1.01.09	Transcutaneous Electrical Nerve Stimulation and Transcutaneous Afferent Patterned Stimulation		
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Policy Statement

I. A trial of transcutaneous electrical nerve stimulation (TENS) of at least 30 days may be considered **medically necessary** to establish efficacy for the management of refractory chronic pain (e.g., chronic musculoskeletal pain or neuropathic pain) that causes significant disruption of function when **both** of the following conditions have been met:
   A. The pain is unresponsive to at least 3 months of conservative medical therapy
   B. The trial is monitored by a provider.

II. Continued use of TENS may be considered **medically necessary** for treatment of refractory chronic pain (e.g., chronic musculoskeletal or neuropathic pain) that causes significant disruption of function when **both** of the following conditions have been met:
   A. Efficacy has been demonstrated in an initial therapeutic trial (see Policy Guidelines section)
   B. Compliance has been demonstrated in the therapeutic trial with the device used on a regular basis (e.g., daily or near daily use) throughout the trial period.

III. TENS is considered **investigational** for the management of acute pain (e.g., postoperative or during labor and delivery).

IV. TENS is considered **investigational** for the prevention or treatment of migraine headache.

V. TENS is considered **investigational** for the management of attention deficit hyperactivity disorder.

VI. Transcutaneous afferent patterned stimulation (TAPS) is considered **investigational** for the following conditions:
   A. Essential tremor;
   B. Action tremor for Parkinson disease

VII. The use of TENS or TAPS for any other condition, including but not limited to the treatment of dementia is considered **investigational**.

NOTE: Refer to Appendix A to see the policy statement changes (if any) from the previous version.

Policy Guidelines

For the purposes of these policy guidelines, refractory chronic pain is defined as pain that causes significant disruption of function and has not responded to at least 3 months of conservative therapy, including nonsteroidal anti-inflammatory medications, ice, rest, and/or physical therapy.

Documentation for the trial should include:

- Initial assessment/evaluation of the nature, duration, and perceived intensity of pain
- The types and duration of prior treatments
- Treatment plan including ongoing medications and proposed use of transcutaneous electrical nerve stimulation (TENS) unit, including the frequency and duration of treatment

Clinical summary of the trial to determine efficacy should include **all** of the following:

- Actual use of TENS on a daily basis (frequency and duration of application)
- Ongoing medication requirements for pain relief (if any)
- Other modalities (if any) in use for pain control
- Perceived intensity of pain with and without TENS (e.g., 2-point or 30% improvement in visual analog scale [VAS])

TENS devices may be delivered through a practitioner and require a prescription or obtained without a prescription. It is possible that prescribed devices provide higher intensity stimulation than units sold directly to the public.

Coding
There is no specific coding for the Cefaly device. Coding would most likely be reported with the miscellaneous durable medical equipment code E1399.

See the Codes table for details.

Description

Transcutaneous electrical nerve stimulation (TENS) describes the application of electrical stimulation to the surface of the skin. In addition to more traditional settings such as a physician's office or an outpatient clinic, TENS can be self-administered in a patient's home.

Related Policies

- Interferential Current Stimulation
- Percutaneous Electrical Nerve Stimulation and Percutaneous Neuromodulation Therapy
- Temporomandibular Joint Disorder

Benefit Application

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal mandates (e.g., Federal Employee Program [FEP]) prohibits plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

Regulatory Status

TENS devices consist of an electrical pulse generator, usually battery-operated, connected by wire to 2 or more electrodes, which are applied to the surface of the skin at the site of the pain. Since 1977, a large number of devices have been cleared for marketing by the U.S. Food and Drug Administration (FDA) through the 510(k) process. Marketing clearance via the 510(k) process does not require data on clinical efficacy; as a result, these cleared devices are considered substantially equivalent to predicate devices marketed in interstate commerce before May 1976, the enactment date of the Medical Device Amendments. The cleared devices are also equivalent to devices that have been reclassified and do not require a premarket approval application. FDA product code: GZJ.

In 2014, the Cefaly® (STX-Med), which is a TENS device, was granted a de novo 510(k) classification by the FDA for the prophylactic treatment of migraine in patients 18 years of age or older.[1,] The Cefaly® Acute and Cefaly® Dual devices were cleared by the FDA through the 510(k) process for the acute treatment of migraine in patients in 18 years of age or older and for both the acute treatment and prophylaxis of migraines in adults, respectively, in 2017.[2,3,] Other TENS devices cleared by the FDA through the 510(k) process for the prophylactic treatment of migraine in patients include Allive (Nu Eyne Co), Relivion (Leurolief Ltd.) and HeadaTerm (EEspress) among others.[4,5,6,]FDA product code: PCC.

In 2018, the FDA reviewed the Cala ONE™ TENS device (Cala Health) via the de novo pathway and granted approval for the device as an aid in the transient relief of hand tremors following stimulation in the affected hand of adults with essential tremor. This prescription device is contraindicated for use in patients with an implanted electrical medical device, those that have suspected or diagnosed epilepsy or other seizure disorder, those who are pregnant, and patients with swollen, infected, inflamed areas, or skin eruptions, open wounds, or cancerous lesions. In October 2020, the FDA granted breakthrough device designation to the Cala Trio™ device for the treatment of action tremors in the hands of adults with Parkinson's disease.[7,] In November 2022, the Cala kIQ™ device was approved via the 510(k) pathway (K222237). The device is indicated to aid in the temporary relief of hand tremors in the treated hand following stimulation in adults with essential tremor. It was also approved to aid in the temporary relief of postural and kinetic hand tremor symptoms that impact some activities of daily living in the treated hand of adults with Parkinson's disease. Cala Trio and Cala kIQ use transcutaneous afferent patterned stimulation (TAPS) therapy which consists of bursts of non-invasive electrical stimulation applied to the median and radial nerves.

In 2019, the FDA permitted marketing of the first medical device to treat attention deficit hyperactivity disorder (ADHD) - the Monarch® external Trigeminal Nerve Stimulation (eTNS) System by NeuroSigma.[8,] The FDA reviewed the system through the de novo premarket review pathway. This prescription only TENS device is indicated for patients 7 to 12 years of age who are not currently taking prescription ADHD medication. The Monarch eTNS System is intended to be used in the home under the supervision of a caregiver. The device generates a low-level electrical pulse and connects via a wire to a small patch that adheres to a patient's forehead, just above the eyebrow.

In 2021, the FDA approved the Axon Therapy device (Neuralace Medical, Inc.) for marketing through the 510(k) process for relief of chronic, intractable postsurgical or posttraumatic pain in adults.[9,] The Axon Therapy device is an electromagnetic transcutaneous peripheral nerve stimulator. FDA product codes: QPL, IPF.

Rationale

Background

Transcutaneous electrical nerve stimulation (TENS) has been used to treat chronic intractable pain, postsurgical pain, and pain associated with active or posttrauma injury unresponsive to other standard pain therapies. It has been proposed that TENS may provide pain relief through the release of endorphins in addition to potential blockade of local pain pathways. TENS has also been used to treat dementia by altering neurotransmitter activity and increasing brain activity that is thought to reduce neural degeneration and stimulate regenerative processes.

Percutaneous electrical nerve stimulation (see Blue Shield of California Medical Policy: Percutaneous Electrical Nerve Stimulation and Percutaneous Neuromodulation Therapy) is similar to TENS but uses microneedles that penetrate the skin instead of surface electrodes. Interferential stimulation (see Blue Shield of California Medical Policy: Interferential Current Stimulation) uses a modulated waveform for deeper tissue stimulation, and the stimulation is believed to improve blood flow to the affected area.

Literature Review

Evidence reviews assess the clinical evidence to determine whether the use of technology improves the net health outcome. Broadly defined, health outcomes are the length of life, quality of life (QOL), and ability to function including benefits and harms. Every clinical condition has specific outcomes that are important to individuals and managing the course of that condition. Validated outcome measures are necessary to ascertain whether a condition improves or worsens; and whether the magnitude of that change is clinically significant. The net health outcome is a balance of benefits and harms.

To assess whether the evidence is sufficient to draw conclusions about the net health outcome of technology, 2 domains are examined: the relevance, and quality and credibility. To be relevant, studies must represent 1 or more intended clinical use of the technology in the intended population and compare an effective and appropriate alternative at a comparable intensity. For some conditions, the alternative will be supportive care or surveillance. The quality and credibility of the evidence depend on study design and conduct, minimizing bias and confounding that can generate incorrect findings. The randomized controlled trial (RCT) is preferred to assess efficacy; however, in some circumstances, nonrandomized studies may be adequate. Randomized controlled trials are rarely large enough or long enough to capture less common adverse events and long-term effects. Other types of studies can be used for these purposes and to assess generalizability to broader clinical populations and settings of clinical practice.

Promotion of greater diversity and inclusion in clinical research of historically marginalized groups (e.g., People of Color [African-American, Asian, Black, Latino and Native American]; LGBTQIA (Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual); Women; and People with Disabilities [Physical and Invisible]) allows policy populations to be more reflective of and findings more applicable to our diverse members. While we also strive to use inclusive language related to these groups in our policies, use of gender-specific nouns (e.g., women, men, sisters, etc.) will continue when reflective of language used in publications describing study populations.

Transcutaneous Electrical Nerve Stimulation for Chronic Pain

A large number of systematic reviews, most conducted by Cochrane, have assessed the use of transcutaneous electrical nerve stimulation (TENS) in the treatment of a variety of pain conditions, including the topics of osteoarthritis, rheumatoid arthritis, pancreatitis, myofascial trigger points, temporomandibular joint pain, cancer pain, neck pain, acute pain, phantom limb pain, labor pain, and chronic back pain.[10,11,12,13,14,15,16,17,18,19,20,21,22,23,24,25,26,][28,29,30,31,32,] In 2010 (reaffirmed 2024), the American Academy of Neurology (AAN) published an evidence-based review of the efficacy of TENS for the treatment of pain in neurologic disorders, including low back pain and diabetic peripheral neuropathy.[33,]

Clinical Context and Therapy Purpose

The purpose of TENS is to provide a treatment option that is an alternative to or an improvement on existing therapies in individuals with chronic pain (e.g., musculoskeletal, neuropathic, and mixed pain conditions).

The following PICO was used to select literature to inform this review.

Populations

The relevant population of interest is individuals with chronic pain conditions (e.g., musculoskeletal, neuropathic, and mixed pain conditions).

Interventions

The therapy being considered is TENS.

Comparators
The following therapies are currently being used to treat chronic pain: physical therapy and pharmacotherapy.

Outcomes
The general outcomes of interest are reductions in symptoms and medication use, and improvements in functional outcomes and QOL. Given the different types of pain conditions, follow-up will vary and some cases will be life-long (e.g., fibromyalgia, arthritis).

Study Selection Criteria
Methodologically credible studies were selected using the following principles:

- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;
- In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
- To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
- Studies with duplicative or overlapping populations were excluded.

Review of Evidence
Low Back Pain
Systematic Reviews
Wu et al (2018) conducted a meta-analysis of RCTs comparing the efficacy of TENS with a control and other nerve stimulation therapies for the treatment of chronic back pain.[34,] Reviewers searched 4 databases (PubMed, Cochrane, Google Scholar, ClinicalTrials.gov) and identified 12 RCTs involving 700 patients. Analysis indicated that TENS had efficacy for providing pain relief similar to control treatment (standard mean difference [SMD], -0.20; 95% confidence interval [CI], -0.5 to 0.18; p=.293) and that other types of nerve stimulation therapies were more effective than TENS (SMD, 0.86; 95% CI, 0.15 to 1.57; p=.017).

Dubinsky et al (2010), who conducted an evidence-based review for AAN, evaluated the efficacy of TENS for treating pain in neurologic disorders.[33,] The evidence on TENS for chronic low back pain of various etiologies (some neurologic) included 2 class I studies (prospective randomized trial with masked outcome assessment in a representative population) and 3 class II studies (randomized trial not meeting class I criteria or a prospective matched group cohort study in a representative population). The class I studies compared TENS with sham TENS for 4 or 6 weeks of treatment.

Although both studies were adequately powered to find a 20% or greater difference in pain reduction by visual analog scale (VAS), after correction for multiple comparisons, no significant benefit was found for TENS compared with sham TENS. In 2 of the 3 class II studies, no significant differences were found between TENS and sham TENS. In the third class II study, the benefit was found in 1 of 11 patients treated with conventional TENS, 4 of 11 treated with burst-pattern TENS, and 8 of 11 treated with frequency-modulated TENS. Overall, evidence was conflicting. Because class I studies provide stronger evidence, AAN considered the evidence sufficient to conclude that TENS is ineffective for the treatment of chronic low back pain.

Cochrane reviews by Khadilkar et al (2005; 2008), concluded that there is limited and inconsistent evidence for the use of TENS as an isolated treatment for low back pain.[18,19,]

Randomized Controlled Trials
Jalavandi et al (2022) compared the effects of TENS (n=22) to back exercises (including strengthening and stretching; n=22) in operating room nurses with chronic low back pain.[35,] After 6 weeks, average pain and disability scores significantly decreased in both treatment groups as compared to baseline. After adjusting for the baseline values, the TENS group had a significantly higher pain score

reduction (mean difference [MD], 4.23; p=.030) and a significantly greater decrease in the disability scores (MD, -3.99; p=.021) when compared to the back exercises group.

