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## FEP Medical Policy Manual

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### FEP 1.01.09 Transcutaneous Electrical Nerve Stimulation

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**Effective Policy Date: April 1, 2020**

**Original Policy Date: September 2012**

**Related Policies:**

- 1.01.24 - Interferential Current Stimulation
- 2.01.21 - Temporomandibular Joint Disorder
- 7.01.29 - Percutaneous Electrical Nerve Stimulation and Percutaneous Neuromodulation Therapy

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## Transcutaneous Electrical Nerve Stimulation

### Description

Transcutaneous electrical nerve stimulation (TENS) describes the application of electrical stimulation to the surface of the skin at the site of pain. In addition to more traditional settings such as a physician's office or an outpatient clinic, TENS can be self-administered in a patient's home.

### OBJECTIVE

The objective of this evidence review is to determine whether the application of transcutaneous electrical nerve stimulation improves the net health outcome in individuals who suffer from chronic and/or acute pain.

### POLICY STATEMENT

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 (eg, chronic musculoskeletal pain or neuropathic pain) that causes significant disruption of function when the following conditions have been met:

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

Continued use of TENS may be considered **medically necessary** for treatment of refractory chronic pain (eg, 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 Policy Guidelines section); and
- Compliance has been demonstrated in the therapeutic trial with the device used on a regular basis (eg, daily or near daily use) throughout the trial period.

TENS is considered **investigational** for the management of acute pain (eg, postoperative or during labor and delivery).

The use of TENS for any other condition, including but not limited to the treatment of dementia and prevention of migraine headaches, is considered **investigational**.

## POLICY GUIDELINES

For the purposes of these policy guidelines, refractory chronic pain is defined as pain that causes significant disruption of function and has not responded to at least 3 months of conservative therapy, including nonsteroidal 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 transcutaneous electrical nerve stimulation (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 (eg, 2-point or 30% improvement in visual analog scale);
- 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.

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

## BENEFIT APPLICATION

Experimental or investigational procedures, treatments, drugs, or devices are not covered (See General Exclusion Section of brochure).

## FDA REGULATORY STATUS

TENS devices consist of an electrical pulse generator, usually battery-operated, connected by wire to two 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 been cleared for marketing by the

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U.S. Food and Drug Administration (FDA) through the 510(k) process. Marketing clearance via the 510(k) process does not require data on clinical efficacy; as a result, these cleared devices are considered substantially equivalent to predicate devices marketed in interstate commerce before May 1976, the enactment date of the Medical Device Amendments. The cleared devices are also equivalent to devices that have been reclassified and do not require a premarket approval application. FDA product code: GZJ.

In 2014, the Cefaly (STX-Med), which is a TENS device, was granted a de novo 510(k) classification by the FDA for the prophylactic treatment of migraine in patients 18 years of age or older.<sup>1</sup> FDA product code: PCC.

## RATIONALE

### Summary of Evidence

For individuals who have chronic pain (eg, musculoskeletal, neuropathic, and mixed pain conditions) who receive transcutaneous electrical nerve stimulation (TENS), the evidence includes numerous randomized controlled trials (RCTs) and systematic reviews. The relevant outcomes are symptoms, functional outcomes, quality of life (QOL), and medication use. The overall strength of the evidence is weak. The best evidence exists for the 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 that the technology results in a meaningful improvement in the net health outcome.

For individuals who have acute pain (eg, surgical, musculoskeletal, labor, and mixed pain conditions) who receive TENS, the evidence includes RCTs and systematic reviews. The relevant outcomes are symptoms, functional outcomes, QOL, 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, two large RCTs found no benefit of TENS compared with sham TENS. A subsequent systematic review found that TENS reduced pain in the immediate postoperative period (24 hours) after total knee arthroplasty compared with a control intervention, however, neither the intensity nor optimal duration time for TENS have been established. For the prevention of migraine headaches, a small RCT reported a greater proportion of patients achieving at least a 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. For the relief of pain during office-based hysteroscopy, an RCT found decreased pain and higher patient satisfaction in patients receiving TENS compared with placebo or control. The evidence is insufficient to determine the effects of the technology on health outcomes.

## SUPPLEMENTAL INFORMATION

### 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, recommended that there was insufficient evidence for the use of TENS in headache prophylaxis and to abort an acute headache.<sup>75</sup>

#### Osteoarthritis Research Society International

Guidelines from the Osteoarthritis Research Society International (2014) recommended that TENS was inappropriate for use in patients with multi-joint osteoarthritis; moreover, the guidelines suggested that TENS has an uncertain value for the treatment of knee-only

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osteoarthritis pain.<sup>76</sup>

## National Comprehensive Cancer Network

National Comprehensive Cancer Network guidelines on adult cancer pain (v.1.2018) indicate that non-pharmacologic interventions, including TENS, may be considered in conjunction with pharmacologic interventions as needed (category 2A).<sup>72</sup>

## National Cancer Institute

National Cancer Institute's Physician Data Query identifies TENS as a potential other non-pharmacological modality for pain control for post-thoracotomy pain syndrome.<sup>77</sup>

## North American Spine Society

The North American Spine Society (2011) clinical guidelines on the diagnosis and treatment of cervical radiculopathy from degenerative disorders discussed the role of ancillary treatments such as bracing, traction, electrical stimulation, acupuncture, and TENS in the treatment of cervical radiculopathy from degenerative disorders.<sup>78</sup> A consensus statement from the Society recommended 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.

