COLORADO
Department of Health Care Policy & Financing

Acentra HEALTH

Prior Authorization Request 2810 N. Parham Road Suite 305 Henrico, VA 23219	**ColoradoPAR Program** Medical Review Department	Phone: 1-720-689-6340 Fax: 1-800-922-3508

QUESTIONNAIRE #9
Transcutaneous Electrical Nerve Stimulator (TENS), Neuromuscular Electrical Nerve Stimulator, (NMES), Functional Electrical Stimulation (FES)

Member Name		Health First Colorado ID #	

Height		Weight	

TENS or NMES is an acceptable treatment modality for some types of chronic intractable pain. Generally, a physician should be able to assess if a member is likely to derive a significant therapeutic benefit from continuous use of a TENS or NMES unit within a trial period of two (2) months. Refer to the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Billing Manual for proper modifier use. The information requested below is required to determine medical necessity. Complete this form and attach to the completed Prior Authorization Request (PAR).

FES: Complete questions 1, 2, 3, & 11
NMES for muscle atrophy: Complete questions 1, 4, 5, 6, & 11
NMES or TENS for pain: Complete questions 1, 7, 8, 9, 10, & 11

1. What is the complete diagnosis with complicating factors?	
2. If request is for a FES, what prior interventions have been trialed and failed in improving movement?	
3. If this is a convert to purchase FES, how has the FES improved movement to the treated area?	
4. If request is for a NMES to treat muscle atrophy, what interventions have been trialed and failed to improve muscle atrophy?	
5. If unit will be used on a contracted extremity, describe how this will be useful in addressing member's needs.	
6. If this is a convert to purchase NMES to treat muscle atrophy, how has the NMES improved muscle atrophy?	
7. If this request is for treatment of pain, list used or prescribed analgesics (drug/dose/route/frequency) prior to using TENS or NMES.	

8. Provision of a TENS unit is considered the final alternative in pain management. Explain the trigger point, traction, drug, and/or if appropriate, include the clinical results of each. This information is required to establish medical necessity. **Note**: Failure to respond fully will result in denial of this request.	
9. Identify any of the above medications that were reduced/discontinued dosage/frequency as a result of the use of TENS or NMES.	
10. If this is a convert to purchase request to treat pain during the trial period, did the TENS or NMES:	□ Produce no relief □ Produce greater discomfort than the original pain □ Significantly alleviate pain
11. Supply any additional information that will assist us in determining **medical necessity** for this request:	

Print Prescriber Name _____

Prescriber Signature _____

Date _____