Leemans et al (2020) evaluated the effects of heat and TENS in 50 patients with chronic low back pain.[36,] Patients were randomized to heat plus TENS or no treatment. At 24 hours after the procedure, there was no significant difference between the groups for average pain in the last 24 hours or maximum pain experienced in the last 24 hours. Measurements were repeated at 4 weeks and no significant differences in pain scores were found between groups at that time point either.

Keskin et al (2012) reported on an RCT of TENS for pregnancy-related low back pain.[37,] Seventy-nine patients were randomized to 6 TENS sessions over 3 weeks, a home exercise program, acetaminophen, or no-treatment control. In the control group, pain intensity increased in 57% of participants. Pain decreased in 95% of participants in the exercise group and in all participants in the acetaminophen and TENS groups. The VAS score improved by a median of 4 points in the TENS group and by 1 point in the exercise and acetaminophen groups. In the control group, the VAS score worsened by 1 point. Roland-Morris Disability Questionnaire scores indicated significantly greater improvement in function in the TENS group (-8.5) compared with the control (+1), exercise (-3), and acetaminophen (-3) groups. This trial lacked a sham TENS control. In a subsequent RCT by Jamison et al (2019) that also lacked a sham control group and had fewer patients (n=33), compared to treatment-as-usual, use of high-frequency TENS along with a smartphone tracking app resulted in greater reductions in pain intensity.[38,]

Diabetic Peripheral Neuropathy

Systematic Reviews

The AAN's 2010 evidence-based review also identified 2 class II studies comparing TENS with sham TENS and 1 class III study comparing TENS with high-frequency muscle stimulation for patients with mild diabetic peripheral neuropathy.[33,] The studies found a modest reduction in VAS scores for TENS compared with sham, and a larger proportion of patients experiencing benefit with high-frequency muscle stimulation than with TENS. Reviewers concluded that, on the basis of these 2 class II studies, TENS was likely effective in reducing pain from diabetic peripheral neuropathy; however, no studies compared TENS with other treatment options.

Randomized Controlled Trials

A small RCT by Gossrau et al (2011) found no difference between microcurrent TENS (micro-TENS) compared with sham in 41 patients with diabetic peripheral neuropathy. [39,] In this trial, the current was applied at an intensity of 30 to 40 microamps rather than the usual intensity of several milliamps, and patients were treated for 30 minutes, 3 times per week. After 4 weeks of treatment, 29% of the micro-TENS group and 53% of the sham group showed a response to therapy, defined as a minimum 30% reduction in neuropathic pain score. Median Pain Disability Index was reduced to a similar extent in the TENS (23%) and sham (25%) groups.

Cancer Pain

Systematic Reviews

For a Cochrane review by Robb et al (2008), which evaluated TENS for cancer pain, only 2 RCTs (N=64 participants) met the selection criteria.[28,] There were no significant differences between TENS and placebo in the included studies. One RCT found no differences between TENS and placebo for pain secondary to breast cancer treatment. The other RCT examined acupuncture-type TENS in palliative care patients but was underpowered. The results of the review were considered inconclusive due to a lack of suitable RCTs. A 2012 update of the Cochrane review identified an additional RCT (a feasibility study of 24 patients with cancer bone pain) that met selection criteria.[17,] The small sample sizes and differences in patient study populations across the 3 RCTs precluded meta-analysis. Results on TENS for cancer pain remain inconclusive.

Fibromyalgia

Systematic Review

Amer-Cuenca et al (2023) conducted a systematic review and meta-analysis of TENS for analgesia in patients with fibromyalgia.[40,] When the 11 included RCTs were analyzed with a random-effects model, there was no effect of TENS on pain (p>.05). In contrast, a mixed-effects model that considered the TENS dosage found significant effect sizes with the number of TENS sessions (p=.005), TENS frequency (p=.014), and TENS intensity (p=.047). The authors concluded that TENS can reduce fibromyalgia pain when used at high frequency, high intensity, or for more than 10 sessions. A limitation of the review is that about half of the included studies had a high risk of bias.

Randomized Controlled Trials

A placebo-controlled crossover randomized trial by Dailey et al (2013) investigated the effect of a single treatment of TENS in 41 patients with fibromyalgia.[41,] Patients were blindly allocated to no treatment, active TENS treatment, or placebo treatment. Each treatment arm had therapy once weekly for a 3-week period. Patients rated the average pain intensity before and after treatment on a 0-to-10 scale and found less pain with movement during active TENS than with placebo or no TENS (p<.05). Patients also rated fatigue with movement and found that fatigue decreased with active TENS compared with placebo or no TENS (p<.05 and p<.01, respectively). Pressure pain threshold improvement was significantly greater with active TENS (30% ; p<.05) than with placebo (11%) or no TENS (14%).

Another RCT by Lauretti et al (2013) investigated TENS in fibromyalgia.[42,] However, there was no comparison between active treatment and placebo reported; only change from baseline within each group was reported. TENS was administered for 20 minutes at 12-hour intervals for 7 consecutive days. In the dual placebo group, VAS pain scores did not improve compared with baseline. Patients who had a single site of active TENS reported a reduction in pain of 2.5 cm (p<.05 vs. baseline), and patients in the dual TENS group experienced the greatest reduction in pain (4.2 cm; p<.02 vs. baseline). Consumption of medication for pain also decreased significantly from baseline in the single TENS (p<.05) and dual TENS groups (p<.02). Sleep improvements were reported by 10 patients in the dual TENS group, 8 in the single TENS group, and 4 in the placebo group. Fatigue increased for 3 patients in the placebo group but decreased in 7 patients in the dual TENS group; moreover, fatigue decreased for 5 patients in the single TENS group. No adverse events were reported.

Jamison et al (2021) evaluated the efficacy and safety of a wearable TENS device in adults with fibromyalgia.[43,] In this single-center, parallel-group study, 119 patients were randomly assigned to a wearable TENS device (Quell®; n=62) or a sham device (n=57) for 3 months. The primary outcome measure was the Patient Global Improvement of Change (PGIC), which represents the patient's overall belief about the efficacy of treatment on a 7 point categorical verbal rating scale. Selection of 1 means "no change or condition has gotten worse" to 7 meaning "a great deal better and a considerable improvement that has made all the difference." Overall, no differences were found between active and sham treatment on PGIC scores at 3 months (MD , 0.34; 95% CI, -0.37 to 1.04; p=.351) in the intention-to-treat population. In the higher pain sensitivity subgroup, the mean PGIC score at 3 months was 4.05 for active treatment versus 2.86 for sham treatment (MD , 1.19; 95% CI, 0.24 to 2.13; p=.014). After 3 months of active treatment, all secondary efficacy measures (e.g., disease impact and health-related QOL) exhibited significant within-group improvement compared to pre-treatment baseline. A total of 12 (5 active, 7 sham) adverse events were reported. Nine of the events were definitely or possibly related to TENS use, but were minor and self-limited. The authors concluded that the study demonstrated modest treatment effects of reduced disease impact, pain, and functional impairment from wearable TENS in patients with fibromyalgia.

Refractory Chronic Pelvic Pain

Observational Data

There is limited literature on the use of TENS for chronic pelvic pain. No RCTs were identified. An observational study by Schneider et al (2013) assessed 60 men consecutively treated with TENS for

refractory chronic pelvic pain syndrome.[44,] TENS was performed at home for 12 weeks with participants keeping a pain diary to calculate VAS scores. A successful treatment response was defined as a 50% or greater reduction in VAS and absolute VAS of less than 3 at the end of treatment. TENS was successful in 29 (48%) patients, and treatment response was sustained at a mean follow-up of 44 months (95% CI, 33 to 56 months). After 12 weeks of treatment, VAS scores decreased significantly (p<.001) from 6.6 to 3.9. QOL, assessed by the National Institutes of Health Chronic Prostatitis Symptom Index, improved significantly after 12 weeks of TENS treatment (p<.001). No adverse events were reported.

Osteoarthritis of the Knee

Systematic Reviews

A Cochrane review by Rutjes et al (2009) found that the evidence on TENS for pain relief in patients with osteoarthritis of the knee was inconclusive.[29,] Included in the review were 18 trials assessing 813 patients; 11 trials used TENS, 4 used interferential current stimulation, 1 used both TENS and interferential current stimulation, and 2 used pulsed electrostimulation. Methodologic quality and quality of reporting were rated as poor. Additionally, there was a high degree of heterogeneity among the trials, and the funnel plot for pain was asymmetrical, suggesting both publication bias and bias from small studies.

Randomized Controlled Trials

Additional randomized trials were published after the Rutjeset al (2009) systematic review. Reichenbach et al (2022) compared treatment with TENS (n=108) to sham TENS (n=112) in patients with knee osteoarthritis in 6 outpatient clinics in Switzerland.[45,] The primary outcome of mean Western Ontario and McMaster Universities Arthritis Index (WOMAC) pain subscale score at 3 weeks did not significantly differ between the TENS (2.20) and sham TENS group (2.34; MD , -0.06; 95% CI, -0.41 to 0.29; p=.74); there was also no significant between-group difference at 15 weeks (2.53 vs. 2.60, respectively; MD , 0.01; 95% CI, -0.37 to 0.39; p=.98).

Cherian et al (2016) compared TENS with the standard of care in the treatment of 70 patients who had knee osteoarthritis; all patients had previously taken part in a prospective 3-month trial of TENS, allowing researchers to collect data on the long-term efficacy of TENS (mean follow-up time, 19 months).[46,] The follow-up study evaluated pain (using a VAS) and function (measured by new Knee Society Scale and Lower-Extremity Functional Scale scores) and a number of secondary outcomes, including medication usage, QOL, device use, and conversion to total knee arthroplasty. For all outcomes, reviewers reported a general trend of improvement for the TENS group compared with the standard of care group; however, no statistical analyses were provided for secondary outcomes, and several differences were not significant among primary outcomes. When measured from pretreatment to final follow-up, Knee Society Scale (p=.002) and Lower-Extremity Functional Scale (p<.001) scores were significantly increased for the TENS group. The trial's limitations included its small sample size and possible variance in the amount of medication taken by each patient. Also, the interviews were not conducted in person, meaning that some conclusions about functional improvement were not confirmed by a physical examination.

An RCT by Palmer et al (2014) evaluated 224 participants with osteoarthritis of the knee who were assigned to 1 of 3 interventions: TENS combined with education and exercise (n=73), sham TENS combined with education and exercise (n=74), or education and exercise alone (n=77).[47,] Investigators and participants were blinded to treatment. Participants were treated for 6 weeks and directed to use the TENS device as needed for pain relief. WOMAC pain, function, and total scores improved significantly over time from baseline to 24 weeks but did not vary between groups (p>.05). TENS as an adjunct to exercise did not elicit additional benefits.

In another RCT, Vance et al (2012) assessed 75 patients given a single session of high-frequency TENS, low-frequency TENS, or placebo TENS.[48,] All 3 groups reported a reduction in pain at rest and during the Timed Up & Go test, and there were no differences in pain scores between groups.

An RCT by Chen et al (2013) compared intra-articular hyaluronic acid injections with TENS for the management of knee osteoarthritis in 50 participants.[49,] Twenty-seven patients were randomized to hyaluronic acid and received 1 intra-articular injection weekly for 5 weeks. Twenty-three patients in the TENS group received 20-minute sessions of TENS 3 times weekly for 4 weeks. The TENS group exhibited a modest but significantly greater improvement (p=.03) than the hyaluronic acid group on VAS pain score (mean final score, 4.17 vs. 5.31, respectively) at 2 weeks, but there was no difference between groups at 2 or 3 months post-treatment. The TENS group also had greater improvement on the Lequesne Index at a 2-week follow-up compared with the hyaluronic acid group (mean final score, 7.78 vs. 9.85, respectively; p=.01) and at 3-month follow-up (mean final score, 7.07 vs. 9.2, respectively; p=.03). Both treatment groups reported significant improvements from baseline to 3 months on scores in walking time, patient global assessment, and disability in activities of daily life.

Rheumatoid Arthritis

Systematic Reviews

Two Cochrane reviews (2002, 2003) concluded that outcomes for patients with rheumatoid arthritis treated with TENS were conflicting.[12,13,]

Multiple Sclerosis

Systematic Reviews

Sawant et al (2015) reported a systematic review of 4 RCTs of TENS for the management of central pain in multiple sclerosis.[50,] Sample sizes ranged from 10 to 60 patients. One study examined the effect of TENS on upper-extremity pain, and the other 3 studied the effect of TENS on low back pain. The exact electrode placement could not be identified. Effect sizes, extracted from the 4 studies, showed a medium-sized effect of TENS (Hedges' *g*=0.35, p=.009). The overall level of evidence was considered to be GRADE 2. Similar findings were reported in a subsequent review by Amatya et al (2018).[51,]

Phantom Limb Pain

Systematic Reviews

A Cochrane review by Johnson et al (2015) found no RCTs on TENS for phantom limb or stump pain after amputation.[52,] Reviewers concluded that the published literature on TENS for phantom limb pain in adults lacked the methodologic rigor and robust reporting needed to assess its effectiveness confidently and that RCT evidence is required.

