3), and acetaminophen (-3) groups. This study lacked a sham TENS control.

**Chronic Pain: Diabetic Peripheral Neuropathy**

AAN’s 2010 evidence-based review of the efficacy of TENS in the treatment of pain in neurologic disorders identified 2 class II studies comparing TENS with sham TENS and 1 class III study comparing TENS with high-frequency muscle stimulation for patients with mild diabetic peripheral neuropathy. The studies found a modest reduction in VAS for TENS compared with sham, and a larger proportion of patients experiencing benefit with high-frequency muscle stimulation than with TENS. The authors concluded that, on the basis of these 2 class II studies, TENS is probably effective in reducing pain from diabetic peripheral neuropathy, although presently no studies compare TENS with other treatment options.

A small 2011 RCT found no difference between microcurrent TENS (micro-TENS) compared with sham in 41 patients with diabetic peripheral neuropathy.
this study, current was applied at an intensity of 30 to 40 microamps rather than the usual intensity of several milliamps, and patients were treated for 30 minutes, 3 times per week. After 4 weeks of treatment, 29% of the micro-TENS group and 53% of the sham group showed a response to therapy, defined as a minimum 30% reduction in neuropathic pain score. Median Pain Disability Index was reduced to a similar extent in the TENS group (23%) and the sham group (25%).

**Chronic Pain: Cancer Pain**

For the 2008 Cochrane review on TENS for cancer pain, only 2 RCTs (N=64 participants) met the selection criteria for inclusion in the systematic review. There were no significant differences between TENS and placebo in the included studies. One RCT found no differences between TENS and placebo for pain secondary to breast cancer treatment. The other RCT examined acupuncture-type TENS in palliative care patients but was underpowered. Results of the review were considered inconclusive due to a lack of suitable RCTs. A 2012 update of the Cochrane review identified 1 additional RCT (a feasibility study of 24 patients with cancer bone pain) that met selection criteria. The small sample sizes and differences in patient study populations of the 3 RCTs precluded meta-analysis. Results on TENS for cancer pain remain inconclusive.

**Chronic Pain: Fibromyalgia**

A placebo-controlled crossover RCT from 2013 investigated the effect of a single treatment of TENS in 41 patients with fibromyalgia. Patients were blindly allocated to either no treatment, active TENS treatment, or placebo treatment. Each treatment arm had therapy once weekly for a 3-week period. Patients rated the average pain intensity before and after treatment on a 0-to-10 scale and found that pain with movement was less during active TENS compared with placebo or no TENS (p<0.05). Patients also rated fatigue with movement and found that fatigue decreased with active TENS compared with placebo or no TENS (p<0.05 and p<0.01, respectively). Pressure pain threshold improvement was significantly greater with active TENS (30%, p<0.05) than with placebo (11%) or no TENS (14%).

Another RCT published in 2013 investigated TENS in fibromyalgia. In this trial, 39 patients were randomized into 3 groups: a group with placebo devices at both lumbar and cervical sites, a group with a single active TENS device at the lumbar or cervical site and a placebo device at the second site, and a group with 2 active TENS devices at both lumbar and cervical sites. TENS was administered for 20 minutes at 12-hour intervals for 7 consecutive days. In the dual placebo group, VAS pain scores did not improve compared with baseline. Patients who had a single site of active TENS reported a reduction in pain of 2.5 cm (p<0.05 vs baseline), and patients in the dual TENS group experienced the greatest reduction in pain of 4.2 cm (p<0.02 vs baseline). Consumption of medication for pain was also decreased significantly from baseline in the single TENS and dual TENS groups (p<0.05 and p<0.02, respectively). Sleep improvements were reported by 10 patients in the dual TENS group, 8 in the single TENS group, and 4 in the placebo group. Fatigue increased for 3 patients in the placebo group, but decreased in 7
patients in the dual TENS group and 5 patients in the single TENS group. No adverse events were reported.

**Chronic Pain: Refractory Chronic Pelvic Pain**

There is limited literature on the use of TENS for chronic pelvic pain. No RCTs were identified. An observational study of 60 men consecutively treated with TENS for refractory chronic pelvic pain syndrome was published in 2013.(29) TENS was performed at home for 12 weeks with participants keeping a pain diary for the calculation of VAS score. A successful treatment response was defined as a 50% or greater reduction in VAS and absolute VAS of less than 3 at the end of treatment. TENS was successful in 29 (48%) of patients, and treatment response was sustained at a mean follow-up of 44 months (95% confidence interval [CI], 33 to 56). After 12 weeks of treatment, VAS score decreased significantly (p<0.001) from 6.6 to 3.9. Quality of life, assessed by the National Institutes of Health Chronic Prostatitis Symptom Index, improved significantly after 12 weeks of TENS treatment (p<0.001). No adverse events were reported.

**Chronic Pain: Osteoarthritis of the Knee**

A 2009 Cochrane review found that the evidence on TENS for pain relief in patients with osteoarthritis of the knee was inconclusive.(22) Included in the review were 18 small trials in 813 patients; 11 trials used TENS, 4 used interferential current stimulation, 1 trial used both TENS and interferential current stimulation, and 2 trials used pulsed electrostimulation. Methodologic quality and quality of reporting were rated poor. Additionally, there was a high degree of heterogeneity among the trials, and the funnel plot for pain was asymmetrical, suggesting both publication bias and bias from small studies.

