**ACTION:** Final

**ENACTED** 

## ENACTED DATE: 03/30/2007 10:19 AM Onio Department of Medical Necessity/Prescription **Transcutaneous Electrical Nerve Stimulator (TENS)**

SECTION A: Consumer/Provider Information

Certification Type:						Recertifi	cation	
Consumer's Name: Provider's Name:								
Consumer DOB:		Consumer Sex:  Female	□ M	Consumer HT (in.): Cons		Consumer WT (lbs.):		
(If consumer is not resid	ding at home add	ress)	Prescriber's Name:					
Facility Name:				Prescriber's NPI Number:				
Facility Address:			Prescriber's Telephone:					
Facility City, State and Zip Code:				Prescriber's Medicaid Legacy Number:				
SECTION B: Information below may not be completed by the provider of the Items/Supplies								
Est. Length of Need (# of Months): 1-99 (99= <b>LIFETIME</b> )					Diagnosis Codes (ICD-9) and Descriptions:			
Last Consumer Medical Examination (MM/DD/YR):								
ANSWERS	T							
	(Check Y for Yes, N for No, or D for Does Not Apply, Unless Otherwise Noted)							
□ Y □ N □ D	Does the consumer have acute post-operative pain?							
/ /	2. What is the date of surgery resulting in acute post-operative pain?							
□ Y □ N □ D	3. Does the consumer have chronic, intractable pain?							
[ months]	4. How long has the consumer had intractable pain? (Enter number of months, 1-99)							
□ 1 □ 2 □ 3 □ 4 □ 5	<ul> <li>5. Is the TENS unit being prescribed for any of the following conditions? (Check the appropriate number)</li> <li>1- Headache; 2- Visceral abdominal pain; 3- Pelvic pain; 4-Temporomandibular joint (TMJ) pain;</li> <li>5- None of the above</li> </ul>							
□ Y □ N □ D	6. Is there documentation in the medical record of multiple medications and/or other therapies that have been tried and failed?							
	7. Has the consumer received a TENS unit trial?							
Begin/Ended	8. What are the dates that the trial of TENS unit began and ended?							
/ /								
/ /	9. What is the date you reevaluated the consumer at the end of the trial period?							
□ 1 □ 2 □ 3	10. How often has the consumer been using the TENS unit? (Check the appropriate number) 1= Daily; 2 = 3 to 6 days per week; 3 = 2 or less days per week							
□ Y □ N □ D	11. Do you and the consumer agree that there has been a significant improvement in the pain and the long term use of a TENS unit is warranted?							
□ 2 □ 4	12. Number of TENS unit leads (i.e., separate electrodes) routinely needed and used by the consumer at any one time:  (Check appropriate number) 2 = 2 leads 4 = 4 leads							
NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PRESCRIBER (Please Print):  NAME: EMPLOYER:								
NAME: TITLE: EMPLOYER:  SECTION C: Narrative Description of Equipment and Cost								
(1) Narrative description of all items, accessories and options ordered; (2) Provider charge; and (3) Medicaid Fee Schedule Allowance for each item, accessory, and option.								
I certify that I am the prescriber identified above. I certify that the information on this certificate of medical necessity and any information on any attached documents signed and dated by me is true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability. (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)								
Prescriber's Signature:  Date:							e:	

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