Neck Pain

Systematic Reviews

A Cochrane review reported by Martimbianco et al (2019) assessed the evidence of TENS for the treatment of chronic neck pain.[21,] Seven RCTs (N=651) comparing TENS alone or in combination with other treatments versus active or inactive treatments were included. Due to heterogeneity in interventions and outcomes, the results were not pooled for a meta-analysis. There was very low-certainty evidence from 2 trials about the effects of conventional TENS versus sham TENS at short-term (up to 3 months after treatment) follow-up. There was no statistically significant difference in outcomes between groups for pain, as assessed by the VAS, (MD , -0.10; 95% CI, -0.97 to 0.77) and the percentage of participants presenting improvement of pain (relative risk [RR] , 1.57; 95% CI, 0.84 to 2.92). The authors concluded that there is insufficient evidence regarding the use of TENS in patients with chronic neck pain.

Randomized Controlled Trials

Martins-de-Sousa et al (2023) conducted an RCT of TENS combined with a therapeutic exercise program in patients with chronic neck pain.[53,] Patients were randomized to 8 sessions of placebo TENS (n=20), high frequency TENS (n=20), or low frequency TENS (n=20). The primary outcome, disability after 8 treatment sessions, was similar between groups (p>.05). Other outcomes including pain intensity at the end of treatment and 4 weeks after the end of treatment were also similar

between groups. The small sample size may have limited the power to detect a difference between groups.

Diaz-Pulido et al (2021) compared the effects of manual therapy versus TENS on cervical active mobility and muscle endurance in 90 adults diagnosed with subacute and chronic mechanical neck disorders.[54,] TENS (n=43) and manual therapy (n=47) interventions each consisted of 10 sessions, provided by primary care physical therapists for 30 minutes on alternate days. Outcome measures included active range of motion and endurance of the neck muscles; evaluated pre- and post-intervention and at 6 month follow-up. Of the 90 participants, 72 completed all interventions. Results revealed that manual therapy yielded a significant improvement in active mobility and endurance at post-intervention. At 6 month follow-up, the differences were only significant in endurance and in sagittal plane active mobility. No significant improvement was noted in the TENS group.

Pain After Stroke

Systematic Reviews

Evidence on the efficacy of TENS for shoulder pain after stroke was considered inconclusive in a Cochrane review by Price et al (2000).[26,]

Pain After Spinal Cord Injury

Systematic Reviews

A Cochrane review by Boldt et al (2014) evaluating nonpharmacologic interventions for chronic pain in individuals with spinal cord injury identified an RCT on TENS.[55,] This trial had a high-risk of bias, and no conclusion could be drawn on the effectiveness of TENS compared with sham for reducing chronic pain in this population.

Facial Myalgia

Randomized Controlled Trials

An RCT by De Giorgi et al (2017) evaluated the efficacy of TENS in treating subjective and objective pain in 49 women diagnosed with chronic facial myalgia; 34 patients received TENS treatment daily for 10 weeks and were evaluated for pain up to 25 weeks, and 15 patients received no treatment and were evaluated for pain up to 10 weeks.[56,] TENS treatment consisted of daily 60-minute sessions at 50 Hz, and VAS scores were taken for average and maximum pain intensity in the previous 30 days, as well as the level of pain at an examination. The other primary outcome was the assessment of pain at muscular palpation sites, measured by the Pericranial Muscle Tenderness Score and Cervical Muscle Tenderness Score. For this outcome and that of VAS (mean and maximum measurements), patients in the TENS group had significantly lower pain levels than those for the control group at 10 weeks ($p<.05$). Within the TENS group, the trialists found that VAS scores tended to decrease during the trial, as did Pericranial Muscle Tenderness and Cervical Muscle Tenderness scores ($p<.05$). These differences were significant except for the period between 15 and 25 weeks. Secondary outcomes included mandibular movement and range of motion, and the TENS group showed no significant improvement over the control group for either outcome. Although a limitation of the trial was that observation of control patients ended at 10 weeks, these results confirmed the results of several similar studies of TENS in treating musculoskeletal pain. The trialists concluded that TENS is an effective treatment for chronic facial myalgia, although studies with more participants are needed.

Temporomandibular Disorder

Systematic Reviews

de Castro-Carletti et al (2023) conducted a systematic review and meta-analysis of controlled trials with electrotherapy for orofacial pain.[57,] The systematic review yielded 43 studies (N=1939) for temporomandibular disorder and none for other types of orofacial pain. The quality of evidence was low, but meta-analysis was performed with 20 studies. Regardless of the type of temporomandibular disorder, TENS did not demonstrate a significant benefit compared to placebo or other forms of eletrotherapy for pain intensity, maximal mouth opening, or tenderness. A limitation of the analysis is that almost all studies (n=41) had a high risk of bias.

Serrano-Munoz et al (2023) conducted a systematic review and meta-analysis of electrical stimulation modalities for temporomandibular disorders.[58,] Seven RCTs were included, 4 of which evaluated TENS. Overall, TENS reduced pain intensity (MD, -1.09; 95% CI, -0.71 to -1.47; I^2=72%). TENS did not have a significant effect on range of movement or muscle activity.

Randomized Controlled Trials

A randomized placebo-controlled trial by Ferreira et al (2017) evaluated TENS in the treatment of individuals with temporomandibular disorder; 40 patients (30 female, 10 male) were randomized into 2 groups (placebo or active TENS).[59,] The trial used both high- and low-frequency TENS, allotting to the active TENS patients 25 minutes of 4 Hz followed by 25 minutes of 100 Hz; measuring pain intensity and pressure pain threshold immediately after treatment and again 48 hours later. When compared with baseline values, pain intensity was reduced for patients in the active TENS group, and pressure pain threshold was significantly increased ($p<.05$). For those in the placebo group, there were no significant improvements for either primary outcome. Limitations of the trial included the short duration of the assessment, and the absence of control groups either receiving no treatment or evaluating the same treatment in patients without the temporomandibular disorder.

Myofascial Trigger Points

Systematic Reviews

A systematic review by Ahmed et al (2019) evaluated the effects of various electric stimulation techniques in individuals with myofascial trigger points, including 13 RCTs of TENS compared with sham TENS. High-frequency TENS (>50 Hz) was used in the majority of RCTs. Unclear allocation concealment and blinding were the most common study limitations. Meta-analysis of post-treatment pain intensity scores found that TENS did not significantly reduce pain (SMD, -0.16; 95% CI, 0.39 to 0.07).[60,]

Randomized Controlled Trials

Effects of TENS combined with ultrasound were more positive in an RCT by Takla et al (2019) of 70 participants with acute mechanical neck pain and at least 2 active myofascial trigger points. Participants were randomized to 3 sessions per week for 4 consecutive weeks of low-frequency, high-intensity burst TENS combined with ultrasound, medium-frequency, low-intensity amplitude modulated frequency TENS combined with ultrasound or sham combined therapy. Pressure pain threshold and active cervical lateral flexion range of motion were improved in both combined therapy groups - more so in the high-intensity burst TENS combined with ultrasound - but not in the sham group.[61,]

Mixed Chronic Pain Conditions

Systematic Reviews

A systematic review and meta-analysis by Johnson et al (2022) investigated TENS for relief of various acute and chronic pain conditions in adults.[62,] In total, the review included 381 RCTs (N=24,543), with 164 RCTs having sufficient data for meta-analyses. In the subgroup of patients with chronic pain (31 RCTs; n=1417), TENS reduced pain intensity when compared to placebo (SMD, -0.87; 95% CI, -1.19 to -0.55). The authors concluded that for the overall population of patients with acute and chronic pain, there was moderate-certainty evidence that pain intensity is lower during or immediately after TENS compared with placebo. However, levels of evidence were downgraded because of small-sized trials contributing to imprecision in magnitude estimates.

An overview of a Cochrane review by Gibson et al (2019) evaluated the evidence from 8 Cochrane reviews consisting of 51 RCTs that compared TENS versus sham or usual care/no treatment/waiting list control in 2895 participants with various chronic pain conditions. As with previous reviews, due to the serious methodological limitations described below, authors were unable to draw conclusions about the effects of TENS on pain control, disability, health-related QOL, use of pain-relieving medications, global impression of change, or harms.[63,]

Section Summary: Transcutaneous Electrical Nerve Stimulation for Chronic Pain

For individuals who have chronic pain (e.g., musculoskeletal, neuropathic, and mixed pain conditions) who receive TENS, the evidence includes numerous RCTs and systematic reviews. The overall strength of the evidence is weak. The best evidence exists for the treatment of chronic, intractable pain. Systematic reviews have found potential pain relief benefits with TENS for diabetic peripheral neuropathy and fibromyalgia. For low back pain and myofascial trigger points, available evidence suggests that TENS is ineffective. Available evidence from systematic reviews are inconclusive for cancer pain, osteoarthritis of the knee, rheumatoid arthritis, phantom knee pain, chronic neck pain, temporomandibular disorder, pain after stroke, and pain after spinal cord injury.

Transcutaneous Electrical Nerve Stimulation for Acute Pain

Clinical Context and Therapy Purpose

The purpose of TENS is to provide a treatment option that is an alternative to or an improvement on existing therapies in individuals with acute pain (e.g., surgical, musculoskeletal, labor, and mixed pain conditions).

The following PICO was used to select literature to inform this review.

Populations

The relevant population of interest is individuals with acute pain conditions (e.g., surgical, musculoskeletal, labor, and mixed pain conditions).

Interventions

The therapy being considered is TENS.

Comparators

The following therapy is currently being used to treat acute pain: pharmacotherapy.

Outcomes

The general outcomes of interest are symptoms, functional outcomes, QOL, and medication use. Given the different types of pain conditions, follow-up at 2, 4, and 6 weeks is of interest to monitor outcomes.

Study Selection Criteria

Methodologically credible studies were selected using the following principles:

- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;
- In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
- To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
- Studies with duplicative or overlapping populations were excluded.

Review of Evidence

Injury

Systematic Review

Davison et al (2022) conducted a systematic review of 4 studies that evaluated the effect of electrical stimulation after hip fracture.[64,] Based on the results of one study, TENS decreased pain as assessed by VAS scores (MD, 3.3 points; p<.001), increased range of motion at 10 days (MD, 25.7 degrees; p<.001), and improved functional recovery (p<.001). Results were conflicting regarding the effects of TENS on muscle strength and mobility. The authors concluded that additional high quality trials were needed.

Randomized Controlled Trials

One double-blind, randomized, sham-controlled trial reported by Lang et al (2007) found that during emergency transport of 101 patients, TENS reduced posttraumatic hip pain (change in VAS score, 89 to 59), whereas the sham-stimulated group remained relatively unchanged (change in VAS score, 86 to 79).[65,]

Surgical Pain

Systematic Reviews

Zimpel et al (2020) conducted a systematic review with meta-analysis to investigate the efficacy of various complementary alternative therapies, including TENS, for post-caesarean pain.[31,] Ten studies were included that evaluated TENS, with or without analgesia, for pain relief. One study (N=40) evaluated TENS with no treatment and found that it may reduce pain at 1 hour (MD , -2.26; 95% CI, -3.35 to -1.17). TENS plus analgesia, as compared to placebo plus analgesia, may reduce pain at 1 hour (SMD, -1.10 ; 95% CI -1.37 to -0.82 based on 3 studies with 238 women). Both findings were rated as low-certainty evidence by the Cochrane review.

Zhu et al (2017) conducted a systematic review with meta-analysis to investigate the efficacy of TENS on patients experiencing pain after total knee arthroplasty.[66,] Two independent investigators searched PubMed, Embase, Web of Sciences, EBSCO, and Cochrane Library databases and identified 6 RCTs that assessed the effect TENS had on VAS scores of 529 patients who had a total knee arthroplasty. A meta-analysis indicated that, compared with a control intervention, TENS significantly reduced VAS scores over a 24-hour period (SMD , -0.47; 95% CI, -0.87 to -0.08; p=.02). The study was limited by the number of RCTs and sample sizes (4 of 6 selected RCTs had <100 patients), as well as differences in TENS intensities, differences in follow-up times, the ethnic diversity of patients, and possible unpublished or missing data.

Randomized Controlled Trials

Ögren et al (2024) evaluated TENS for postoperative pain in 163 patients undergoing laparoscopic cholecystectomy in a 2-center RCT in Sweden.[67,] Patients were randomized to IV opioids or high-intensity TENS. Pain intensity at discharge from the post-anesthesia care unit (PACU; pain score 1.7 vs. 1.6; p=.58), time in the PACU (138 vs. 142 minutes; p=.74), and time to relieve pain to a numeric rating scale less than 3 (median of 10 minutes in both groups) were similar between groups. Nearly half (46%) of patients in the TENS group did not respond to 2 stimulations and were administered IV opioids. Participants were not blinded to treatment, and blinding of study personnel was unclear. Hatefi et al (2023) conducted a double-blind RCT of TENS for pain associated with chest tube removal in 120 patients who underwent coronary artery bypass grafting.[68,] The 4 treatment groups were TENS, cold compress, TENS plus cold compress, and placebo (room temperature compress plus sham TENS), all administered for 15 minutes before chest tube removal. Mean pain intensity scores were lowest in the combined TENS plus cold compress group compared to the other groups at all time points (during chest tube removal, immediately after removal, and 15 minutes after removal [p<.001]). Safety of the intervention was not addressed.