Additional randomized trials were published after this systematic review. The largest is a 2014 RCT of 224 participants with osteoarthritis of the knee that assigned patients to 1 of 3 interventions: TENS combined with education and exercise (n=73), sham TENS combined with education and exercise (n=74), or education and exercise alone (n=77).(30) Investigators and participants were blinded to treatment. Participants were treated for 6 weeks and directed to use the TENS device as needed for pain relief. Western Ontario and McMaster Universities Arthritis Index pain, function, and total scores improved significantly over time from baseline to 24 weeks but did not vary between groups (p>0.05). TENS as an adjunct to exercise did not elicit additional benefits.

An RCT with 75 patients examined the effect of a single session of high-frequency TENS, low-frequency TENS, or placebo TENS.(31) Double-blind assessment during the treatment session found a significant increase in pressure pain threshold at the knee for both low- and high-frequency TENS. There was no effect of TENS on cutaneous mechanical pain threshold, heat pain threshold, or heat temporal summation. All 3 groups reported a reduction in pain at rest and during the Timed Up-and-Go (TUG) test, and there were no differences in pain scores between groups. These pain score results suggest a strong placebo component of TENS treatment.
Another small RCT compared intra-articular hyaluronic acid (HA) injections with TENS for the management of knee osteoarthritis in 50 participants.(32) Twenty-seven patients were randomized to HA and received 1 intra-articular injection weekly for 5 weeks. Twenty-three patients in the TENS group received 20-minute sessions of TENS 3 times weekly for 4 weeks. The TENS group exhibited a modest but significantly greater improvement (p=0.03) than the HA group on VAS pain score (mean [SD] final score, 4.17 [1.98] vs 5.31 [1.78], respectively) at 2 weeks, but there was no difference between groups at 2 or 3 months posttreatment. The TENS group also had a greater improvement on the Lequesne Index at 2-week follow-up compared with the HA group (mean [SD] final score, 7.78 [2.08] vs 9.85 [3.54], respectively; p=0.01) and at 3-month follow-up (mean [SD] final score, 7.07 [2.85] vs 9.24 [4.04], respectively; p=0.03). Both treatment groups had significant improvements from baseline to 3 months on scores in walking time, patient global assessment, and disability in activities of daily life.

**Chronic Pain: Rheumatoid Arthritis**
Cochrane reviews from 2002 and 2003 concluded that results in patients with rheumatoid arthritis were conflicting.(4,5)

**Chronic Pain: Multiple Sclerosis**
Sawant et al reported a meta-analysis of 4 RCTs of TENS for the management of central pain in multiple sclerosis.(33) Two studies had a sample size of 10; the other 2 studies had sample sizes of 59 and 60. One study examined the effect of TENS on upper-extremity pain and the other 3 studied the effect of TENS on low back pain. The exact electrode placement could not be identified. Effect sizes extracted from the 4 studies showed a medium sized effect of TENS (Hedges’ g=0.35, p=0.009). The overall level of evidence was considered to be GRADE 2.

**Chronic Pain: Phantom Limb Pain**
A 2015 Cochrane review found no RCTs on TENS for phantom limb pain or stump pain after amputation.(34) The authors concluded that the published literature on TENS for phantom limb pain in adults lacks the methodologic rigor and robust reporting needed to confidently assess its effectiveness and that RCT evidence is required.

**Chronic Pain: Neck Pain**
A 2013 report by the Cochrane Collaboration reviewed the evidence on TENS for the treatment of chronic neck pain.(13) Four studies (2 with high risk of bias, 2 with low risk of bias) compared TENS versus placebo for immediate pain relief. Three studies with a high risk of bias also compared TENS with electrical muscle stimulation, ultrasound, or manual therapy for the treatment of chronic neck pain. The treatment schedules and differing outcomes precluded pooling of results, and group sizes were very small (7-43 participants) with varied results for TENS therapy. Overall, the quality of this evidence is very low for TENS versus all comparators for the treatment of chronic neck pain.
Chronic Pain: Pain After Stroke
Evidence on the efficacy of TENS for shoulder pain after stroke was considered inconclusive in a 2000 Cochrane review.(19)

Chronic Pain: Pain After Spinal Cord Injury
A 2014 Cochrane review on nonpharmacologic interventions for chronic pain in individuals with spinal cord injury identified 1 RCT on TENS.(35) This study had a high risk of bias, and no conclusion could be drawn on the effectiveness of TENS compared with sham for reducing chronic pain in this population.

Chronic Pain: Headache
A 2004 Cochrane review assessed noninvasive physical treatments for chronic/recurrent headache.(3) Twenty-two studies with a total of 2628 patients (age range, 12-78 years) met inclusion criteria. The review included 5 types of headache and various noninvasive treatments including spinal manipulation, electromagnetic fields, and a combination of TENS and electrical neurotransmitter modulation. Combination TENS and electrical neurotransmitter modulation had weak evidence of effectiveness for migraine headache. Both combination treatment and TENS alone had weak evidence of effectiveness for the prophylactic treatment of chronic tension-type headache. The authors concluded that, although these treatments appear to be associated with little risk of serious adverse effects, clinical effectiveness and cost-effectiveness of noninvasive physical treatments require further research using scientifically rigorous methods.

The Cefaly device (Cefaly; STX-Med, Herstal, Belgium) is a TENS headband device intended for the prophylactic treatment of migraine in patients 18 years of age or older.(1) Clinical information on Cefaly was supplied by 2 studies, the Prevention of Migraine using the STS Cefaly (PREMICE) trial,(36) and a European postmarketing surveillance study.(37) PREMICE was a double-blind, sham-controlled RCT conducted at 5 tertiary care headache clinics in Belgium. Sixty-seven patients were randomized to active (n=34) or sham (n=33) neurostimulation for 3 months, and 59 (88%) completed the trial on protocol. No serious adverse events occurred, although 1 patient discontinued the trial because of a reported device caused headache. After a 1-month run-in period, patients were instructed to use the device daily for 3 months. Adherence was recorded by the TENS device. Ninety stimulation sessions were expected, but on average, 56 sessions were completed by the active group, and 49 were completed by the sham group. Primary outcome measures were changes in the number of migraine days and the percent of responders.