## American Academy of Neurology

The American Academy of Neurology (2010) published an evidence-based review of the efficacy of TENS for the treatment of pain in neurologic disorders.<sup>24</sup> The Academy did not recommend TENS for the treatment of chronic low back pain due to lack of proven efficacy (level A, established evidence from two class I studies), and that TENS should be considered for the treatment of painful diabetic neuropathy (level B, probably effective, based on two class II studies).

## American Society of Anesthesiologists et al

The practice guidelines from the American Society of Anesthesiologists and American Society of Regional Anesthesia and Pain Medicine (2010) recommended that TENS 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).<sup>79</sup>

## National Institute for Health and Care Excellence (NICE)

The NICE (2016) guidance on low back pain indicated that, despite the long history of use of TENS for back pain, the quality of research studies is poor.<sup>80</sup> This guidance recommended against TENS as a treatment.

The NICE (2014) guidance on osteoarthritis care and management in adults indicated that TENS be considered "as an adjunct to core treatments for pain relief."<sup>81</sup>

The NICE (2017) guidance on intrapartum care recommended against the use of TENS for "established labour."<sup>82</sup>

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## American Congress of Obstetricians and Gynecologists (ACOG)

The ACOG guidelines (2007) for women's health care state that methods of neurostimulation, such as TENS, acupuncture, and massage, were based on the gate theory of pain control.<sup>83</sup> These treatments can be useful for pain control, particularly when the pain is severe. The guidelines recommended 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 ACOG guidelines (2004) on chronic pelvic pain found that clinical trials evaluating the efficacy of acupuncture, acupressure, and TENS therapies have been performed only for primary dysmenorrhea, not for nonmenstrual pelvic pain.<sup>84</sup> The guidelines recommended that acupuncture, acupressure, and TENS therapies be considered to decrease the pain of primary dysmenorrhea.

The ACOG guidelines (2019) on labor and delivery found that TENS may "help women cope with labor more than directly affect pain scores."<sup>85</sup>

## American College of Physicians

The American College of Physicians (2017) published guidelines on noninvasive therapies for acute and low back pain.<sup>86</sup> No recommendations for TENS were made; the College concluded that "evidence was insufficient to determine the effectiveness" of TENS and that there was no long-range data.

## European Federation of Neurological Societies

The European Federation of Neurological Societies (2007) published guidelines on neurostimulation for neuropathic pain.<sup>87</sup> The guidelines did not offer conclusive recommendations, with only approximately 200 patients with different diseases, based on studies using different parameters and comparators, and having variable results. The societies 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 & Medicaid Services currently have a number of national coverage decisions on TENS.<sup>88,89,90,91,92</sup> The different coverage decisions address the use of TENS in the treatment of chronic intractable pain, noncoverage of TENS for chronic low back pain except to conduct research for said indication, and coverage for acute postoperative pain.

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## POLICY HISTORY - THIS POLICY WAS APPROVED BY THE FEP® PHARMACY AND MEDICAL POLICY COMMITTEE ACCORDING TO THE HISTORY BELOW:

Date	Action	Description
September 2012	New policy	
December 2013	Replace policy	Policy updated with literature review, references 22, 24, 26, 32 35, 36 & 54 added. Policy statements are unchanged.
June 2014	Replace policy	Policy updated with literature review; References 1, 26-28, 3135, 45-48, 50-52 added; last policy statement revised to specifically list use of TENS in prevention of migraine headaches as not medically necessary.
June 2015	Replace policy	Policy updated with literature review. References 33, 43, and 45-46 added, and references 55-56 updated; policy statements unchanged.
June 2016	Replace policy	Policy updated with literature review through October 12, 2015 references 33-34, 50, and 52 added. Policy statements unchanged.
March 2018	Replace policy	Policy updated with literature review through September 12, 2017; references 33, 39-40, 49, and 55 added. Policy statements unchanged except "not medically necessary" corrected to "investigational" due to 510(k) status.
March 2019	Replace policy	Policy updated with literature review through September 18, 2018; references 25, 27-28, 51, and 63 added; references 72-74 updated. Policy statements unchanged.
March 2020	Replace policy	Policy updated with literature review through September 7, 2019, references added. Policy statements unchanged.

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