Ramanathan et al (2017) published a prospective RCT of 66 patients having undergone total knee arthroplasty who were assigned to active or placebo TENS. Patients used the device as needed for 2 hours and had follow-up visits 2, 4, and 6 weeks after surgery.[69,] For the primary outcome (reduction of opioid intake), no significant difference was observed between active and placebo TENS groups (p=.60). This was also the case for secondary outcomes, which included assessment of pain, function, and clinical outcomes. The trial was limited by a high withdrawal rate (only 66 of 116 patients enrolled completed the trial) and a lack of uniformity in the device settings chosen by patients. The investigators found no significant benefit of TENS treatment following total knee arthroplasty. Parseliunas et al (2020) evaluated TENS use as a component of multimodal pain control after open inguinal hernia surgery in a randomized, double-blind, placebo-controlled trial.[70,] Eighty male patients with unilateral inguinal hernia treated by elective surgery were enrolled and randomly allocated to TENS (n=40) or placebo-TENS (n=40) on the first postoperative day. The primary

outcome measure was the change in pain intensity after each TENS application, using VAS and an algometer. Results revealed a significant reduction in VAS pain scores in the TENS group following the procedure (p<.001). Absolute and relative pain relief were significantly improved in the TENS group for pain at rest (p<.01), when walking (p<.01), and when standing up from the bed (p<.01). Administration of additional nonopioid analgesics was reduced in the TENS group on the first and second postoperative days (p<.001). No postoperative surgical complications or TENS-related adverse effects were seen.

Smaller studies with a higher risk of bias - often due to lack of a sham TENS group - have tended to support the use of TENS. In an RCT of 48 patients who had undergone abdominal surgery, compared to a control group that did not receive any electrical stimulation, Oztas et al (2019) found significantly lower pain scores and analgesic consumption in patients who underwent TENS.[71,] In an assessor-blinded study of TENS in 74 living kidney donors, Galli et al (2015) found a modest reduction in pain at rest and during the measurement of pulmonary function 1 day postoperatively.[72,] A patient-blinded study post abdominal surgery (N=55) by Tokuda et al (2014) found that the application of TENS for 1 hour per day resulted in a significant reduction in pain, particularly at rest, measured both during and immediately after treatment compared with sham TENS.[73,] Pulmonary function (vital capacity, cough peak flow) was also significantly better in the active TENS arm. In a single-blind, randomized trial with 42 patients, Silva et al (2012) assessed the analgesic effect of TENS after laparoscopic cholecystectomy.[74,] Pain improved by a median of 2.4 points after TENS compared with 0.4 points after placebo treatment. The relative risk of nausea and/or emesis was 2.2 times greater for patients in the placebo group. In a double-blind RCT of 40 patients undergoing inguinal herniorrhaphy, DeSantana et al (2008) reported that two 30-minute sessions of TENS at 2 and 4 hours after surgery (vs. sham) reduced both analgesic use and pain scores when measured up to 24 hours postsurgery.[75,] Pulmonary function (vital capacity, cough peak flow) was also significantly better in the active TENS arm. One exception comes from a single-blind RCT by Forogh et al (2017) of 70 male athletes, which found that adding 20 sessions of high-frequency TENS for 35 minutes a day to semi-supervised exercise did not significantly improve VAS scores.[76,]

Bone Marrow Sampling

Randomized Controlled Trials

Tucker et al (2015) reported on a double-blind RCT of TENS administered during bone marrow sampling in 70 patients.[77,] There was no significant difference in a numeric pain score between patients who received strong TENS impulses and the control group that received TENS just above the sensory threshold as reported immediately after the procedure (5.6 vs. 5.7, respectively). Over 94% of patients in both groups felt they benefited from TENS.

Low Back Pain

Systematic Reviews

A systematic review by Binny et al (2019) included 3 placebo-controlled studies with 192 women with acute low back pain. Although a low-quality RCT found that TENS in an emergency-care setting provided clinically worthwhile pain relief for moderate to severe acute low back pain, evidence was inconclusive in the other 2 RCTs. Review authors concluded that, overall, the evidence is insufficient to support or refute the use of TENS for acute low back pain.[78,]

Koukoulithras et al (2021) reported a systematic review that included 13 RCTs evaluating the effectiveness of non-pharmaceutical interventions upon pregnancy-related low back pain in 2213 patients.[79,] TENS and muscle relaxation exercises accompanied by music were found to be the most effective interventions , having a statistically significant impact on lumbar pain. There was high heterogeneity among the studies including sample sizes.

Dysmenorrhea

Systematic Reviews

Arik et al (2020) conducted a meta-analysis evaluating the effectiveness of TENS for primary dysmenorrhea.[80,] Four RCTs (N=260) that compared TENS to a sham device were included in the analysis. Pain, as measured by VAS scores, was statistically reduced in the TENS group compared to the sham group (SMD , 1.384; 95% CI, 0.505 to 2.262).

A Cochrane systematic review by Han et al (2024) evaluated TENS for primary dysmenorrhea.[81,] A total of 20 RCTs in 585 women were included. High-frequency TENS was considered separate from low-frequency TENS. High-frequency TENS lowered pain scores compared with placebo or no treatment (mean difference [MD] -1.39; 95% CI, -2.51 to -0.28; 10 RCTs (n=345); low-certainty evidence; I^2=88%) as did low-frequency TENS (MD, -2.04; 95% CI, -2.95 to -1.14; 3 RCTs (n=645); low-certainty evidence; I^2=0%). Pain scores were similar between high-frequency and low-frequency TENS (MD 0.89; 95% CI, -0.19 to 1.96; 3 RCTs (n=54); low-certainty evidence; I^2=0%). The authors concluded that the evidence for TENS is limited due to substantial heterogeneity and a small number of trials.

Randomized Controlled Trials

Guy et al (2022) reported on a crossover RCT that took place in France and compared TENS (n=20) to sham TENS (n=20) for primary dysmenorrhea.[82,] The change in pain intensity (measured using VAS) after the first 2 applications (the primary outcome) was significantly greater with TENS (-36.6) versus sham TENS (-2.6; between-group difference , -34.1; p<.0001).

Hysteroscopy

Randomized Controlled Trials

Platon et al (2020) reported the pain relief effects in 74 patients who were randomized to TENS or morphine 5 mg in the post-anesthesia care unit (PACU) after hysteroscopy.[83,] At PACU discharge, both groups reported a significant reduction in pain, with a decrease of VAS scores from 5.6 to 1.4 in the TENS group and 5.1 to 1.3 in the opioid group. There were no significant differences between groups. Sixteen patients in each group reported a VAS ≥3 after initial treatment and were crossed over to receive the other treatment during the study as defined by the protocol.

Lison et al (2017) published an RCT assessing the effect of TENS on pain in women undergoing hysterectomy without sedation; the trial included 138 women receiving active TENS, placebo TENS, or neither treatment during the procedure.[84,] Women in the active TENS group reported significantly lower VAS scores than women in the control or placebo TENS groups reported. This was the case at each stage measured (entry, contact, biopsy [when necessary], and residual). To validate these measurements, the investigators included a second pain scale (Likert scale) and found a significant correlation with the VAS results (p<.001). For secondary endpoints (e.g., procedure duration, vital parameters, vasovagal symptoms), the trialists reported that differences between the groups were not statistically significant. However, patient satisfaction was significantly higher in the active TENS group than in either placebo TENS or control groups (p<.001 and p=.001, respectively). Trial limitations included the failure to account for the use of a flexible hysteroscope, instead of using a rigid hysteroscope; this might have limited the generalizability of the results.

Labor and Delivery

Systematic Reviews

A Cochrane review by Deussen et al (2020) included 28 studies involving 2749 women experiencing uterine cramping after vaginal delivery.[85,] There was a very low certainty that TENS is better than no TENS for adequate pain relief as reported by 32 women in 1 applicable RCT.

A systematic review and meta-analysis by Thuvarakan et al (2020) evaluating the efficacy of TENS for labor pain included 26 studies with 3348 patients.[86,] TENS showed a statistically significant effect in the reduction of pain intensity (pooled RR, 1.52; 95% CI, 1.35 to 1.70). The authors noted that there

was high study heterogeneity (I^2=89%) and the majority of included studies were judged to be low quality.

A Cochrane review by Dowswell et al (2009) included 19 studies with 1671 women in labor.[16,] Overall, there was little difference in pain ratings between TENS and control groups, although women receiving TENS to acupuncture points were less likely to report severe pain (RR, 0.41). Reviewers found limited evidence that TENS reduced pain in labor or had any impact (either positive or negative) on other outcomes for mothers or babies.

Randomized Controlled Trials

Kurata et al (2022) published the results of an RCT comparing TENS (n=60), sham TENS (n=60), and no TENS (n=60) after cesarean birth.[87,] The primary outcome of median opioid consumption within 60 hours of cesarean delivery was 7.5 morphine milligram equivalents (MME) with TENS versus 0 MME with sham TENS (p=.31). In the no TENS group, the median opioid consumption within 60 hours of cesarean delivery was 7.5 MME (p=.57 vs. sham TENS).

In a randomized, single-blind RCT comparing TENS with placebo in postpartum women (N=138) who had undergone cesarean birth in Turkey, Sabanci Baransel et al (2024) found improved Postoperative Recovery Index scores with active TENS (113.58) compared with placebo (134.67) or control (136.61).[88,] Findings from this study are the lack of blinding of the investigator administering treatment and the single-center design of the study.

A placebo-controlled, randomized trial by Kayman-Kose et al (2014) assessed 200 women who gave birth between January and July 2010.[89,] One hundred women who gave birth vaginally were allocated to active TENS or sham TENS in a 1:1 ratio; this same assignment was performed for 100 women who gave birth by cesarean delivery. TENS was performed once for 30 minutes after childbirth was completed. After vaginal or cesarean delivery, but before the administration of TENS, the placebo and active groups did not significantly differ in VAS or verbal numeric scale scores. However, after active TENS in the cesarean group, there was a significant reduction in VAS (p<.001) and verbal numeric scale (p<.001) scores compared with the placebo group. A similar benefit was observed in the vaginal delivery group with the active treatment showing a significant reduction in VAS (p=.022) and verbal numeric scale (p=.005) scores. The investigators also assessed whether TENS reduced the need for additional analgesia. There was no difference between the active TENS and the placebo groups for vaginal delivery (p=.83), but, in the cesarean arm, the active treatment group had a significant reduction in analgesic need (p=.006). Results were consistent in a much smaller RCT by Baez Suarez et al (2019) of 10 women in labor with a breech vaginal delivery. In this RCT, only women who received active TENS experienced a clinically significant improvement in VAS scores.[90,]

Njogu et al (2021) assessed the effects of TENS during the first stage of labor in a single-blind RCT involving 326 adult pregnant women anticipating spontaneous vaginal delivery.[91,] Enrolled patients were randomly assigned to TENS (n=161) or routine obstetric care (n=165) at the beginning of active labor until the second labor stage. The primary outcome was labor pain intensity as assessed by VAS immediately after randomization, at 30, 60, and 120 minutes after TENS therapy, and 2 to 24 hours post-delivery. Prior to the TENS intervention, there was no statistically significant difference in mean VAS scores between the groups (p>.05). The TENS group had significantly lower mean VAS scores as compared to control at all time points post-intervention and at 2 to 24 hours post-delivery (all p<.0001). The TENS group had a significantly shorter duration of the active labor phase compared to controls (p<.001) and the time of the second and third stages of labor were similar between the groups (p>.05). The authors concluded that TENS can be used as a non-pharmacologic therapy to reduce labor pain and shorten the active labor phase duration. Limitations cited were lack of a double-blind, sample size, single-center analysis, and inclusion of only a low-risk pregnancy population.

Medical Abortion

Randomized Controlled Trials

Goldman et al (2021) evaluated whether the use of TENS reduced pain with medical abortion in a randomized, placebo-controlled trial involving 40 patients.[92,] Enrolled women underwent a medical abortion with mifepristone and misoprostol and were randomly assigned to high-frequency TENS (80 Hz; n=20) or a sham device (n=20) to use at home. The primary outcome was a comparison of maximum pain scores within the first 8 hours after misoprostol administration using an 11-point numeric rating scale. Thirty-seven patients had data evaluable for the primary outcome. Median maximum pain scores within 8 hours after misoprostol were 7 and 10 for the high-frequency TENS and sham device, respectively. Patients administered high-frequency TENS experienced a significant reduction in post-treatment pain score compared to those who were administered the sham device (-2.0 vs. 0; p=.008). No significant differences between the devices were found with regard to additional analgesia use, distribution of maximum pain scores at 24 hours, adverse effects, or measures of acceptability.

Mixed Acute Pain Conditions

Systematic Reviews

A systematic review by Johnson et al (2022) was previously introduced.[62,] In the subgroup of patients with acute pain (57 RCTs; n=3348), TENS significantly reduced pain intensity compared to placebo (SMD , -1.02; 95% CI, -1.24 to -0.79). The authors concluded that for the overall population of patients with acute and chronic pain, there was moderate-certainty evidence that pain intensity is lower during or immediately after TENS compared with placebo. However, levels of evidence were downgraded because of small-sized trials contributing to imprecision in magnitude estimates.

Randomized Controlled Trials

Butera et al (2018) conducted a trial to determine the efficacy of using TENS to reduce musculoskeletal pain and improve function after exercise-induced muscle pain.[93,] In this RCT, 36 patients were divided into 3 groups and received TENS, placebo TENS, or no treatment as a control. Treatment was administered for 90 minutes at 24, 48, and 72 hours after the onset of muscle soreness. Analysis indicated that active TENS and placebo TENS had no significant effect on pain. Limitations included a small sample size of young, relatively healthy individuals.

