



# Using DME to Treat Pain

There is more to managing pain than prescribing medications and administering steroid injections.

BY PAUL KESSELMAN, DPM

Anyone who has seen patients dealing with chronic pain, or have suffered from it themselves, understands how debilitating this can be. Pain can literally take over your life, prevent you from managing the simplest of physical or mental tasks, and leave you physically and mentally exhausted. This edition of DME for DPMS will review some pain management tools for podiatrists. It will also provide insights into Medicare Local Carrier Determinations (LCD),

for acute and chronic pain. For short-term post-op pain, payment is covered for a one-month rental (30 days). Typically, this would be dispensed around the time of surgery. For chronic long-term use, the pain must have been present for at least three months prior to implementation of TENS. It is then covered, initially on a trial basis for a minimum of 30 days, but not to exceed two months. The trial period will be paid as rental. The trial period must be monitored by the treating (prescribing) practitioner to determine

bilateral polyneuropathy would likely need a four-lead unit.

In addition to the TENS unit, the actual supplies (e.g., gel, electrodes, and adhesives) are separately initially payable as follows:

- 2 TENS lead supplies—a maximum of one unit of A4595 per month.
- 4 TENS lead supplies—a maximum of two units of A4595 per month

The actual replacement of the lead wires (A4557) is separately covered every 12 months if reasonable and necessary.

Conductive sock-like garments (E0731) may be used with a TENS unit instead of electrodes. However, the LCD states that this garment (sock) is rarely necessary. But they are covered if all the following conditions are met:

- There is such a large area or so many sites to be stimulated, and
- The stimulation would have to be delivered so frequently that it is not feasible to use conventional electrodes, adhesive tapes, and lead wires.
- The beneficiary cannot manage without the conductive garment for the treatment of chronic intractable pain because the areas or sites to be stimulated are inaccessible with the use of conventional electrodes, adhesive tapes, and lead wires.
- The beneficiary has a documented medical condition, such as skin problems, that preclude the application of conventional electrodes, adhesive tapes, and lead wires.
- The beneficiary requires electrical stimulation beneath a cast to treat chronic intractable pain.

Due to a large area of multiple nerves providing nerve supply to the foot/ankle and lower leg, garments,

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which address pain management tools. Please note that there is a wide variation of coverage for pain management services covered by third-party payers. Please always refer to the specific carrier for their coverage parameters.

This article will *not* address the use of any oral, compound, topical IM or IV pharmaceuticals, or traditional orthotics/prosthetics used for pain management.

### **Trans Electrical Nerve Stimulation (TENS):**

TENS is covered under Fee for Service Medicare and many other third-party payers. Until recently TENS was subject to the National Competitive Bidding (CB) program. But regardless of whether it is on the CB radar screen, DPMS under-utilize the prescribing and dispensing of this covered DME service.

The Fee for Service LCD (L33802) is very specific regarding TENS coverage

the effectiveness of the TENS unit in modulating the pain.

For coverage of a purchase, the treating practitioner must determine that the beneficiary is likely to derive significant therapeutic benefit from continuous use of the unit over a long period of time. An example of a podiatry patient who would be covered for long-term use would be a diabetic with chronic painful neuropathy. Again, they must have first had chronic pain for at least three months, and previous failed therapy must be documented in the medical record.

The LCD goes into further detail on the various types of TENS units available: E0720 TENS Two leads and E0730 Four or more leads.

Note that additional medical necessity for the E0730 supporting the need for multiple nerve stimulation is required. For example, a patient with



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in lieu of electrodes, may satisfy these requirements. Garments are only covered during the trial period if the patient has a documented skin condition prior to the trial period. However, before launching into billing for garments, be aware that this code may be highly vulnerable to audits.

All TENS claims are highly audited, with high failure rates. However, many failures (>40%) are because the patient did not meet the medical necessity requirements of the LCD. For those patients, well over 80% of initial claim denials were overturned on review, and the providers paid. Ultimately, studies have shown that if your charting is supportive of medical necessity, there is less than a 20% failure rate for meeting the LCD criteria. That's better than for both AFO and Therapeutic Shoe claims.

HCPCS MODIFIERS associated with TENS include one of the following:

EY—No physician or other licensed health care provider order for this item or service.

GA—Waiver of liability statement issued as required by payer policy, individual case.

GZ—Item or service expected to be denied as not reasonable and necessary.

KX—Requirements specified in the medical policy have been met.

Whether you choose to provide TENS or refer it to a commercial DME provider, there is extensive literature supporting its use. The use of TENS is consistent with reducing patients' reliance on opioids and potential side-effects associated with long-term use of NSAIDs.

Other therapies for which you may want to consider referring patients to a pain management specialist include:

**Percutaneous Electric Nerve Stimulation:** PENS differs from TENS in that needles are inserted around or immediately adjacent to the nerve serving the painful area, and then stimulated.