The authors presented both intention-to-treat (ITT) and per-protocol analyses, but only the ITT will be discussed. The reduction in the number of migraine days (run-in vs 3-month) was 2.06 (95% CI, -0.54 to -3.58) for the TENS group versus 0.32 (-0.63 to +1.27) for the sham group; this difference was not statistically significant (p=0.054). The proportion of responders (≥50% reduction in the number of migraine days/month) was 38% (95% CI, 22% to 55%) in the TENS group versus 12% (95% CI, 1% to 23%) in the sham group (p=0.014). The number of migraine attacks from the run-in period to the 3-month evaluation was
significantly lower for the active TENS group (decrease of 0.82 in the TENS group vs 0.15 in the sham group, p=0.044). Number of headache days also was lower in the TENS group than in the sham group (decrease of 2.5 vs 0.2, p=0.041). Patients in the active TENS group reported a 36.6% reduction in the number of acute antimigraine drugs taken compared with a 0.5% reduction in the sham group (p=0.008). Severity of migraine days did not differ significantly between groups.

Participants rated their satisfaction with treatment more highly in the active group (70.6%) than in the sham group (39%). During postmarketing surveillance, 53% (1226/2313) of participants were satisfied with the device and willing to continue using it. Ninety-nine participants (4%) reported a complaint with the device, although none was a serious adverse event. The most commonly reported adverse events included: insomnia in 4 participants (0.2%), reversible forehead skin irritation in 5 participants (0.2%), headache after a TENS session in 12 participants (0.5%), sleepiness during a Cefaly session (0.5%), and a dislike of how the device felt, leading to discontinuation in 29 participants (1.3%).

**Chronic Pain: Mixed Chronic Pain Conditions**

A 2008 Cochrane review updated the evidence on the use of TENS for the treatment of various chronic pain conditions, including rheumatoid arthritis with wrist pain, temporomandibular joint dysfunction, multiple sclerosis with back pain, osteoarthritis with knee pain, neuropathy, pancreatitis, and myofascial trigger points; it included 25 RCTs (1281 patients). Due to heterogeneity, meta-analysis was not possible; slightly more than half of the studies found a positive analgesic outcome in favor of active TENS treatments. The authors concluded that the 6 studies added since the 2001 review did not provide sufficient additional information to change the conclusions, ie, the published literature still lacked the methodologic rigor needed to make confident assessments of the role of TENS in chronic pain management.

An industry-sponsored meta-analysis by Johnson and Martinson (2007) included 38 randomized controlled comparisons (1227 patients from 29 publications) of TENS or percutaneous electrical nerve stimulation (PENS) for chronic musculoskeletal pain, using any stimulation parameters on any location (eg, back, neck, hip, knee). Data were converted to percentage improvement in VAS scores, then transformed into standardized differences (a continuous measure that adjusts for variability in different outcome measures). Based on the combined standardized difference, the authors concluded that TENS provided “nearly 3 times” the pain relief provided by placebo. A number of sources of bias in the analysis seriously limited interpretation of the results. First, statistical heterogeneity of the individual studies (I²=82%) raises questions about the appropriateness of combining these studies in a meta-analysis (see previous discussion on the decision not to combine studies for the 2000 and 2008 Cochrane reviews on chronic pain). Further limiting interpretation is the transformation of data to standardized effect sizes, which appears to have led to discrepant effect sizes of otherwise similar results. For example, comparison of the untransformed and transformed data showed that while 2 of the included trials (Deyo et al,
Machin et al(40)) found similar percentage-point differences in VAS scores between active and control groups (5% and 8%, respectively), standardized effect sizes were not equivalent.

Positive standardized effect sizes from data that were not statistically or clinically significant (eg, 47% vs 42% change from baseline in Deyo et al) also raises concerns about the appropriateness of the data transformation. Inclusion of poor-quality studies is another concern, because several studies with the greatest effect sizes reported dropout rates exceeding 25%. Furthermore, bias for publication of small positive studies may not have been adequately addressed, because the “fail-safe N” method used to assess publication bias is problematic. Another major constraint in interpretation of this meta-analysis is the lack of clarity about whether PENS resulted in a clinically meaningful improvement. For example, there was no discussion of the magnitude of the combined change in VAS scores or of the proportion of patients who achieved clinically meaningful improvements. Examination of the data indicated that the difference was less than 15% between the electrical nerve stimulation and placebo groups (average difference, 4%) for 13 (34%) of the 38 comparisons. The small effect observed in many of these small studies raises further questions about the impact of publication bias on the meta-analysis. Also at issue is the relative contribution of PENS, because meta-regression found PENS to be more effective than TENS. Given the substantial uncertainty regarding the appropriateness of the studies included, how data were transformed, and the clinical significance of the results, results from this meta-analysis are considered inconclusive.