Tennis Elbow

Randomized Controlled Trials

A multicenter RCT of TENS as an adjunct to primary care management for tennis elbow was reported by Chesterton et al (2013).[94,] Thirty-eight general practices in the United Kingdom recruited 241 adults who had a new or first diagnosis of tennis elbow. Participants were randomized to TENS once a day for 45 minutes over 6 weeks or until resolution of pain plus primary care management (consultation with a general practitioner followed by information and advice on exercise) versus primary care management alone. Both groups saw large (>25%) within-group improvements in pain intensity, with the greatest improvement during the first 6 weeks of treatment. Intention-to-treat analysis revealed no difference in improvement of pain (-0.33 ; 95% CI, -0.96 to 0.31; p=.31) between the 2 groups at 6 weeks, 6 months (-0.20; 95% CI, -0.81 to 0.42; p=.526), or 12 months (0.45; 95% CI, -0.15 to 1.06; p=.139). However, adherence to exercise and TENS was very poor, with only 42 (35%) meeting prior adherence criteria. Per-protocol analyses only showed a statistically significant difference in favor of TENS at 12 months (p=.03).

Section Summary: Transcutaneous Electrical Nerve Stimulation for Acute Pain

The evidence for the use of TENS from high-quality trials remains inconclusive for most indications of acute pain. A systematic review of TENS for acute and chronic pain found some evidence that TENS reduces pain intensity over and above that seen with placebo and other control groups in patients with acute pain, but small-sized trials contributed to imprecision in magnitude estimates. Systematic reviews have found that TENS may help reduce pain in patients with post-operative pain (post-caesarean and total knee arthroplasty), dysmenorrhea, and pain associated with labor and delivery.

For low back pain, systematic reviews have found insufficient evidence to support or refute the use of TENS. Randomized controlled trials have reported mixed results in the efficacy of TENS across various acute pain conditions.

Transcutaneous Afferent Patterned Stimulation for Essential Tremor

Clinical Context and Therapy Purpose

The purpose of transcutaneous afferent patterned stimulation (TAPS) is to provide a treatment option that is an alternative to or an improvement on existing therapies in individuals with essential tremor.

The following PICO was used to select literature to inform this review.

Populations

The relevant population of interest is individuals with essential tremor.

Interventions

The therapy being considered is TAPS. TAPS provides stimulation that alternates between the median and radial nerves with calibration to tremor frequency.

Comparators

The following therapies are currently being used to treat essential tremor: pharmacotherapy.

Outcomes

The general outcomes of interest are reductions in symptoms and medication use, and improvements in functional outcomes and QOL.

Study Selection Criteria

Methodologically credible studies were selected using the following principles:

- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;
- In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
- To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
- Studies with duplicative or overlapping populations were excluded.

Review of Evidence

Randomized Controlled Trials

Dai et al (2023) conducted a pragmatic RCT in which adult patients with essential tremor were selected from an insurance database and randomized to a wrist-worn, FDA-approved, TAPS device (Cala Trio) plus standard of care or standard of care alone for 1 month.[95,] Standard of care included a variety of medications with the majority of patients receiving propranolol or another beta-blocker. After 1 month, all enrolled patients were provided open-label treatment with TAPS. All enrolled patients had the device delivered to their home. Characteristics and results of the trial are summarized in Tables 1 and 2, respectively. The primary outcome of the trial was tremor power as measured by motion sensors in the device at 1 month. Tremor power is a calculation of amplitude and frequency. Tremor power decreases with lower amplitude and lower frequency motions. The majority of the patients were White (84.42%) and male (66.30%) with a mean age of 68.21 years. The trial is limited by the open-label design and the lack of reporting of long-term outcomes.

Table 1. Summary of Key RCT Characteristics

Study	Countries	Sites	Dates	Participants	Interventions	
					Active	Comparator

Study	Countries	Sites	Dates	Participants	Interventions	
Dai et al (2023)[95,]	U.S.	NA	2021-2023	310 adults (≥22 years) with essential tremor	TAPS (n=158)	SOC (n=152)

NA: not applicable; RCT: randomized controlled trial; SOC: standard of care; TAPS: transcutaneous afferent patterned stimulation.

Table 2. Summary of Key RCT Results

Study	Tremor Power (geometric mean ± SD)	Change in BF-ADL
Dai et al (2023)[95,]	N=276	N=134
TAPS	0.017 $(m/s^2)^2$ ± 0.003	1.6
SOC	0.08 $(m/s^2)^2$ ± 0.014	0.2
Effect size	0.063	1.4
p-value	<.0001	.0187

BF-ADL: Bain & Findley Activities of Daily Living; RCT: randomized controlled trial; SD: standard deviation; SOC: standard of care; TAPS: transcutaneous afferent patterned stimulation.

Nonrandomized Studies

Isaacson et al (2020) evaluated the repeated home use of an FDA-cleared, wrist-worn TAPS device in the Prospective Study for Symptomatic Relief of Essential Tremor with Cala Therapy (PROSPECT) trial.[96,] Key characteristics of the trial are summarized in Table 3. For each active treatment session, the device electrically stimulated the median and radial nerves for 40 minutes with an alternating burst pattern tuned to the frequency of each patient's tremor. The pre-specified co-primary endpoints were improvements on the clinician-rated Tremor Research Group Essential Tremor Rating Assessment Scale (TETRAS) and patient-rated Bain & Findley Activities of Daily Living (BF-ADL) dominant hand scores. Of the 263 enrolled patients, 205 completed the visit 3 follow-up and were included in the primary analysis. Results revealed a significant improvement in TETRAS and BF-ADL from pre- to post-stimulation at each clinic visit (p<.0001 for all comparisons). Pre-stimulation tremor levels were improved from Visit 1 to 3 on both TETRAS and BF-ADL (p<.0001 for both). Patients rated as "severe" or moderate" improved with both TETRAS (49.3% at baseline to 21% at study exit) and BF-ADL (64.8% at baseline to 23% at study exit) scoring. Tremor power was also noted to significantly improve with therapy from pre- to post-stimulation (p<.0001). No device-related serious adverse events were reported. Non-serious device-related adverse events occurred in 18% of patients (e.g., persistent skin irritation, sore/lesion, discomfort, electrical burns, and minor skin irritation). Conclusions were that the repeated in home use of this neuromodulation device over 3 months was effective and safe for patients with essential tremor. Limitations identified were the open-label, single-arm design, the lack of consensus for the definition of clinically meaningful improvement in TETRAS or BF-ADL, as well as the exclusion of 58 patients who exited the study early from the pre-specified primary and secondary endpoint analyses.

Lu et al (2023) evaluated long-term outcomes with a TAPS device (Cala Trio) in patients (N=1223) with essential tremor from the manufacturer's database.[97,] Duration of usage ranged from 90 days to 1223 days with an average use of 5.6 TAPS sessions per week. The geometric mean tremor power improvement was 2.8, a 64.3% improvement in tremor power. Approximately half of the patients (49.8%) had at least 50% tremor reduction.

Table 3. Summary of Nonrandomized Trials

Study	Study Type	Country	Participants	Treatment	Follow-Up
Isaacson et al (2020)[96,]	Prospective, multicenter, single-arm, open-label	U.S. - 26 sites	263 patients (≥22 years) diagnosed with essential tremor having at least 1 dominant hand task scoring ≥2 on the clinician-	Cala wrist-worn TAPS device; patients were instructed to use the device twice daily for 3 months	Three in-clinic visits: Visit 1 (patient screening and enrollment); Visit 2 (1

Study	Study Type	Country	Participants	Treatment	Follow-Up
			rated TETRAS and ≥3 on the self-rated BF-ADL, and having a total score across all dominant hand tasks ≥6 on TETRAS and ≥8 on BF-ADL		month follow-up); Visit 3 (3 month follow-up and study completion)
Lu et al (2023)[97,]	Retrospective database	U.S.	1123 patients prescribed TAPS for essential tremor who had used TAPS for ≥90 days	Cala-Trio wrist-worn TAPS device	

BF-ADL: Bain & Findley Activities of Daily Living; TAPS: transcutaneous afferent patterned stimulation; TETRAS: Tremor Research Group Essential Tremor Rating Assessment Scale.

Section Summary: Transcutaneous Afferent Patterned Stimulation for Essential Tremor
The evidence for the use of TAPS for essential tremor includes results from a single pragmatic RCT; a prospective, open-label, post-clearance, single-arm study; and a retrospective database study. Although the RCT indicated reduced tremor power among patients receiving TAPS, the trial lacked thorough analysis of more clinically relevant outcomes, was open-label, and short-term. Results of the prospective trial suggest that repeated in-home non-invasive TAPS therapy is effective and safe for patients with essential tremor. Limitations identified were the open-label, single-arm design, the lack of consensus for the definition of clinically meaningful improvement in TETRAS or BF-ADL, as well as the exclusion of 58 patients who exited the study early from the pre-specified primary and secondary endpoint analyses. Further studies comparing TAPS to pharmacologic therapy for essential tremor are needed.

Transcutaneous Afferent Patterned Stimulation for Action Tremor Associated with Parkinson Disease

Clinical Context and Therapy Purpose
The purpose of TAPS in patients who have action tremor associated with Parkinson disease is to provide a treatment option that is an alternative to or an improvement on existing therapies in individuals with tremor associated with Parkinson disease.

The following PICO was used to select literature to inform this review.

Populations
The relevant population of interest is individuals with tremor associated with Parkinson disease.

Interventions
The therapy being considered is TAPS. TAPS provides stimulation that alternates between the median and radial nerves with calibration to tremor frequency.

Comparators
The following therapies currently being used to treat action tremor associated with Parkinson disease: pharmacotherapy

Outcomes
The general outcomes of interest are reductions in symptoms and medication use, and improvements in functional outcomes and QOL.

Study Selection Criteria

Methodologically credible studies were selected using the following principles:

- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;
- In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
- To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
- Consistent with a 'best available evidence approach,' within each category of study design, studies with larger sample sizes and longer durations were sought.
- Studies with duplicative or overlapping populations were excluded.

Review of Evidence

An industry-sponsored, single-arm study of TAPS in patients with action tremor in Parkinson disease was reported by Brillman et al (2023).[98,] Forty patients with action tremor who had impaired activities of daily living (ADL) as measured by a score 2 or more on the Movement Disorder Society-Unified Parkinson Disease Rating Scale (MDS-UPDRS) in the medication-off state were enrolled in the study.

Exclusion criteria were numerous. Patients were treated with twice daily sessions of TAPS for 4 weeks with study visits before and after the 4 weeks of home use in the medication-off state. The primary outcome, change in tremor power measured by the device accelerometer before and immediately after a stimulation session, was reduced by 64% with 79% of patients showing at least 50% reduction. Additional endpoints, collected before the first session and immediately after the last stimulation session, were the change in the MDS-UPDRS, BF-ADL scale, and clinical global impression-improvement (CGI-I) and patient global impression-improvement (PGI-I). These showed statistically significant improvement when measured immediately after the last session, but durability of the treatment effect in minutes was assessed only by survey, with 78% of patients reporting a median 60-minute duration of post-stimulation relief in this single-arm study. Limitations of the study include having assessments immediately after stimulation, the subjective assessment of durability, and the lack of a control group or blinding. See Table 4 for study summary.

Table 4. Summary of Key Nonrandomized Trial

Study	Study Type	Country	Participants	Treatment	Follow-Up
Brillman et al (2023)[98,]	Prospective, single-center, single-arm, open-label	U.S.	40 patients diagnosed with PD and impaired ADL as measured by a score ≥2 on the MDS-UPDRS in the medication-off state	Cala wrist-worn TAPS device; patients were instructed to use the device twice daily for 1 month	Two in-clinic visits: Visit 1 (training) Visit 2 (1 month follow-up)

ADL: activities of daily living; MDS-UPDRS: Movement Disorder Society Unified PD Rating Scale; PD: Parkinson disease; TAPS: transcutaneous afferent patterned stimulation.

Section Summary: Transcutaneous Afferent Patterned Stimulation for Action Tremor Associated with Parkinson Disease

The evidence for the use of TAPS for action tremor associated with Parkinson disease includes results from a prospective, open-label, single-arm study. Results of the prospective trial suggest that repeated in-home TAPS therapy is effective for reducing tremor power and safe for patients with essential tremor. Limitations identified were the open-label, single-arm design, and lack of long-term outcomes. Further studies comparing TAPS to pharmacologic therapy for tremor associated are needed.

Attention Deficit Hyperactivity Disorder

Clinical Context and Therapy Purpose

The purpose of TENS is to provide a treatment option that is an alternative to or an improvement on existing therapies in patients with attention deficit hyperactivity disorder (ADHD).
The following PICO was used to select literature to inform this review.

Populations

The relevant population of interest is individuals with ADHD (7 to 12 years of age) who are not currently taking prescription ADHD medication.

Interventions

The therapy being considered is TENS. Monarch® external Trigeminal Nerve Stimulation (eTNS) System is based on a purported mechanism of action that the trigeminal nerve stimulates brain areas thought to be involved in ADHD. While the exact mechanism of action is not yet known, neuroimaging studies have shown that eTNS increases activity in the brain regions that are known to be important in regulating attention, emotion, and behavior.

Comparators

The following therapies are currently being used to treat ADHD: pharmacotherapy.

Outcomes

The general outcomes of interest are reductions in symptoms and medication use, and improvements in functional outcomes and QOL.

Study Selection Criteria

Methodologically credible studies were selected using the following principles:

- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;
- In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
- To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
- Studies with duplicative or overlapping populations were excluded.

