Ohio Department of Job and Family Services

Certificate of Medical Necessity/Prescription
Transcutaneous Electrical Nerve Stimulator (TENS)

SECTION A: Consumer/Provider Information

Certification Type: ☐ **Initial** ☐ **Revised** ☐ **Recertification**			
Consumer's Name:		Provider's Name:	
Consumer DOB:	Consumer Sex: ☐ Female ☐ Male	Consumer HT (in.):	Consumer WT (lbs.):
(If consumer is not residing at home address) Facility Name:		Prescriber's 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=**LIFETIME**)	Diagnosis Codes (ICD-9) and Descriptions:
Last Consumer Medical Examination (MM/DD/YR):	

ANSWERS	ANSWER QUESTIONS 1-6 FOR RENTAL OF TENS UNIT, AND 3-12 FOR PURCHASE OF TENS UNIT. (Check **Y** for Yes, **N** for No, or **D** for Does Not Apply, Unless Otherwise Noted)
☐ Y ☐ N ☐ D	1. 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	5. Is the TENS unit being prescribed for any of the following conditions? (Check the appropriate number) 1- Headache; 2- Visceral abdominal pain; 3- Pelvic pain; 4-Temporomandibular joint (TMJ) pain; 5- None of the above
☐ Y ☐ N ☐ D	6. Is there documentation in the medical record of multiple medications and/or other therapies that have been tried and failed?
☐ Y ☐ N ☐ D	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: 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 <u>each</u> 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:

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