LIFE HEALTH DME

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Statement of Medical Necessity for TENS Unit/Garment

Patient Name: _____ DOB:_____ Date: ___/___/___

Patient is being prescribed a **TENS unit Durable Medical Equipment device** for the following medically necessary reasons:
❑ treat pain related to musculoskeletal conditions ❑ treat pain associated with active or post-traumatic injury

Patient presents with pain in the ❑ cervical region ❑ torso ❑ upper extremity ❑ lower extremity
Duration: ❑ < 3 months ❑ > 3 months ❑ 1+ years
Presumed cause: ❑ accident/injury ❑ idiopathic ❑ chronic degenerative

Patient has attempted the following treatments in the past for the pain:
❑ Prescription medication ❑ OTC medication ❑ Physical therapy ❑ Chiropractic ❑ Surgery ❑ Topical creams

Results of prior treatment: ❑ No relief ❑ Limited relief – not sustained

A **TENS garment** is also medically necessary for this patient for the following reasons:
❑ Area of pain is too large to treat with conventional electrodes, adhesive tapes and lead wires
❑ Area to be stimulated is inaccessible with the use of conventional electrodes, adhesive tapes and lead wires.
❑ there is a documented medical condition such as skin problems that preclude the application of conventional electrodes, adhesive tapes

HCPCS
❑ E0730 TENS Unit, 4 lead
❑ E0731 TENS Garment ◊ glove ◊ sock ◊ knee ◊ elbow ◊ back

INSTRUCTIONS FOR USE:
◊Treatment time: (30 mins, other _____) ◊Frequency: (____ times per day) ◊Duration: (_____ days, weeks, months)

DIAGNOSIS:
❑ G89.29 Other chronic pain
❑ G89.21 Chronic pain due to trauma
❑ G89.11 Acute pain due to trauma
❑ M25.50 Pain in unspecified joint
❑ M54.6 Thoracic pain
❑ M54.2 Cervicalgia
❑ M25.519 Pain in unspecified shoulder

Provider Name: _____Provider Signature: _____

REEVALUATION: **Date**:_____
This patient utilized the prescribed TENS unit/garment for (❑ 10 ❑ 15 ❑ 20 ❑ 30) minutes (❑ 2-3x/day ❑ Daily ❑ 2-3 times/week ❑ Weekly) resulting in (❑ No relief ❑ Limited relief ❑ Moderate relief ❑ Complete relief) from symptoms.

The results of a 30-60 day trial period demonstrate that this patient is (❑ likely ❑ not likely) to derive significant therapeutic benefit from continuous use of the above prescribed TENS unit/garment going forward.

Provider Name: Provider Signature:

(Please attach SOAP note from reevaluation.)