
Medical Policy



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***Current Policy Effective Date: 5/1/26**

(See policy history boxes for previous effective dates)

Title: Tonic Motor Activation (TOMAC) For Restless Legs Syndrome

Description

Tonic motor activation (TOMAC) is a peroneal nerve stimulation device that uses electrodes worn on the lower legs to deliver bilateral high-frequency electrical stimulation to the common peroneal nerves located near the fibula in the lower legs. This stimulation is proposed to activate the tibialis anterior muscle, producing sustained, low-level muscle contractions that mimic the effects of voluntary leg movements like walking or stretching, which are activities known to relieve restless legs syndrome RLS symptoms.

Medical Policy Statement

Tonic Motor Activation (TOMAC) for treatment of restless legs syndrome is experimental and investigational. There is insufficient evidence to determine that the technology results in an improvement in net health outcomes.

Inclusionary and Exclusionary Guidelines (Clinically based guidelines that may support individual consideration and pre-authorization decisions)

N/A

CPT/HCPCS Level II Codes *(Note: The inclusion of a code in this list is not a guarantee of coverage. Please refer to the medical policy statement to determine the status of a given procedure.)*

Established codes:

N/A

Other codes (investigational, not medically necessary, etc.):

A4544

E0743

Note: Code(s) may not be covered by all contracts or certificates. Please consult customer or provider inquiry resources at BCBSM or BCN to verify coverage.

Background

Restless Legs Syndrome

Restless legs syndrome (RLS) is a neurological condition characterized by an uncontrollable urge to move the legs, often accompanied by uncomfortable sensations. These symptoms typically worsen during periods of rest or inactivity, especially in the evening or at night, and are temporarily relieved by movement. RLS is frequently associated with sleep disturbances and periodic limb movements during sleep (PLMS), which can further impair rest and daytime functioning. When PLMS occurs without RLS or other related disorders, it is classified as periodic limb movement disorder (PLMD). Treatment for RLS generally involves pharmacologic therapy, with options including alpha-2-delta calcium channel ligands, dopaminergic agents, opioids, and benzodiazepines. Therapy is tailored based on symptom severity, patient age, comorbidities, and individual preferences, aiming to improve sleep quality and overall life functioning. Dopaminergic therapies have a known risk of augmentation.

For individuals with refractory RLS, where symptoms persist despite first-line treatments like gabapentinoids, alternative strategies are considered. These include combination pharmacotherapy using different drug classes, low-dose opioids, and a thorough review of iron levels, potential exacerbating substances, behavioral interventions, and bilateral peroneal nerve stimulation.

Tonic Motor Activation

Tonic motor activation (TOMAC), also known as bilateral peroneal nerve stimulation, is proposed to work by delivering bilateral high-frequency electrical stimulation to the common peroneal nerves located near the fibula in the lower legs. This stimulation activates the tibialis anterior muscle, producing sustained, low-level muscle contractions that mimic the effects of voluntary leg movements like walking or stretching, which are activities known to relieve RLS symptoms.

The proposed biological mechanism involves afferent feedback.⁽¹⁾ The stimulation sends signals back to the central nervous system, which may help suppress the abnormal sensory signals that drive the urge to move the legs. By activating the same circuits used during natural

movement, TOMAC may modulate spinal and supraspinal pathways involved in RLS pathophysiology.

TOMAC differs from transcutaneous electrical nerve stimulation (TENS) devices. TOMAC targets the common peroneal nerve with a goal of tonic activation of motor pathways to mimic movement with high frequency, sustained, bilateral stimulation. TENS targets superficial sensory nerves often with the goal of pain relief by administering pulsed, often intermittent, stimulation.

Clinical Pathway

TOMAC is not a first-line therapy for RLS. It is indicated for moderate-to-severe primary RLS that is refractory to pharmacologic treatment. First-line therapies include iron supplementation, gabapentinoids, lifestyle modifications (e.g., regular moderate exercise, sleep habits, etc.).