A 2006 randomized, sham-controlled trial (163 patients with diverse pain states) by Oosterhof et al reported that, although no differences in VAS pain scores were observed, more patients were satisfied (ie, willing to continue treatment) after 10 days (10-12 h/d) of TENS (58%) than after use of a sham device (43%).(41) Analysis of the results by type of pain (osteoarthritic, neuropathic, or bone/soft tissue/visceral) in a subsequent report showed no difference in patient satisfaction for the group with osteoarthritis and related disorders (39% vs 31%, n=31, 26, both respectively) or in patients with neuropathic pain (63% vs 48%, n=16, 25, both respectively), greater satisfaction with TENS in the group of patients with bone and soft tissue injury or visceral pain (74% vs 48%, n=34, 31, both respectively).(42) The nearly 50% patient satisfaction rating in the sham control group suggests a strong nonspecific effect with this treatment protocol. Survival analysis over the course of 1 year revealed no significant difference in the percentage of patients satisfied with treatment (willing to continue).(43) At 1-year follow-up, 30% of the TENS group and 23% of the sham TENS group remained satisfied with treatment (not significantly different). For the satisfied patients, there was no significant difference between the TENS and sham groups in the magnitude of improvement (61.7% vs 63.9%), pain intensity (change in VAS, 27.7 vs 29.4), disability (12.4 vs 12.2), or perceived health status (5.2 vs 5.8), all respectively. This study supported a sustained placebo effect.
Acute Pain

Acute Pain: Injury
One double-blind, randomized, sham-controlled trial found that during emergency transport of 101 patients, TENS reduced posttraumatic hip pain (change in VAS, 89 to 59), whereas the sham-stimulated group remained relatively unchanged (change in VAS, 86 to 79).(44)

Acute Pain: Surgical Pain
The largest RCT on postsurgical TENS was published by Rakel et al in 2014.(45) This double-blind study compared TENS once or twice daily for 6 weeks versus sham TENS versus standard care to reduce pain during rehabilitation in 317 patients who had undergone total knee arthroplasty (TKA). The primary outcome was pain intensity during range of motion and during walking, measured by a 21-point numeric rating scale on postoperative day 1 and week 6. Secondary outcomes were pain intensity at rest, hyperalgesia, and function. ITT analysis showed that patients who used TENS during exercises had less pain compared with standard care in the near postoperative period, but there was no significant difference in subjective pain compared with patients who used sham TENS. There was also no significant difference between the active and control groups when tested at 6 weeks. This study, which found no benefit of TENS over placebo or sham, had good methodologic quality and a low risk of bias.

Smaller studies with higher risk of bias tend to support the use of TENS. In 1 double-blind RCT of 40 patients undergoing inguinal herniorrhaphy, two 30-minute sessions of TENS at 2 and 4 hours after surgery (vs sham) reduced both analgesic use and pain scores when measured up to 24 hours postsurgery.(46) A patient-blinded study post abdominal surgery (N=55) found that application of TENS for 1 h/d resulted in a significant reduction in pain, particularly at rest, measured both during and immediately after treatment compared with sham TENS.(47) Pulmonary function (vital capacity, cough peak flow) was also significantly better in the active TENS arm. Another assessor-blinded study of TENS in 74 living kidney donors found a modest reduction in pain at rest and during the measurement of pulmonary function 1 day postoperatively.(48) A single-blinded randomized trial with 42 patients assessed the analgesic effect of TENS after laparoscopic cholecystectomy.(49) Pain improved by a median of 2.4 points of 10 after TENS compared with 0.4 points after placebo treatment. The relative risk of nausea and/or emesis was 2.2 times greater for patients in the placebo group.

It is unclear whether the difference in findings between the RCT by Rakel et al and the smaller RCTs is due to increased risk of bias in small studies, or to differences in time since surgery or type of surgery. One can conclude with relative certainty that TENS has no greater effect than placebo on pain measured at least 1 day following TKA. Additional study is needed to determine the effect of TENS in the immediate postoperative period after other types of surgery.
**Acute Pain: Bone Marrow Sampling**
Tucker et al reported a double-blind RCT of TENS administered during bone marrow sampling in 70 patients. (50) There was no significant difference in a numeric pain score between patients who received strong TENS impulses and the control group that received TENS just above the sensory threshold as reported immediately after the procedure (5.6 vs 5.7, respectively). Over 94% of patients in both groups felt they benefited from TENS.

**Acute Pain: Dysmenorrhea**
One 2002 Cochrane review of 9 small, controlled trials found high-frequency TENS to be effective for the treatment of dysmenorrhea. (20)

**Acute Pain: Labor and Delivery**
A 2009 Cochrane review included 19 studies with 1671 women in labor. (8) Overall, there was little difference in pain ratings between TENS and control groups, although women receiving TENS to acupuncture points were less likely to report severe pain (risk ratio, 0.41). The review found limited evidence that TENS reduces pain in labor or has any impact (either positive or negative) on other outcomes for mothers or babies. The authors concluded that, although it is unclear whether TENS reduces pain, women should have the choice of using TENS in labor if they think it will be helpful.

A placebo-controlled, randomized trial of TENS assessed 200 women who gave birth between January 2010 and July 2010. (51) One hundred women who gave birth vaginally were allocated to active TENS or to sham TENS in a 1:1 ratio; this same assignment was performed for 100 women who gave birth by cesarean delivery. TENS was performed once for 30 minutes after childbirth was completed. After vaginal delivery or cesarean delivery but before administration of TENS, the placebo and active groups did not significantly differ in VAS scores or verbal numeric scale (VNS) scores. However, after active TENS in the cesarean group, there was a significant reduction in VAS score (p<0.001) and VNS score (p<0.001) compared with the placebo group. Similar benefit was observed in the vaginal delivery group with the active treatment showing a significant reduction in VAS (p=0.022) and VNS (p=0.005) scores. The authors also assessed whether TENS reduced the need for additional analgesia. There was no difference between the active TENS and the placebo groups for vaginal delivery (p=0.83), but, in the cesarean arm, the active treatment group had a significant reduction in analgesic need (p=0.006).

