Fax orders to (817)473-1839 or email imsexpertsintake@att.net

Rep Name: _____

IMS Experts
Physician Detail Written Order and Letter of Medical Necessity (LMN)
Transcutaneous Electrical Nerve Stimulators (TENS)

PATIENT NAME:		**ICD-10 / DX:**	
DOB:		**HCPC CODE:**	
PHYSICIAN:		**NPI:**	
PHYSICIAN PH #:		**MED LICENSE:**	

These prescribed durable medical equipment product(s) are for treatment of the referenced patient. It is both reasonable and medically necessary to effectuate a maximum and expedient recovery.

TENS Unit FOR PRESCRIBED PT: Choose option which applies to patient

A TENS Unit prescribed for Acute Post-Operative Pain must meet the following:

◯ TENS is covered for acute post-operative pain. Coverage is limited to 30 days (one month's rental) from the day of surgery. A TENS unit will be denied as not reasonable and necessary for acute pain (less than three months duration) other than for post-operative pain.

Chronic Pain Other than Low Back Pain: TENS is covered for chronic, intractable pain other than chronic low back pain when all of the following criteria must be met:

◯ The presumed etiology of the pain must be a type that is accepted as responding to TENS therapy. Examples of conditions for which TENS therapy is not considered to be reasonable and necessary are (not all-inclusive):

◯ Headache
◯ Visceral abdominal pain
◯ Pelvic pain
◯ Temporomandibular joint (TMJ) pain

The following must also apply:

◯ Pain has been present for at least three months:
◯ Other appropriate treatment modalities must have been tried and failed

Type of Brace/Manufacturer issued to patient:_____ Qty:_____
Date of Order:_____ Patient Start Date:_____
Length of Need: (**check one**) ◯ 99 months/lifetime ◯ Rental ◯ Other Duration_____

X_____ Date_____
Physician Signature (NO STAMP)

This information will become part of the dictation and permanent clinical record of the above patient.