Summary of Evidence

For individuals with restless legs syndrome (RLS) who are refractory to medication who receive tonic motor activation (TOMAC), the evidence includes randomized controlled trials (RCTs), nonrandomized studies, and a systematic review and meta-analysis. Relevant outcomes are changes in symptoms, functional outcomes, quality of life, and medication use. The pivotal RCT showed a higher Clinical Global Impression of Improvement (CGI-I) responder rate in the TOMAC group compared to the control group (45% vs. 16%; difference: 28%). They also showed greater reductions in International RLS Study Group Rating Scale (IRLS) scores in the TOMAC group compared to the sham group (-7.2 vs. -3.8). The meta-analysis, which includes the RCT results comparing TOMAC to sham controls, showed significantly reduced IRLS scores (mean difference: -3.66), improved Patient Global Impression of Improvement (PGI-I) response (risk ratio: 3.16), and enhanced sleep quality (MOS-I mean difference: -9.28; MOS-II mean difference: -10.06). Across studies, adverse events were mild with no serious device-related events reported. Limitations included underpowered sample sizes, short study durations, potential loss of blinding due to perceived treatment, a lack of long-term randomized data, and risk of bias from patient-reported outcomes. Sufficiently powered RCTs, with long-term follow-up to investigate safety and durability, are needed to further evaluate the net health outcomes. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Rationale

Evidence reviews assess the clinical evidence to determine whether the use of a technology improves the net health outcome. Broadly defined, health outcomes are length of life, quality of life, and ability to function including benefits and harms. Every clinical condition has specific outcomes that are important to individuals and to 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. The following is a summary of the key literature to date.

Tonic Motor Activation in Individuals with Restless Legs Syndrome Refractory to Medication

Review of Evidence

Randomized Controlled Trials

The pivotal trial, published by Bogan et al (2023), was a multicenter, randomized, double-blind, sham-controlled clinical trial (RESTFUL Study) evaluating the efficacy and safety of TOMAC for treating medication-refractory RLS (N=133).(7) Adults with moderate-to-severe primary RLS unresponsive to standard medications were randomized 1:1 to receive either active TOMAC or sham treatment for 4 weeks (stage 1), followed by 4 weeks of open-label active TOMAC for all participants (stage 2). The primary endpoint, the Clinical Global Impression of Improvement (CGI-I) responder rate, was significantly higher in the TOMAC group compared to the sham group (45% vs. 16%; difference: 28%; 95% CI: 14% to 43%; $p=.00011$). Secondary endpoints showed greater reductions in International RLS Study Group Rating Scale (IRLS) scores in the TOMAC group compared to the sham group (-7.2 vs. -3.8; $p=.00093$). No serious device-related adverse events occurred. Mild discomfort and site irritation were the most common side effects, both resolving quickly and decreasing over time. Limitations included some loss of blinding due to perceived treatment, short study duration, and lack of medication washout.

Singh et al (2024) conducted a multicenter, randomized, participant-blinded, sham-controlled clinical trial evaluating the efficacy and safety of TOMAC for treating moderate-to-severe RLS in both medication-naïve and medication-refractory adults (N=45).(8) Participants were randomized 1:1 to receive either TOMAC or sham treatment over two weeks, with self-administered 30-minute sessions during symptomatic periods. The primary outcome was the change in IRLS score, and secondary outcomes included the Patient Global Impression of Improvement (PGI-I) and sleep quality indices (MOS-I and MOS-II). TOMAC significantly reduced IRLS scores compared to sham (-6.59 vs. -2.17; $p=.004$) (mean difference = 4.42; 95% CI: 1.57 to 7.26; $p=.0040$), with similar effect sizes in both medication-naïve and refractory subgroups. PGI-I responder rates were notably higher in the TOMAC group (36% vs. 4%; $p=.0073$). The device was well tolerated, with no serious adverse events; mild discomfort and site irritation were the most common issues. Limitations included the short treatment duration and underpowered sample.

Buchfuhrer et al (2021) conducted a randomized, participant-blinded, crossover trial investigating the efficacy and safety of TOMAC as a treatment for moderate-to-severe RLS (N=43).(9) Participants self-administered both TOMAC and sham treatments nightly for 14 days each, in randomized order. The TOMAC device delivered 30-minute electrical stimulation sessions to the common peroneal nerve via wearable units. The primary outcome was change in the IRLS, with secondary outcomes including the CGI-I scale and numerical rating scales (NRS) for symptom severity. TOMAC significantly reduced IRLS scores by 6.81 points versus 3.38 for sham ($p<.01$) and yielded a 66% CGI-I responder rate compared to 17% for sham ($p<.01$). No moderate or serious device-related adverse events were reported; mild events included transient discomfort and skin irritation. Limitations included potential unblinding due to paresthesia, short treatment duration, and underpowered sample.