**Acute Pain: Mixed Acute Pain Conditions**
A 2015 Cochrane review assessed the efficacy of TENS as a sole treatment for acute pain conditions that included procedural pain (eg, cervical laser treatment, venipuncture, screening flexible sigmoidoscopy) and nonprocedural pain (eg, postpartum uterine contractions, rib fractures). (52) Nineteen RCTs involving 1346 participants at entry were included. Data on pain intensity were pooled for 6 trials, showing a mean difference of -24.62 mm on a 100-mm VAS in favor of TENS, with significant heterogeneity between the trials. Data on the proportion of participants achieving at least 50% reduction in pain was pooled for 4 trials, with a relative risk
of 3.91 in favor of TENS over placebo. There was a high risk of bias associated with inadequate sample sizes in the treatment arms and unsuccessful blinding of treatment interventions. The authors concluded that the analysis provided tentative evidence that TENS reduces pain intensity over and above that seen with placebo, but the high risk of bias makes definitive conclusions impossible.

A systematic review and meta-analysis of TENS for acute pain management in the prehospital setting was published in 2014.(53) A literature search identified 4 sham-controlled RCTs of TENS, including 128 patients. On pooled analysis of these studies, TENS was superior to sham, with a clinically significant reduction in pain severity and a 38-mm reduction on VAS (95% CI, 28 to 48; p<0.001). The 4 studies had significant heterogeneity (I²=94%). The difference in final pain score for TENS versus sham was 33 mm (95% CI, 21 to 44; p<0.001). The authors found that TENS significantly reduced anxiety compared with sham treatment, with an overall 26 mm lower score on VAS for TENS (95% CI, 17 to 35; p<0.001). No studies reported adverse events for TENS.

**Acute Pain: Tennis Elbow**

A multicenter RCT of TENS as an adjunct to primary care management for tennis elbow was identified. Thirty-eight general practices in the West Midlands, U.K., recruited 241 adults who had a new or first diagnosis of tennis elbow.(54) Participants were randomized to TENS once a day for 45 minutes over 6 weeks or until resolution of pain plus primary care management (consultation with a general practitioner followed by information and advice on exercise) versus primary care management alone. Both groups saw large (>25%) within-group improvements in pain intensity, with the greatest improvement during the first 6 weeks of treatment. ITT analysis revealed no difference in improvement of pain (-0.33; 95% CI, -0.96 to 0.31; p=0.31) between the 2 groups at 6 weeks, 6 months (-0.20; 95% CI, -0.81 to 0.42; p=0.526), or 12 months (0.45; 95% CI, -0.15 to 1.06; p=0.139). However, adherence to exercise and TENS was very poor, with only 42 (35%) meeting a prior adherence criteria. Per protocol analyses only showed a statistically significant difference in favor of TENS at 12 months (p=0.030).

**Other**

**Other: Dementia**

Efficacy of TENS for dementia was considered inconclusive in a 2003 Cochrane review.(6)

**Other: Recovery From Stroke**

A 2011 systematic review included 15 randomized or quasi-randomized trials (446 patients) on the use of TENS to enhance motor recovery following stroke.(55) Although methodologic quality of the trials was considered generally good, only 4 studies were large RCTs. In most studies (9/15), fewer than 15 subjects received TENS. Stimulation targets for the various studies included nerves, muscles, acupuncture points, and the entire hand or foot. Most studies reported significant effects on at least 1 outcome measure, although effect sizes were generally small
and there were insignificant effects for many outcome measures. Meta-analysis could not be performed for most outcomes because of variability between studies and insufficient data. A moderate effect was determined for force production of ankle dorsiflexion (but not plantarflexion) and for the TUG test (but not the 10-meter gait velocity test or the 6-Minute Walk Test). Overall, results from studies of TENS after stroke were inconsistent.

A paired-sample randomized crossover trial of TENS for improving strength, proprioception, and balance was conducted in 29 mobile stroke survivors who had no preexisting mobility limitations. Participants were given a single session of active TENS plus a session of control sham treatment with each session lasting approximately 1 hour. The authors found that all participants were able to tolerate the TENS treatment, although 1 participant did not feel any stimulation even at maximum intensity of active treatment. Participants improved in forward reach with a difference of 4.16 cm (p=0.009), velocity with a difference of 0.03 ms (p=0.002), plantarflexor strength with a difference of 4.34 N/m, and joint position sense (JPS) plantarflexion with a difference of -1.8° (p=0.029). Differences for JPS dorsiflexion and dorsiflexor strength did not vary significantly between the TENS and control arms.

Ongoing and Unpublished Clinical Trials
Some currently unpublished trials that might influence this review are listed in Table 1.

Table 1. Summary of Key Trials

<table>
<thead>
<tr>
<th>NCT No.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCT01641471a</td>
<td>Prospective Evaluation of Transcutaneous Electrical Nerve Stimulation (TENS) for Pain Relief Following Total Knee Arthroplasty (TKA)</td>
<td>116</td>
<td>Jun 2015 (completed)</td>
</tr>
<tr>
<td>NCT01875042</td>
<td>Does Transcutaneous Electrical Nerve Stimulation (TENS) Affect Pain and Function in Patients With Osteoarthritis of the Knee? ETRELKA, a Randomised Controlled Trial</td>
<td>220</td>
<td>Aug 2015 (completed)</td>
</tr>
</tbody>
</table>

NCT: national clinical trial.

a Denotes industry-sponsored or cosponsored trial.

Summary of Evidence
The evidence for transcutaneous electrical nerve stimulation (TENS) in individuals who have chronic pain includes numerous randomized controlled trials (RCTs) and systematic reviews. Relevant outcomes are symptoms, functional outcomes, quality of life, and medication use. The overall strength of the evidence is weak. The best evidence exists for treatment of chronic, intractable pain. Available evidence indicates that TENS can improve chronic intractable pain in some patients, and there is support for its use in clinical guidelines by specialty societies. To best direct TENS toward patients who will benefit, a shortterm trial of TENS is appropriate, with continuation only in patients who show an initial
improvement. The evidence is sufficient to determine qualitatively that the technology results in a meaningful improvement in the net health outcome.