Review of Evidence

Randomized Controlled Trials

McCough et al (2019) assessed the efficacy and safety of TENS in a double-blind, sham-controlled pilot study of pediatric patients with ADHD.[99,] Key characteristics of the trial are summarized in Table 5. The study was a 4-week trial followed by 1 blinded week without intervention. Clinical assessments included weekly clinician-administered ADHD-Rating and Clinical Global Impression (CGI) scales, and quantitative electroencephalography (EEG) at baseline and week 4. The primary outcome measure was the clinician completed ADHD-Rating Scale total score. Results revealed that ADHD-Rating Scale totals showed significant group-by-time interactions, demonstrating a differential treatment effect (F=8.12; df=1/228; p=.005). The CGI-Improvement scale also favored active treatment over sham (p=.003). Quantitative EEG readings were obtained in both groups but there was no participant specific correlations to other outcomes. No serious adverse events were observed in either group and no patient withdrew from the study due to adverse events. Significant increases in weight and pulse were seen with active TENS over the trial period; however, no differences between active and sham TENS with regard to blood pressure were seen. Conclusions were that TENS therapy is efficacious and well-tolerated in pediatric patients with ADHD. Limitations cited were sample size and short duration of treatment and follow-up.

Table 5. Summary of Key RCT Characteristics

Study	Countries	Sites	Dates	Participants	Interventions	
					Active	Comparator
McGough et al (2019)[99,]	US	1	NR	62 patients (8 to 12 years) with ADHD based on the KSADS and clinical interview with a minimum total of 24 on the clinician-administered parent ADHD-IV Rating Scale, baseline CGI-S ≥4, and full-scale IQ ≥85. Children were medication-free for at least 1 month prior to enrollment.	TENS device (Monarch eTNS System) administered nightly for 4 weeks (n=32)	Sham TENS device administered nightly for 4 weeks (n=30)

ADHD: attention deficit hyperactivity disorder; CGI-S: Clinical Global Impression-Severity; IQ: intelligence quotient; KSADS: Kiddie Schedule for Affective Disorders and Schizophrenia; NR: not reported; RCT: randomized controlled trial; TENS: transcutaneous electrical nerve stimulation.

Section Summary: Transcutaneous Electrical Nerve Stimulation for Attention Deficit Hyperactivity Disorder

The evidence for the use of TENS for ADHD includes an RCT. Results concluded that TENS is an effective and safe treatment option for pediatric patients with ADHD; however, the study included a small patient sample and was of relatively short duration.

Migraine

Clinical Context and Therapy Purpose

The purpose of TENS in individuals with migraine is to provide a treatment option that is an alternative to or an improvement on existing therapies in individuals with migraine.

The following PICO was used to select literature to inform this review.

Populations

The relevant population of interest is individuals with episodic or chronic migraine.
Migraine is categorized as episodic or chronic depending on the frequency of attacks. Generally, episodic migraine is characterized by 14 or fewer headache days per month and chronic migraine is characterized by 15 or more headache days per month.[100,]

Specific International Classification of Headache Disorders[101,] diagnostic criteria are as follows:

- Episodic migraine:
    1. Untreated or unsuccessfully treated headache lasting 4 to 72 hours;
    2. Headache has at least 2 of the following characteristics:
        1. Unilateral location;
        2. Pulsating quality;
        3. Moderate or severe pain intensity;
        4. Aggravation by or causing avoidance of routine physical activity.
    3. At least 1 of the following during headache:
        1. Nausea and/or vomiting;
        2. Photophobia or phonophobia.
- Chronic migraine:
    1. Migraine-like or tension-type headache on 15 or more days per month for more than 3 months.
    2. At least 5 headache attacks without aura meet episodic migraine criteria 1 to 3, and/or at least 5 headache attacks with aura meet episodic migraine criteria 2 to 3.

3. On more than 8 days per month for more than 3 months, fulfilling any of the following criteria:
    1. For migraine without aura, episodic migraine criteria 2 and 3;
    2. For migraine with aura, episodic migraine criteria 1 and 2;
    3. Believed by the patient to be migraine at onset and relieved by a triptan or ergot derivative.

Interventions

The therapy being considered is TENS. Several TENS devices are approved for both prevention and treatment of migraine.

Comparators

The following therapies are currently being used to treat acute migraine due to episodic or chronic migraine: Medical management or no treatment. A number of medications are used to treat acute migraine. First-line therapy for mild or moderate migraine includes oral non-steroidal anti-inflammatory drugs (NSAIDs) or acetaminophen. More severe migraine can be treated through the use of triptans or an NSAID-triptan combination through a variety of routes (e.g., oral, nasal [spray or powder], subcutaneous). Antiemetics can be added for migraine accompanied by nausea or vomiting. Other pharmacologic interventions used to treat acute migraine include calcitonin-gene related peptide antagonists, which can be used in patients with an insufficient response or contraindications to triptans, lasmiditan, and dihydroergotamine.

The following therapies are currently being used to prevent acute migraine in individuals with episodic or chronic migraine: medical management or no treatment. A number of medications are used as prevention for migraine. For most adults with episodic migraines who may benefit from preventive therapy, initial therapy with an antiepileptic drug (divalproex sodium, sodium valproate, topiramate) or beta-blockers (metoprolol, propranolol, timolol) is recommended. Frovatriptan may be beneficial as initial therapy for prevention of menstrually-associated migraine. Antidepressants (eg, amitriptyline, venlafaxine), alternative beta-blockers (atenolol, nadolol), and additional triptans (naratriptan, zolmitriptan for menstrually-associated migraine prevention) may be considered if initial therapy is unsuccessful. For preventive treatment of pediatric migraine, many children and adolescents who received placebo in clinical trials improved and most preventive medications were not superior to placebo. Possibly effective preventive treatment options for children and adolescents may include amitriptyline, topiramate, or propranolol.

Outcomes

For treatment of acute migraine, specific important health outcomes include freedom from migraine pain and bothersome symptoms, restored function (e.g., return to normal activities), and patient-assessed global impression of treatment. Examples of relevant outcome measures appear in Table 6. Follow-up over several hours is needed to monitor for treatment effects.

For prevention of acute migraine in individuals with chronic or episodic migraine, specific important health outcomes include reduction of future attack frequency, severity, and duration, improved responsiveness to acute treatments, improved function and reduced disability, and prevention of progression of episodic migraine to chronic migraine. Follow-up over several days to months is needed to monitor for preventive treatment effects.

Table 6. Health Outcome Measures Relevant to Acute Migraine Attack[100,102,103,]

Outcome	Description
Pain free	No pain at defined assessment time (e.g., 2 hours)
Pain relief	Improvement of pain from moderate to severe at baseline to mild or none or pain scale improved at least 50% from baseline at defined assessment time (e.g., 2 hours)
Sustained pain free	No pain at initial assessment (e.g., 2 hours) and remains at follow-up assessment (e.g., 1 day) with no use of rescue medication or relapse (recurrence) within that time frame
Sustained pain relief	Improvement of pain from moderate to severe at baseline to mild or none or pain scale improved at least 50% from baseline at defined assessment time (e.g., 2 hours) and remains

Outcome	Description
	improved at follow-up assessment (e.g., 1 day) with no use of rescue medication or relapse (recurrence) within that time frame
Symptom relief	Improvement of most bothersome symptom(s) from moderate to severe at baseline to mild or none at defined assessment time (e.g., 2 hours)
Function relief	Improvement of function from moderate to severe at baseline to mild or none at defined assessment time (e.g., 2 hours)
Restored function	No restriction to perform work or usual activities at a defined assessment time (e.g., 2 hours)
Global impact of treatment	Patient assessment of functional disability and health-related quality of life using a Likert or other validated scale at a defined assessment time (e.g., 2 hours)
Global evaluation of treatment	Patient assessment of overall treatment effect (pain, symptom relief, adverse events) using a Likert or other validated scale at a defined assessment time (e.g., 2 hours)

Study Selection Criteria

Methodologically credible studies were selected using the following principles:

- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;
- In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
- To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
- Studies with duplicative or overlapping populations were excluded.

Review of Evidence

Treatment of Acute Migraine

Randomized Controlled Trials

Three double-blind, sham-controlled RCTs evaluated TENS for acute migraine treatment (Tables 7 and 8). Two of the studies evaluated healthcare-provider administration of the device during a single episode in emergency departments, and 1 evaluated self-administration of the device at home during acute episodes over a 3-month period.

Chou et al (2019) conducted an RCT of TENS to the trigeminal nerve with the Cefaly device in 106 individuals experiencing migraine headaches with or without aura.[104,] Eligibility criteria specified that participants may have used any acute medications to treat the attack, but not within the 3 hours before enrollment; 29% had treated the current migraine with an acute medication prior to enrollment. Patients received 1 hour of TENS or sham treatment. The primary outcome, mean pain intensity at 1 hour compared to baseline (using a VAS score of 0 to 10), improved by 3.46 ± 2.32 points in the TENS group versus 1.78 ± 1.89 points in the sham group (p<.0001). Patients without aura had significant improvement in pain intensity at 1 hour compared to sham (p=.0006) but there was no difference between treatments among patients with aura (p=.06). Seven minor adverse effects were reported, and there were no serious adverse events.

Hokonek et al (2021) conducted a single center RCT (N=78) to evaluate the use of TENS in individuals presenting to an emergency department with a migraine.[105,] Participants had not received any medication prior to being admitted to the emergency department. Participants were randomized to TENS or a sham device, and their pain was assessed after 20 and 120 minutes. The change in VAS (0 to 100 mm) score from 0 to 20 min was -51.13 ± 2.94 for the TENS group, while the mean VAS score in the sham group was similar between baseline and 20 minutes (73 ± 3 vs. 72 ± 2). The change in VAS (0 to 100 mm) score from 0 to 120 min was -65 ± 25 for the TENS group and -9 ± 2 for the sham group (p<.001). Following randomization, 3 participants in the intervention group withdrew due to paresthesia caused by TENS administration and 2 in the control group withdrew due to severe pain; these individuals were not included in the analysis.

Domingues et al (2021) evaluated the analgesic efficacy of a portable, disposable, and home self-applied TENS device during migraine attacks.[106,] Participants (74 adults) who had been diagnosed with migraine by a specialist were randomized in this double-blind clinical trial to the active intervention (n=42) or a sham (n=32) with monthly follow-up for 3 months. The primary outcome measure was an evaluation of pain intensity following treatment. Subjects in both groups reported reduced pain scores; with significantly lower pain scores in the intervention group compared to the sham group (p=.004). Patients in the active intervention group also showed a significant improvement in functional disability scores. No adverse effects were reported.
Study limitations are summarized in Tables 9 and 10. Strengths of the RCTs included the use of a sham device and blinded outcome assessment using validated outcome measures. Although short-term pain relief was demonstrated at some time points, the quality of the overall body of evidence was downgraded due to inconsistency of results and heterogeneity in study settings. Supporting evidence from additional RCTs is needed.

Table 7. Summary of Key RCT Characteristics

Study; Trial	Setting	Sites	Dates	Participants	Interventions	
					Active	Comparator
Chou et al (2019)[104,]	Emergency Departments, US	3	2016-2017	Adults (18 to 65 years of age) with IHS-defined acute migraine attack with or without aura for at least 3 hours before enrollment. Participants may have used any acute medications to treat the attack, but not within the 3 hours before enrollment. 29% had treated the current migraine with an acute medication prior to enrollment.	TENS (1 hour) with the Cefaly device (n=52)	Sham TENS (1 hour) using low-frequency pulses (n=54)
Hokonek et al (2021)[105,]	Emergency Department, Turkey	1	June-Oct 2019	Adults (ages 18 to 50 years) with IHS-defined migraine with or without aura, no preventive migraine treatment in the prior 30 days, presenting to the ED with an untreated acute migraine episode. Participants had not received any medication prior to being admitted to the ED.	TENS (20 minutes) (n=39)	Sham TENS using a device with an empty battery (20 minutes) (n=39)
Domingues et al (2021)[106,]	Home, Brazil	NR	Nov 2017-Jul 2018	Adults (18 to 65 years of age) with IHS-defined migraine with or without aura. Most participants were under pharmacological treatment for migraine but specifics of	TENS (20 minutes, self-applied at home) (n=42)	Sham TENS using a device with settings that did not meet those required for effective analgesic treatment by TENS devices (20 minutes, self

Study; Trial	Setting	Sites	Dates	Participants	Interventions
				treatment for acute episodes during the study period were not reported.	applied at home) (n=32)

ED: emergency department; IHS: International Headache Society; RCT: randomized controlled trial; TENS: transcutaneous electrical nerve stimulation.