PENS is generally reserved for patients who fail to obtain pain relief from TENS, due to physical barriers to the conduction of electrical stimulation (e.g., scar tissue, obesity). PENS must be distinguished from

acupuncture with electrical stimulation. In electrical acupuncture, needles are also inserted just below the skin, but the placement of needles is based on specific theories regarding energy flow throughout the human body. In PENS, the location of stimulation is determined by proximity to the pain rather than the theories of energy flow that guide placement of stimulation for acupuncture.

One study conducted by Hamza et al., reported in *Diabetes Care* in 2000, suggested that short-term PENS therapy was effective. But since no long-term results are available and questions have been raised about

local neurosurgeon is another piece of the referral puzzle for your practice to build upon.

**Referral to Physical Therapy:** Don't dismiss providing therapy in your office or referring patients to a therapist as an effective way to provide pain relief. Having patients exercise and stretch daily at home, even on those "off" days when they are not receiving physical therapy, is important. Take the time to provide and demonstrate those exercises to your patients to reinforce the care provided by their physical therapists. If you are performing in-office PT, remember that a plan of care is required.

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whether the study was properly conducted, most payers are still not covering PENS therapy.

At this time, PENS is mostly a CASH service or billed as a neurological miscellaneous service (64999), as there is no specific CPT associated with this procedure. While most podiatrists theoretically could provide this service under their state scope of practice, working with a pain-management specialist may be more prudent.

There are several manufacturers that provide true PENS. Others advertise their devices as PENS, but they contain surface electrodes and are more accurately coded as TENS. Since patients cannot self-administer PENS, they are truly not DME and must be provided in a labor-intensive environment in the physician's office.

**Implantable Nerve Stimulators:** There are two basic types of implanted peripheral nerve stimulators. Peripheral stimulators are implanted juxtaposed to a peripheral nerve. Central nerve stimulators are implanted near the spinal nerve of etiology, resulting in the "pain syndrome." The type of implanted stimulator needed is best left to the discretion of a neurosurgeon well versed in pain management. A recent literature search is replete with hundreds of supportive articles about this technique. Coordinating this care with a

**Prolotherapy, laser/light therapy, high-frequency electronic wave technology and injections with sclerosing agents:** Some practitioners find these treatments extremely effective, albeit mostly non-reimbursable. The science of these treatments is beyond the scope of this article but certainly may be worth pursuing. Start by meeting with those already performing such procedures and reading the many reliable resources on this subject.

**Biofeedback:** Referring patients to a psychologist or hypnotist are also measures that can be implemented to reduce pain.

**CBD Oil and Medical Marijuana:** These are now legal in most states and have been used to provide palliative pain treatment for cancer patients and others suffering from chronic debilitating pain. Prescribing this very effective tool varies by state scope of practice. Check with you state board of podiatry and state board of pharmacy for more information.

Last and perhaps most controversial are the CPT billing and coding for peripheral nerve blocks, Morton's Neuroma, trigger-point injections, and the newcomer radiofrequency nerve ablation. Most if not all podiatrists have extensive experience with many of these very effective thera-

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pies. Medicare contractors including CGS, NGS, Noridian, Palmetto, and WPS—which together cover about half the country—have proposed an LCD that would sharply curtail treatment for many of these chronic conditions. For example, the proposed LCD restricts patients to receiving only two injections per lifetime on the same foot for a Morton’s Neuroma. Multiple nerve blocks performed on the same day would be subject to medical review.

Therapeutic radiofrequency neurolysis may also not be reimbursable for clinical conditions other than trigeminal neuralgia. Questions remain about the viability of providing a diagnostic posterior tibial nerve block to assist with diagnosis of tarsal tunnel syndrome.

This proposed LCD has been met with sharp criticism from APMA and from the AMA, along with several

specialty associations representing pain management specialists. All these organizations warned, “The proposed policies would restrict access to evidence-based non-opioid pain treatments and force clinicians to rely on less appropriate or higher-risk alternatives, reinforcing that peripheral nerve blocks are proven, widely supported interventions that improve pain, function, and quality of life for many patients with chronic pain.” Please check with your Medicare contractor, as this situation remains fluid and has NOT yet been implemented.

Podiatrists are often on the forefront of managing lower-extremity pain, and there is more to managing pain than prescribing medications and administering steroid injections. A wide array of other therapies, some reimbursable and some not, can be provided and/or prescribed to manage chronic pain. The modern podiatric physician

should have these treatment options at their disposal, particularly due to the DEA objective of reducing a patient’s reliance on opioids. Make connections with pain-management specialists for those patients who require more complicated treatments than you are comfortable or licensed to provide. Your patients will thank you. **PM**



**Dr. Kesselman** is board certified by ABFAS and ABMSP. He is a member of the Medicare Jurisdictional Councils for the DME MACs and a member of the enrollment subcommittee. He is a noted expert on durable medical equipment (DME) and consultant for DME manufacturers worldwide. He is the owner of Park DPM and co-owner of PARE Compliance. He is also co-owner of [www.codinghelpline.com](http://www.codinghelpline.com), a new online forum for coding and reimbursement. He was elected to the *PM* Podiatry Hall of Fame in 2025.