The evidence for TENS in individuals who have acute pain includes RCTs and systematic reviews. Relevant outcomes are symptoms and medication use. Overall, evidence for the use of TENS from high-quality trials remains inconclusive for most indications. A Cochrane review of TENS for acute pain (eg, cervical laser treatment, venipuncture, screening flexible sigmoidoscopy, postpartum uterine contractions, rib fractures) found some evidence that TENS reduces pain intensity over and above that seen with placebo, but the high risk of bias made definitive conclusions impossible. For the treatment of pain after total knee arthroplasty, 1 large RCT found no benefit of TENS compared with sham TENS. For the prevention of migraine headaches, 1 small RCT reported a greater proportion of patients achieving at least 50% reduction in migraines with TENS than with sham placebo, and modest reductions in the number of total headache and migraine days. This manufacturer-sponsored trial needs corroboration before conclusions can be made about the efficacy of TENS for preventing migraine headaches. The evidence is insufficient to determine the effects of the technology on health outcomes.

Clinical Input Received From Physician Specialty Societies and Academic Medical Centers
While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

2011 Input
In response to requests, input was received through 3 physician specialty societies and 5 academic medical centers while this policy was under review in 2011. Clinical input was generally in agreement with a 30-day trial to determine efficacy of TENS for refractory chronic pain. However, the input did not agree that TENS should be considered not medically necessary for chronic low back pain.

2009 Input
In response to requests, input was received through 4 physician specialty societies (5 reviewers) and 3 academic medical centers (4 reviewers) while this policy was under review in 2009. Clinical input was generally in agreement that TENS is investigational for the management of acute pain and for other conditions such as dementia. Clinical input was for the most part in agreement that TENS is a generally accepted treatment modality and can be beneficial for the management of chronic pain in some patients. A trial period, similar to Medicare Coverage guidelines, was recommended by some.
Practice Guidelines and Position Statements

**European Headache Federation**
The European Headache Federation (2013), citing concerns about an ineffective sham procedure for TENS in headache methodology studies and the overall limited level of evidence, recommends that there is insufficient evidence for the use of TENS in headache prophylaxis and to abort an acute headache.(57)

**Osteoarthritis Research Society International**
Guidelines from the Osteoarthritis Research Society International (2014) recommend that TENS is not appropriate for use in patients with multijoint osteoarthritis and is of uncertain value for the treatment of knee-only osteoarthritis pain.(58)

**National Comprehensive Cancer Network**
National Comprehensive Cancer Network clinical practice guidelines on adult cancer pain (v.2.2014) indicate that nonpharmacologic interventions including TENS may be considered in conjunction with pharmacologic interventions as needed (category 2A).(59)

**National Cancer Institute**
National Cancer Institute (2014) guidelines on pain state that noninvasive physical and psychosocial modalities can be used concurrently with drugs and other interventions to manage pain during all phases of treatment. Patients with mild-to-moderate pain may benefit from a trial of TENS to see if it is effective in reducing pain. TENS is a low-risk intervention.(60)

**North American Spine Society**
The North American Spine Society (2011) clinical guideline for the diagnosis and treatment of cervical radiculopathy from degenerative disorders discusses the role of ancillary treatments such as bracing, traction, electrical stimulation, acupuncture, and TENS in the treatment of cervical radiculopathy from degenerative disorders. A consensus statement recommends that ozone injections, cervical halter traction, and combinations of medications, physical therapy, injections, and traction have been associated with improvements in patient-reported pain in uncontrolled case series. Such modalities may be considered, recognizing that no improvement relative to the natural history of cervical radiculopathy has been demonstrated.(61)

**American Academy of Neurology**
In 2010, the Therapeutics and Technology Assessment Subcommittee of American Academy of Neurology (AAN) published an evidence-based review of the efficacy of TENS for the treatment of pain in neurologic disorders.(62) AAN concluded that TENS is not recommended for the treatment of chronic low back pain due to lack of proven efficacy (level A, established evidence from 2 class I studies), and that TENS should be considered for the treatment of painful diabetic neuropathy (level B, probably effective, based on 2 class II studies).
American Society of Anesthesiologists et al
2010 Practice guidelines from the American Society of Anesthesiologists (ASA) and American Society of Regional Anesthesia and Pain Medicine recommend that TENS should be used as part of a multimodal approach to management for patients with chronic back pain and may be used for other pain conditions (eg, neck and phantom limb pain).(63) ASA’s 1997 guidelines on chronic pain management recommended that an office or home trial of TENS should be considered as an early management option or as an adjunctive therapy because of its low complexity and low risk.(64)

National Institute for Health and Clinical Excellence
The U.K.’s National Institute for Health and Clinical Excellence (NICE) 2009 guidance on low back pain states that, despite the long history of use of TENS for back pain, the quality of research studies is poor.(65) These guidelines failed to recommend TENS as a treatment because there is no evidence that it is effective.