Table 8. Summary of Key RCT Results

Study	Pain score	Rescue medication use	Adverse Events
Chou et al (2019)[104,]	N=106	N=106	
TENS	Mean change After 1 hour: -3.46±2.32 After 2 hours: -2.87±2.24 After 24 hours: -3.46±2.65	After 2 hours: 6% After 24 hours: 40%	No serious adverse events. Inability to tolerate paresthesia sensation: 2 discontinued before first 5 mins elapsed 3 discontinued before the full hour
Sham TENS	Mean change After 1 hour: -1.78±1.89 After 2 hours: -1.85±1.96 After 24 hours: -2.38±2.27	After 2 hours: 4% After 24 hours: 41%	1 discontinued before first 5 mins elapsed 1 discontinued before the full hour
p for difference	1 hour: <.0001 .2 hours: 028 24 hours:.062	After 2 hours:.66 After 24 hours: 1.0	
Hokonek et al (2021)[105,]	N=78 Likert-type verbal scale (1=severe pain, 5=more than fine)	78 Additional analgesi medication required at 120 minutes	
TENS	change in pain intensity 1 hour 4.5	1/39 (2.6%)	3/83 withdrew due to paresthesia caused by TENS administration
Sham TENS	mean at 1 hour 1.2	30/39 (76.9%)	2/83 withdrew due to severe pain
p	<.001	74.3%; 95% CI 59.9% to 87.6%)	
Domingues et al (2021)[106,]	N=74	N=74	
TENS	Median (IQR) Month 1: -3 (-10 to 0) Month 2: -2 (-10 to 0) Month 3: -2 (-10 to 0)	0 (0 to 3	
Sham TENS	Median (IQR) Month 1: 0 (-7 to 0) Month 2: -2 (-10 to 0) Month 3: -2 (-10 to 0)	1 (9 to 5)	No adverse events or intolerance to the electrical stimuli
p for difference	Month 1:.001 Month 2:<.001 Month 3:.129	.427	No adverse events or intolerance to the electrical stimuli

IQR: interquartile range; NR: not reported; RCT: randomized controlled trial; TENS: transcutaneous electrical nerve stimulation; VAS: visual analogue scale.

Table 9. Study Relevance Limitations

Study	Population[a]	Intervention[b]	Comparator[c]	Outcomes[d]	Duration of Follow-up[e]
Chou et al (2019)[104],	1. Intended use population is unclear (e.g., treatment naive, those with contraindications to medication, or those who have failed pharmacologic treatment)				
Hokonek et al (2021)[105],	1. Intended use population is unclear (e.g., treatment naive, those with contraindications to medication, or those who have failed pharmacologic treatment)			Pain measure described as "likert-type verbal scale," unclear if validated	
Domingues et al (2021)[106],	1, 2. Intended use population is unclear (e.g., treatment naive, those with contraindications to medication, or those who have failed pharmacologic treatment); no details on timing or type of treatment of acute attacks during the study period.				Followup was for 3 months. There was no difference between groups in pain score at the 3-month timepoint. Longer follow-up could provide more information about the effectiveness of the device over time.

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.
[a] Population key: 1. Intended use population unclear; 2. Study population is unclear; 3. Study population not representative of intended use; 4, Enrolled populations do not reflect relevant diversity; 5. Other.
[b] Intervention key: 1. Not clearly defined; 2. Version used unclear; 3. Delivery not similar intensity as comparator; 4. Not the intervention of interest (e.g., proposed as an adjunct but not tested as such); 5: Other.
[c] Comparator key: 1. Not clearly defined; 2. Not standard or optimal; 3. Delivery not similar intensity as intervention; 4. Not delivered effectively; 5. Other.
[d] Outcomes key: 1. Key health outcomes not addressed; 2. Physiologic measures, not validated surrogates; 3. Incomplete reporting of harms; 4. Not establish and validated measurements; 5. Clinically significant difference not prespecified; 6. Clinically significant difference not supported; 7. Other.
[e] Follow-Up key: 1. Not sufficient duration for benefit; 2. Not sufficient duration for harms; 3. Other.

Table 10. Study Design and Conduct Limitations

Study	Allocation[a]	Blinding[b]	Selective Reporting[c]	Data Completeness[d]	Power[e]	Statistical[f]
Chou et al (2019)[104],						

Study	Allocation[a]	Blinding[b]	Selective Reporting[c]	Data Completeness[d]	Power[e]	Statistical[f]
Hokonek et al (2020)[105],	1. Authors stated that TENS patients probably felt that the unit was active		1. No mention of registration	5/83 randomized not included in analysis (3 TENS, 2 sham); no ITT analysis	Confidence intervals NR for pain scale difference; post hoc analysis for scores at different timepoints. Table 2 does not provide a footnote to explain data points and no statistical comparison. Text provides means and p-value for pain scores but does not specify timepoint.	
Domingues et al (2021)[106],						

TENS: transcutaneous electrical nerve stimulation.
The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.
[a] Allocation key: 1. Participants not randomly allocated; 2. Allocation not concealed; 3. Allocation concealment unclear; 4. Inadequate control for selection bias; 5. Other.
[b] Blinding key: 1. Participants or study staff not blinded; 2. Outcome assessors not blinded; 3. Outcome assessed by treating physician; 4. Other.
[c] Selective Reporting key: 1. Not registered; 2. Evidence of selective reporting; 3. Evidence of selective publication; 4. Other.
[d] Data Completeness key: 1. High loss to follow-up or missing data; 2. Inadequate handling of missing data; 3. High number of crossovers; 4. Inadequate handling of crossovers; 5. Inappropriate exclusions; 6. Not intent to treat analysis (per protocol for noninferiority trials); 7. Other.
[e] Power key: 1. Power calculations not reported; 2. Power not calculated for primary outcome; 3. Power not based on clinically important difference; 4. Other.
[f] Statistical key: 1. Analysis is not appropriate for outcome type: (a) continuous; (b) binary; (c) time to event; 2. Analysis is not appropriate for multiple observations per patient; 3. Confidence intervals and/or p values not reported; 4. Comparative treatment effects not calculated; 5. Other.

Migraine Prevention

Randomized Controlled Trial

One RCT evaluated TENS for acute migraine prevention in individuals with chronic or episodic migraine (Tables 11 and 12). The Cefaly device for prevention of migraine was evaluated in the Prevention of Migraine using the STS Cefaly (PREMICE) trial (2013).[107,] PREMICE was a double-blind, sham-controlled, randomized trial conducted at 5 tertiary care headache clinics in Belgium. Sixty-seven individuals with at least 2 migraine attacks per month were randomized to active (n=34) or sham (n=33) neurostimulation for 3 months, and 59 (88%) completed the trial on protocol. No serious adverse events occurred, although 1 patient discontinued the trial because of a reported device-caused headache. After a 1-month run-in period, patients were instructed to use the device daily for 3 months. Adherence was recorded by the TENS device. Ninety stimulation sessions were expected, but on average, 56 sessions were completed by the active group, and 49 were completed by the sham group. Primary outcome measures were changes in the number of migraine days and the percent of responders.

In the intention-to-treat analysis, the change in the number of migraine days (run-in vs. 3-month) was -2.06 (95% CI, -0.54 to -3.58) for the TENS group and 0.32 (95% CI, -0.63 to +1.27) for the sham group; this difference was not statistically significant (p=.054). The proportion of responders (≥50% reduction in the number of migraine days/month) was 38% (95% CI, 22% to 55%) in the TENS group and 12% (95% CI, 1% to 23%) in the sham group (p=.014). The number of migraine attacks from the run-in period to the 3-month evaluation was significantly lower for the active TENS group (decrease of 0.82 in the TENS group vs. 0.15 in the sham group; p=.044). The number of headache days was lower in the TENS group than in the sham group (decrease of 2.5 vs. 0.2; p=.041). Patients in the active

TENS group reported a 36.6% reduction in the number of acute antimigraine drugs taken compared with a 0.5% reduction in the sham group (p=.008). The severity of migraine days did not differ significantly between groups. No adverse effects were reported among the study participants. Study limitations are summarized in Tables 13 and 14.

Table 11. Summary of Key RCT Characteristics

Study; Trial	Countries	Sites	Dates	Participants	Interventions	
					Active	Comparator
Schoenen et al (2013); PREMICE[107],	Belgium	5	2009-2011	Adults (18 to 65 years of age) with IHS-defined migraine with or without aura and at least 2 migraine attacks per month	TENS (20 minutes daily) for 3 months (n=34)	Sham TENS (20 minutes daily) for 3 months (n=33)

RCT: randomized controlled trial; TENS: transcutaneous electrical nerve stimulation.

Table 12. Summary of Key RCT Results

Study	Change in number of monthly migraine days at month 3	Responders at month 3	Change in antimigraine medication use at month 3
Schoenen et al (2013); PREMICE[107],	N=67	N=67	N=67
TENS	-2.06 (-0.54 to -3.58)	38.24%	-36.6%
Sham TENS	0.32 (-0.63 to 1.27)	12.12%	0.5%
p	.054	.023	.0072

RCT: randomized controlled trial; TENS: transcutaneous electrical nerve stimulation.

Table 13. Study Relevance Limitations

Study	Population[a]	Intervention[b]	Comparator[c]	Outcomes[d]	Duration of Follow-up[e]
Schoenen et al (2013); PREMICE[107],					1. Follow-up limited to 3 months

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.
[a] Population key: 1. Intended use population unclear; 2. Study population is unclear; 3. Study population not representative of intended use; 4, Enrolled populations do not reflect relevant diversity; 5. Other.
[b] Intervention key: 1. Not clearly defined; 2. Version used unclear; 3. Delivery not similar intensity as comparator; 4. Not the intervention of interest (e.g., proposed as an adjunct but not tested as such); 5: Other.
[c] Comparator key: 1. Not clearly defined; 2. Not standard or optimal; 3. Delivery not similar intensity as intervention; 4. Not delivered effectively; 5. Other.
[d] Outcomes key: 1. Key health outcomes not addressed; 2. Physiologic measures, not validated surrogates; 3. Incomplete reporting of harms; 4. Not establish and validated measurements; 5. Clinically significant difference not prespecified; 6. Clinically significant difference not supported; 7. Other.
[e] Follow-Up key: 1. Not sufficient duration for benefit; 2. Not sufficient duration for harms; 3. Other.

Table 14. Study Design and Conduct Limitations

Study	Allocation[a]	Blinding[b]	Selective Reporting[c]	Data Completeness[d]	Power[e]	Statistical[f]
Schoenen et al (2013); PREMICE[107],			1. No mention of registration		4. Power calculated for a different outcome than the outcome described as primary	

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.
[a] Allocation key: 1. Participants not randomly allocated; 2. Allocation not concealed; 3. Allocation concealment unclear; 4. Inadequate control for selection bias; 5. Other.
[b] Blinding key: 1. Participants or study staff not blinded; 2. Outcome assessors not blinded; 3. Outcome assessed by treating physician; 4. Other.
[c] Selective Reporting key: 1. Not registered; 2. Evidence of selective reporting; 3. Evidence of selective publication;

4. Other.
[d] Data Completeness key: 1. High loss to follow-up or missing data; 2. Inadequate handling of missing data; 3. High number of crossovers; 4. Inadequate handling of crossovers; 5. Inappropriate exclusions; 6. Not intent to treat analysis (per protocol for noninferiority trials); 7. Other.
[e] Power key: 1. Power calculations not reported; 2. Power not calculated for primary outcome; 3. Power not based on clinically important difference; 4. Other.
[f] Statistical key: 1. Analysis is not appropriate for outcome type: (a) continuous; (b) binary; (c) time to event; 2. Analysis is not appropriate for multiple observations per patient; 3. Confidence intervals and/or p values not reported; 4. Comparative treatment effects not calculated; 5. Other.

Section Summary: Transcutaneous Electrical Nerve Stimulation for Migraine

The evidence for the use of TENS for treatment of acute migraine includes 3 double-blind, sham-controlled RCTs. Two of the RCTs evaluated healthcare-provider administration of a TENS device during a single episode in emergency departments, and 1 evaluated self-administration of the device at home during acute episodes over a 3-month period. The studies conducted in emergency departments showed clinically and statistically significant reductions in pain intensity and medication use within 2 hours of use. The self-administration study had mixed results: The difference in median pain scores before and after treatment was significantly higher in the TENS group at months 1 and 2, but at month 3 the difference was not statistically significant. Function and analgesic medication use did not differ between groups at any time point. Strengths of the RCTs included the use of a sham device and blinded outcome assessment using validated outcome measures. Although short-term pain relief was demonstrated at some time points, the quality of the overall body of evidence was downgraded due to inconsistency of results and heterogeneity in study settings. It is not clear whether the pain intensity reductions demonstrated in emergency department settings would generalize to other settings over longer time periods. Supporting evidence from RCTs is needed. Additionally, based on the existing evidence, it is unclear how TENS would fit into the current migraine treatment pathway, although it could provide benefit for those who do not receive adequate benefit from pharmacologic first- or second-line therapies, or who may have a contraindication to pharmacologic therapies. The specific intended use must be specified in order to adequately evaluate net health benefit.

The evidence for the use of TENS for prevention of acute migraine in individuals with chronic or episodic migraine includes 1 RCT (N=67) that reported a greater proportion of patients achieving at least a 50% reduction in migraines with TENS than with sham placebo. The RCT also reported modest reductions in the number of total headache and migraine days. This manufacturer-sponsored trial needs corroboration before conclusions can be made about the efficacy of TENS for preventing migraine headaches. Additionally, based on the existing evidence, it is unclear how TENS would fit into the current migraine prevention pathway, although it could provide benefit for those who do not receive adequate benefit from pharmacologic first- or second-line therapies, or who may have a contraindication to pharmacologic therapies.

Supplemental Information

The purpose of the following information is to provide reference material. Inclusion does not imply endorsement or alignment with the evidence review conclusions.

Practice Guidelines and Position Statements

Guidelines or position statements will be considered for inclusion in 'Supplemental Information' if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

American Academy of Neurology

In 2010, the American Academy of Neurology published an evidence-based review of the efficacy of transcutaneous electrical nerve stimulation (TENS) for the treatment of pain in neurologic

disorders.[33,] The Academy did not recommend TENS for the treatment of chronic low back pain due to lack of proven efficacy (level A, established evidence from 2 class I studies), but stated that TENS should be considered for the treatment of painful diabetic neuropathy (level B, probably effective, based on 2 class II studies).

