DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C4-26-05
Baltimore, Maryland 21244-1850

MEMORANDUM

DATE: **August 1, 2012**

FROM: Acting Director
Financial Services Group
Office of Financial Management

SUBJECT: Impact of the Removal of coverage of Transcutaneous Electrical Nerve Stimulation (TENS) Units for Chronic Low Back Pain (CLBP) on Workers' Compensation Medicare Set-Aide Arrangement (WCMSA) proposals – INFORMATION

TO: Consortium Administrators for Financial Management and Fee-for-Service Operations

The purpose of this memorandum is to alert applicable Centers for Medicare & Medicaid Services (CMS) Regional Offices, and to provide guidance to submitters of WCMSA proposal amounts, to a recent CMS coverage change that will affect pricing determinations for Transcutaneous Electrical Nerve Stimulation (TENS) units included within submitted Workers' Compensation Medicare Set-Aside (WCMSA) proposals.

On June 8, 2012, CMS released a Decision Memo that addressed conditions for coverage of a TENS unit for chronic low back pain. This Decision Memo may be viewed in its entirety at http://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=256.

Decision Memo's Definition of Chronic Low Back Pain (CLBP) and Guidance for Coverage of TENS Units:
The CMS Decision Memo defined CLBP as "an episode of low back pain that has persisted for three months or longer; and is not a manifestation of a clearly defined and generally recognizable primary disease entity." The Decision Memo also stated that a TENS unit is not reasonable and necessary for the treatment of CLBP, in accordance with the provisions of section 1862(a)(1)(A) of the Social Security Act.

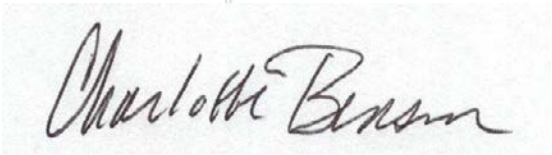
The recent change in coverage of TENS units for CLBP will have the following impacts upon the WCMSA proposal review process:

- **Effective June 8, 2012**, for those workers' compensation (WC) cases settled prior to June 8, 2012, and where the settlement included pricing for TENS for CLBP, CMS will consider funds spent for TENS for CLBP by beneficiaries and claimants as being an appropriate expenditure of funds as part of the WCMSA.

- **For those WC cases** that were **not settled prior to June 8, 2012,** and where the WCMSAs proposal includes funding for TENS for CLBP as part of the WCMSA, CMS will re-review the cases and remove pricing for TENS for CLBP. (Regional Offices shall obtain from submitters requests for a case re-review, along with a signed statement indicating a settlement had not occurred prior to June 8, 2012.)

Once CMS performs a re-review of WCMSAs to remove pricing for TENs for CLBP, beneficiaries and claimants may not use funds from their WCMSA to pay for non-covered TENS for CLBP. Doing so constitutes an inappropriate expenditure of WCMSA funds.

Your staff may direct questions or concerns to Elizabeth V. Poole, of my staff, at (410) 786-6683.



Charlotte Benson