National Collaborating Centre for Chronic Conditions et al
The U.K.’s National Collaborating Centre for Chronic Conditions and NICE 2008 guidance on osteoarthritis care and management in adults states that:

“[T]here is evidence that TENS is clinically beneficial for pain relief and reduction of stiffness in knee osteoarthritis, especially in the short term. However, this was not shown in a community setting. There is no evidence that efficacy trails off over time, or that periodic use for exacerbations is helpful.... People with osteoarthritis should be encouraged to experiment with intensities and duration of application if the desired relief of symptoms is not initially achieved. This enables patients’ control of their symptoms as part of a self-management approach. A further follow-up visit is essential in allowing the health professional to check patients’ usage of TENS and problem solve. No adverse events or toxicity have been reported with TENS.”(66)

National Collaborating Centre for Women’s and Children’s Health et al
The U.K.’s National Collaborating Centre for Women’s and Children’s Health and NICE 2008 guidelines on intrapartum care state that there is high-level evidence that TENS is not an effective analgesic in established labor, and there is no high-level evidence on the analgesic effect of TENS in the latent phase of labor.(67) NICE recommends that TENS not be offered to women in established labor.

American Congress of Obstetricians and Gynecologists
American Congress of Obstetricians and Gynecologists (ACOG) 2007 guidelines for women’s health care state that methods of neurostimulation, such as TENS, acupuncture, and massage, are based on the gate theory of pain control.(68) These treatments can be useful for pain control, particularly when the pain is severe. The guidelines recommend that because different methods of treatment work by different mechanisms (eg, relaxation techniques, TENS, physical therapy, vocational rehabilitation, biofeedback), the use of multiple treatment modalities in synergy should be considered.
The 2004 ACOG guidelines on chronic pelvic pain found that clinical trials evaluating the efficacy of acupuncture, acupressure, and TENS therapies had been performed only for primary dysmenorrhea, not for nonmenstrual pelvic pain. The guidelines recommend that acupuncture, acupressure, and TENS therapies should be considered to decrease pain of primary dysmenorrhea.

**American College of Physicians and American Pain Society**
The American College of Physicians and American Pain Society published guidelines on therapies for acute and low back pain in 2007. No recommendations for TENS were made; the panel concluded that TENS had not been proved effective for chronic low back pain.

**European Federation of Neurological Societies**
The European Federation of Neurological Societies (2007) published guidelines on neurostimulation for neuropathic pain. The task force did not make conclusive recommendations, with only approximately 200 patients with different diseases, based on studies using different parameters and comparators, and having variable results. The task force concluded that standard high-frequency TENS is possibly (level C) better than placebo and probably (level B) worse than acupuncture-like or any other kind of electrical stimulation.

**U.S. Preventive Services Task Force Recommendations**
Not applicable.

**Medicare National Coverage**
The Centers for Medicare and Medicaid Services (CMS) currently have the following national coverage decisions on TENS:

- **National Coverage Determination (NCD) for Transcutaneous Electrical Nerve Stimulators (TENS) (280.13)**

  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 (in the patient's home, a physician's office, or in an outpatient clinic). Payment for TENS may be made under the durable medical equipment benefit. Also see NCDs on Supplies Used in the Delivery of TENS and NMES (§160.13) and TENS for Acute Post-Operative Pain (§10.2).

- **Decision Memo for Transcutaneous Electrical Nerve Stimulation for Chronic Low Back Pain (CAG-00429N)**

  In June 2012, CMS determined that TENS is not reasonable and necessary for the treatment of chronic low back pain. However, to support further research on the use of TENS for chronic low back pain, CMS will provide coverage under evidence development for a period of 3 years after the publication of this decision.
National Coverage Determination for Assessing Patient's Suitability for Electrical Nerve Stimulation Therapy (160.7.1)

Electrical nerve stimulation is an accepted modality for assessing a patient's suitability for ongoing treatment with a transcutaneous or an implanted nerve stimulator. Accordingly, program payment may be made for the following techniques when used to determine the potential therapeutic usefulness of an electrical nerve stimulator:

A. Transcutaneous Electrical Nerve Stimulation (TENS)
This technique involves attachment of a transcutaneous nerve stimulator to the surface of the skin over the peripheral nerve to be stimulated. It is used by the patient on a trial basis and its effectiveness in modulating pain is monitored by the physician, or physical therapist. Generally, the physician or physical therapist is able to determine whether the patient is likely to derive a significant therapeutic benefit from continuous use of a transcutaneous stimulator within a trial period of 1 month; in a few cases this determination may take longer to make. Document the medical necessity for such services which are furnished beyond the first month. (See §160.13 for an explanation of coverage of medically necessary supplies for the effective use of TENS.) If TENS significantly alleviates pain, it may be considered as primary treatment; if it produces no relief or greater discomfort than the original pain electrical nerve stimulation therapy is ruled out. However, where TENS produces incomplete relief, further evaluation with percutaneous electrical nerve stimulation may be considered to determine whether an implanted peripheral nerve stimulator would provide significant relief from pain.

Usually, the physician or physical therapist providing the services will furnish the equipment necessary for assessment. Where the physician or physical therapist advises the patient to rent the TENS from a supplier during the trial period rather than supplying it himself/herself, program payment may be made for rental of the TENS as well as for the services of the physician or physical therapist who is evaluating its use. However, the combined program payment which is made for the physician's or physical therapist's services and the rental of the stimulator from a supplier should not exceed the amount which would be payable for the total service, including the stimulator, furnished by the physician or physical therapist alone.

National Coverage Determination for Supplies Used in the Delivery of Transcutaneous Electrical Nerve Stimulation (TENS) and Neuromuscular Electrical Stimulation (NMES) (160.13)(68)

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, when 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 (ie, a
garment with conductive fibers which are separated from the patients' skin by layers of fabric).

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

1. It has received permission or approval for marketing by the Food and Drug Administration;
2. It has been prescribed by a physician for use in delivering covered TENS or NMES treatment; and
3. 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 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 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, when 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 when 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:

1. The patient has a documented skin problem prior to the start of the trial period; and
2. The carrier's medical consultants are satisfied that use of such an item is medically necessary for the patient.