American College of Rheumatology

In 2019, the American College of Rheumatology made a strong recommendation against the use of TENS for knee and hip osteoarthritis.[108,]

American Congress of Obstetricians and Gynecologists

In 2019 (reaffirmed in 2021), the ACOG guidelines on labor and delivery found that TENS may "help women cope with labor more than directly affect pain scores."[109,]

American Society of Anesthesiologists, et al

In 2010, the practice guidelines from the American Society of Anesthesiologists and American Society of Regional Anesthesia and Pain Medicine recommended that TENS be used as part of a multimodal approach to management for patients with chronic back pain and may be used for other pain conditions (e.g., neck and phantom limb pain).[110,]

National Cancer Institute

The National Cancer Institute's Physician Data Query identifies TENS as a potential nonpharmacological modality for pain control for postthoracotomy pain syndrome.[111,]

National Comprehensive Cancer Network

National Comprehensive Cancer Network guidelines on adult cancer pain (v 2.2024) indicate that nonpharmacologic interventions, including TENS, may be considered in conjunction with pharmacologic interventions as needed (category 2A).[112,]

National Institute for Health and Care Excellence

In 2016 (updated 2020), the NICE guidance on low back pain indicated that, despite the long history of use of TENS for back pain, the quality of research studies is poor. This guidance recommended against TENS as a treatment.[113,]

In 2014, the NICE guidance on osteoarthritis care and management in adults indicated that TENS be considered "as an adjunct to core treatments for pain relief." In 2022, NICE osteoarthritis guidelines recommend against TENS for osteoarthritis.[114,]

In 2017, the NICE guidance on intrapartum care recommended against the use of TENS for "established labour." In 2023, NICE recommendations for TENS included "there is very little evidence of its effectiveness in established labour, but no evidence of harm."[115,]

North American Spine Society

In 2020, the North American Spine Society clinical guidelines on the diagnosis and treatment of low back pain provided guidance on the effectiveness of different physical medicine and rehabilitation therapies.[116,] The guideline noted that there is conflicting evidence that TENS results in improvement in pain or function at short- to medium-term follow-up. The work group further recommended that randomized clinical trials with long-term follow-up are needed to evaluate the benefits of TENS compared to exercise/physical therapy or as adjunctive use to usual care for low back pain.

In 2011, the North American Spine Society clinical guidelines on the diagnosis and treatment of cervical radiculopathy from degenerative disorders discussed the role of ancillary treatments such as bracing, traction, electrical stimulation, acupuncture, and TENS.[117,] A consensus statement from the Society recommended that ozone injections, cervical halter traction, and combinations of medications, physical therapy, injections, and traction have been associated with improvements in

patient-reported pain in uncontrolled case series. Such modalities may be considered, recognizing that no improvement relative to the natural history of cervical radiculopathy has been demonstrated. There were no specific statements about the role of TENS in this population.

Osteoarthritis Research Society International

In 2014, the guidelines from the Osteoarthritis Research Society International recommended that TENS was inappropriate for use in patients with multi-joint osteoarthritis; moreover, the guidelines suggested that TENS has an uncertain value for the treatment of knee-only osteoarthritis pain.[118,] Updated guidance (2019) on the non-surgical management of knee, hip, and polyarticular osteoarthritis does not address TENS nor include it in their patient-focused treatment recommendations.[119,]

World Health Organization

In 2023, the World Health Organization recommended against the use of TENS as part of routine care for patients with chronic low back pain.[120,] They found the net benefits across outcomes and comparators to be small or uncertain.

U.S. Preventive Services Task Force Recommendations

Not applicable.

Medicare National Coverage

The Centers for Medicare & Medicaid Services currently have a number of national coverage decisions on TENS.[121,122,123,] The different coverage decisions address the use of TENS in the treatment of chronic intractable pain, noncoverage of TENS for chronic low back pain except to conduct research for said indication, and coverage for acute postoperative pain.

Ongoing and Unpublished Clinical Trials

Some currently ongoing and unpublished trials that might influence this review are listed in Table 15.

Table 15. Summary of Key Trials

NCT No.	Trial Name	Planned Enrollment	Completion Date
Ongoing			
NCT05939804	The Effect of Transcutaneous Electrical Nerve Stimulation (TENS) Application on Patients' Pain Level and Analgesic Use in Patients Undergoing Hip Replacement	60	Sep 2025
NCT05812885	Transcutaneous Electrical Nerve Stimulation (TENS) and Chronic Low-Back Pain: A Randomized Crossover Trial	34	Dec 2024
Unpublished			
NCT04092088	Effectiveness of Cerebral and Peripheral Electrical Stimulation on Pain and Functional Limitations Associated With Carpal Tunnel Syndrome: A Randomized, Double-blind, Multi-center, Factorial Clinical Trial	180	Oct 2020 (unknown status)
NCT05320432	Transcutaneous Electrical Nerve Stimulation for Pain Control During First Trimester Abortion: a Blinded Randomized Controlled Trial	72	Mar 2024 (published in abstract form)

NCT: national clinical trial.

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Documentation for Clinical Review

Please provide the following documentation:

- History and physical and/or consultation notes including:
  - Multidisciplinary evaluation
  - Pain assessment including nature, duration, and perceived intensity of pain (if applicable)

- Prescription for make and model of the device requested
- Prior and ongoing treatments (including type and duration, and medications)
- Proposed use of device (including frequency and duration of treatment)
- Clinical summary for continued use of a TENS unit (if applicable):
  - Any ongoing pain control requirements (e.g., medication and other modalities)
  - Perceived pain intensity with and without TENS (e.g., visual analog scale [VAS])
  - TENS usage on a daily basis (frequency and duration of application)

Post Service (in addition to the above, please include the following):

- Procedure report(s)
- Product invoice

Coding

This Policy relates only to the services or supplies described herein. Benefits may vary according to product design; therefore, contract language should be reviewed before applying the terms of the Policy.

The following codes are included below for informational purposes. Inclusion or exclusion of a code(s) does not constitute or imply member coverage or provider reimbursement policy. Policy Statements are intended to provide member coverage information and may include the use of some codes for clarity. The Policy Guidelines section may also provide additional information for how to interpret the Policy Statements and to provide coding guidance in some cases.

Type	Code	Description
CPT®	0766T	Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, initial treatment, with identification and marking of the treatment location, including noninvasive electroneurographic localization (nerve conduction localization), when performed; first nerve
	0767T	Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, initial treatment, with identification and marking of the treatment location, including noninvasive electroneurographic localization (nerve conduction localization), when performed; each additional nerve (List separately in addition to code for primary procedure)
	0768T	Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, subsequent treatment, including noninvasive electroneurographic localization (nerve conduction localization), when performed; first nerve
	0769T	Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, subsequent treatment, including noninvasive electroneurographic localization (nerve conduction localization), when performed; each additional nerve (List separately in addition to code for primary procedure)
HCPCS	A4541	Monthly supplies for use of device coded at e0733
	A4542	Supplies and accessories for external upper limb tremor stimulator of the peripheral nerves of the wrist
	A4595	Electrical stimulator supplies, 2 lead, per month, (e.g., TENS, NMES)
	A4630	Replacement batteries, medically necessary, transcutaneous electrical stimulator, owned by patient

Type	Code	Description
	E0720	Transcutaneous electrical nerve stimulation (TENS) device, two-lead, localized stimulation
	E0730	Transcutaneous electrical nerve stimulation (TENS) device, four or more leads, for multiple nerve stimulation
	E0731	Form-fitting conductive garment for delivery of TENS or NMES (with conductive fibers separated from the patient's skin by layers of fabric)
	E0733	Transcutaneous electrical nerve stimulator for electrical stimulation of the trigeminal nerve
	E0734	External upper limb tremor stimulator of the peripheral nerves of the wrist

Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

Effective Date	Action
04/03/2009	Policy Revision • Transcutaneous Electrical Nerve Stimulation (TENS) for the Treatment of Pain • Interferential Stimulation Developed new policy: • High-voltage Galvanic Stimulation • Bioelectric Therapy • Microcurrent Electrical Nerve Stimulation Adopted: • H-wave Electrical Stimulation • Percutaneous Electrical Nerve Stimulation (PENS) or Percutaneous Neuromodulation Therapy • Sympathetic Therapy
10/29/2010	Coding Update
03/13/2012	Coding update
01/25/2013	Policy title change from Electrical Stimulation for Pain with position change
04/11/2013	Policy revision with position change
04/30/2015	Coding Update
07/31/2015	Policy title change from Electrical Stimulation for Pain and Other Conditions Policy revision with position change
09/01/2016	Policy revision without position change
10/01/2017	Policy revision without position change
01/01/2018	Policy revision without position change Coding Update
01/01/2019	Coding update
02/01/2019	Policy revision without position change
02/01/2020	Annual review. No change to policy statement. Literature review updated.
02/01/2024	Policy reactivated. Previously archived from 09/01/2020 to 01/31/2024.
02/01/2025	Annual review. Policy statement, guidelines and literature review updated. Policy title changed from Transcutaneous Electrical Nerve Stimulation to current one

Definitions of Decision Determinations

Medically Necessary: Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by Blue Shield, are: (a) consistent with Blue Shield medical policy; (b) consistent with the symptoms or diagnosis; (c) not furnished primarily for the convenience of the patient, the attending Physician or other provider; (d) furnished at the most appropriate level which can be provided safely and effectively to the patient; and (e) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's illness, injury, or disease.

Investigational/Experimental: A treatment, procedure, or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

Split Evaluation: Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a split evaluation, where a treatment, procedure, or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

Prior Authorization Requirements and Feedback (as applicable to your plan)

Within five days before the actual date of service, the provider must confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department at (800) 541-6652, or the Transplant Case Management Department at (800) 637-2066 ext. 3507708 or visit the provider portal at www.blueshieldca.com/provider.

We are interested in receiving feedback relative to developing, adopting, and reviewing criteria for medical policy. Any licensed practitioner who is contracted with Blue Shield of California or Blue Shield of California Promise Health Plan is welcome to provide comments, suggestions, or concerns. Our internal policy committees will receive and take your comments into consideration.

For utilization and medical policy feedback, please send comments to: MedPolicy@blueshieldca.com

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.

Appendix A

POLICY STATEMENT	
BEFORE Red font: Verbiage removed	**AFTER** Blue font: Verbiage Changes/Additions
Transcutaneous Electrical Nerve Stimulation 1.01.09 **Policy Statement:** I. A trial of transcutaneous electrical nerve stimulation (TENS) of at least 30 days may be considered **medically necessary** to establish efficacy for the management of refractory chronic pain (e.g., chronic musculoskeletal pain or neuropathic pain) that causes significant disruption of function when **both** of the following conditions have been met: A. The pain is unresponsive to at least 3 months of conservative medical therapy B. The trial is monitored by a provider. II. Continued use of TENS may be considered **medically necessary** for treatment of refractory chronic pain (e.g., chronic musculoskeletal or neuropathic pain) that causes significant disruption of function when **both** of the following conditions have been met: A. Efficacy has been demonstrated in an initial therapeutic trial (see Policy Guidelines section) B. Compliance has been demonstrated in the therapeutic trial with the device used on a regular basis (e.g., daily or near daily use) throughout the trial period. III. TENS is considered **investigational** for the management of acute pain (e.g., postoperative or during labor and delivery). IV. TENS is considered **investigational** for the prevention or treatment of migraine headache. V. TENS is considered **investigational** for the management of essential tremor.	**Transcutaneous Electrical Nerve Stimulation** and Transcutaneous Afferent Patterned Stimulation **1.01.09** **Policy Statement:** I. A trial of transcutaneous electrical nerve stimulation (TENS) of at least 30 days may be considered **medically necessary** to establish efficacy for the management of refractory chronic pain (e.g., chronic musculoskeletal pain or neuropathic pain) that causes significant disruption of function when **both** of the following conditions have been met: A. The pain is unresponsive to at least 3 months of conservative medical therapy B. The trial is monitored by a provider. II. Continued use of TENS may be considered **medically necessary** for treatment of refractory chronic pain (e.g., chronic musculoskeletal or neuropathic pain) that causes significant disruption of function when **both** of the following conditions have been met: A. Efficacy has been demonstrated in an initial therapeutic trial (see Policy Guidelines section) B. Compliance has been demonstrated in the therapeutic trial with the device used on a regular basis (e.g., daily or near daily use) throughout the trial period. III. TENS is considered **investigational** for the management of acute pain (e.g., postoperative or during labor and delivery). IV. TENS is considered **investigational** for the prevention or treatment of migraine headache.

POLICY STATEMENT	
BEFORE Red font: Verbiage removed	**AFTER** Blue font: Verbiage Changes/Additions
VI. TENS is considered **investigational** for the management of attention deficit hyperactivity disorder. VII. The use of TENS for any other condition, including but not limited to the treatment of dementia is considered **investigational**.	V. TENS is considered **investigational** for the management of attention deficit hyperactivity disorder. VI. Transcutaneous afferent patterned stimulation (TAPS) is considered **investigational** for the following conditions: A. Essential tremor; B. Action tremor for Parkinson disease VII. The use of TENS or TAPS for any other condition, including but not limited to the treatment of dementia is considered **investigational**.