- National Coverage Determination for Transcutaneous Electrical Nerve Stimulation (TENS) for Acute Post-Operative Pain (10.2)

The use of TENS for the relief of acute postoperative pain is covered under Medicare. TENS may be covered whether used as an adjunct to the use of drugs, or as an alternative to drugs, in the treatment of acute pain resulting from surgery. TENS devices, whether durable or disposable, may be used in furnishing this service. When used for the purpose of treating acute postoperative pain, TENS devices are considered supplies. As such they may be hospital supplies furnished inpatients covered under Part A, or supplies incident to a physician’s service when furnished in connection with surgery done on an
outpatient basis, and covered under Part B. It is expected that TENS, when used for acute postoperative pain, will be necessary for relatively short periods of time, usually 30 days or less. In cases when TENS is used for longer periods, contractors should attempt to ascertain whether TENS is no longer being used.

References:


34. Johnson MI, Mulvey MR, Bagnall AM. Transcutaneous electrical nerve stimulation (TENS) for phantom pain and stump pain following amputation in adults. Cochrane Database Syst Rev. Aug 18 2015;8:CD007264. PMID 26284511


**Billing Coding/Physician Documentation Information**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>64550</td>
<td>Application of surface (transcutaneous) neurostimulator</td>
</tr>
<tr>
<td>A4556</td>
<td>Electrodes, per pair</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>A4557</td>
<td>Lead wires, per pair</td>
</tr>
<tr>
<td>A4558</td>
<td>Conductive paste or gel</td>
</tr>
<tr>
<td>A4595</td>
<td>TENS supplies, 2 leads per month</td>
</tr>
<tr>
<td>A4630</td>
<td>Replacement batteries for TENS</td>
</tr>
<tr>
<td>E0720</td>
<td>Tens, two lead, localized stimulation</td>
</tr>
<tr>
<td>E0730</td>
<td>Tens, four lead, larger area/multiple nerve stimulation</td>
</tr>
<tr>
<td>E0731</td>
<td>Form fitting conductive garment for delivery of tens (with conductive fibers)</td>
</tr>
<tr>
<td>E0762</td>
<td>Transcutaneous electrical joint stimulation device system, includes all accessories</td>
</tr>
<tr>
<td>L8679</td>
<td>Implantable neurostimulator, pulse generator, any type</td>
</tr>
</tbody>
</table>

**ICD-10 Codes:**

- **G89.21** - Chronic pain, not elsewhere classified, code range,
- **G89.8** - Chronic pain syndrome
- **G90.50** - Complex regional pain syndrome I (CRPS I), code range,
- **G90.59** - Pain in joint, code range,
- **M25.50** - Radiculopathy, code range,
- **M25.579** - Cervicalgia
- **M54.10** - Sciatica, code range,
- **M54.32** - Lumbago with sciatica, code range,
- **M54.5** - Low back pain
- **M54.6** - Pain in thoracic spine
- **M54.81** - Other dorsalgia codes
- **M54.89** - Dorsalgia, unspecified
- **M79.1** - Myalgia
- **M79.2** - Neuralgia and neuritis, unspecified
- **R52** - Pain, unspecified

TENS units may be covered for Ford and BPU members when prescribed by a physician. Electrical stimulation (97014 or 97032) provided in the office setting is a covered benefit for Ford and BPU members.

97014, 97032 and G0283 may be billed, but are not correct for TENS.

There is no specific coding for the Cefaly device. It would most likely be reported with the miscellaneous durable medical equipment code E1399.

**Policy Implementation/Update Information**

10/1/88  New policy added to DME section. Considered medically necessary for
chronic refractory pain and acute postoperative pain with criteria. Investigational for other indications.

1/1/01 No policy statement changes.
1/1/02 Policy statement revised to require a one month trial period when used for chronic refractory pain.
1/1/03 No policy statement changes.
3/1/04 Policy statement revised to indicate TENS is investigational for the management of chronic or postoperative pain and to relieve pain of labor and vaginal delivery is considered investigational.
8/1/04 Policy revised to indicate TENS used in the office setting is considered investigational. A considerations statement added indicating TENS units may be covered for Ford members when prescribed by a physician.
10/1/04 Consideration section updated to add coverage for BPU members. Also included electrical stimulation provided in the office would be a benefit for Ford and BPU members.
3/1/05 Policy statement revised to include the use of TENS for the treatment of dementia as investigational.
9/1/05 No policy statement changes.
3/1/06 No policy statement changes.
9/1/06 No policy statement changes.
9/1/07 No policy statement changes.
9/1/08 Policy statements revised to differentiate acute and chronic pain conditions; remains investigational; updated with literature review; older rationale updates condensed; references reordered and new references added.
9/1/09 Policy statement revised; TENS may be medically necessary for chronic pain if effective during a therapeutic trial; other uses of TENS considered investigational. This change is made retroactive to 7/9/09. However, benefit language on most contracts would exclude this service.
9/1/10 No policy statement changes.
9/1/11 No policy statement changes.
9/1/12 No policy statement changes.
9/1/13 No policy statement changes.
9/1/14 Last policy statement revised to specifically list use of TENS in prevention of migraine headaches as investigational.
9/1/15 No policy statement changes.
9/1/16 No policy statement changes.

State and Federal mandates and health plan contract language, including specific provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The medical policies contained herein are for informational purposes. The medical policies do not constitute medical advice or medical care. Treating health care providers are independent contractors and are neither employees nor agents Blue KC and are solely responsible for diagnosis, treatment and medical advice. No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, photocopying, or otherwise, without permission from Blue KC.