A summary of study characteristics and key results are presented in Tables 1 and 2. Study relevance and design and conduct limitations are summarized in Table 3 and 4.

Table1. Summary of Key Randomized Controlled Trials Characteristics

Study; Trial	Countries	Sites	Dates	Participants	Interventions	
Bogan (2023) ⁷ ; RESTFUL Study	US	7	2021-2022	Individuals with medication-refractory moderate-to-severe primary RLS	TOMAC N=68	Sham N=65
Singh (2024) ⁸ ,	US	3	2022-2023	Adults with primary moderate-to-severe RLS	N=22 (medication-refractory, n=12; medication-naive, n=10)	N=23 (medication-refractory, n=13; medication-naive, n=10)
Buchfuhrer (2021) ⁹ ,	US	3	NR	Adults with moderate-to-severe primary RLS (IRLS ≥ 15)	N=21	N=18

IRLS: International Restless Legs Syndrome Score; NR: not reported; RLS: restless legs syndrome; TOMAC: tonic motor activation.

Table 2. Summary of Key Randomized Controlled Trials Results

Study	IRLS Score Change	CGI-I/PGI-I, %
Bogan (2023) ⁷ ; RESTFUL Study		
TOMAC (N=68)	-7.2	45
Sham (N=65)	-3.8	16
p-value	.00093	.00011
Singh (2024) ⁸ .		
TOMAC (N=22)	-6.59	36
Sham (N=23)	-2.17	4
p-value	.004	.0073
Buchfuhrer (2021) ⁹ .		
TOMAC (N=21)	-6.81	66
Sham (N=18)	-3.38	17
p-value	<.01	<.01

CGI-I: Clinician Global Impression of Improvement; IRLS: International Restless Legs Syndrome Score; PGI-I: Patient Global Impression of Improvement.

Table 3. Study Relevance Limitations

Study	Population ^a	Intervention ^b	Comparator ^c	Outcomes ^d	Duration of Follow-up ^e
Bogan (2023) ⁷ ; RESTFUL Study				7. No medication washout	1. Not sufficient duration for benefit
Singh (2024) ⁸ .	3. Medication-naive patients were included				1. Not sufficient duration for benefit
Buchfuhrer (2021) ⁹ .	3. Medication-naive patients were included				1. Not sufficient duration for benefit

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 4. Study Design and Conduct Limitations

Study	Allocation ^a	Blinding ^b	Selective Reporting ^c	Data Completeness ^d	Power ^e	Statistical ^f
Bogan (2023) ⁷ ; RESTFUL Study		4. Some loss of blinding due to perceived treatment				3. Confidence intervals only reported for between group differences
Singh (2024) ⁸ .					1. Power calculations not reported	3. Confidence intervals only reported for between group differences
Buchfuhrer (2021) [Buchfuhrer MJ, Baker FC, Singh H, et al. Noninvasi.... 7(8): 1685-1694. PMID 33949942]						

CGI-I: Clinician Global Impression of Improvement; ITT: intent to treat.

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.

Nonrandomized Studies

Roy et al (2023) reported results of the 24-week open-label extension of the RESTFUL study evaluating the long-term efficacy and safety of TOMAC in adults with medication-refractory moderate-to-severe primary RLS.(10) Among 44 participants receiving TOMAC, 72.7% were CGI-I responders and 75.0% were PGI-I responders at week 24, with a mean IRLS score reduction of -11.3 points (95% CI: -8.8 to -13.9; $p<.0001$) compared to baseline. Sleep quality improved significantly (MOS-II: -17.2; MOS-I: -15.8; both $p<.0001$), and symptom frequency decreased by 46%, from 5.9 to 3.2 days/week. Compared to 59 control participants receiving standard care, TOMAC produced significantly greater improvements across all endpoints (CGI-I: 72.7% vs. 13.6%, $p<.0001$; IRLS: -11.3 vs. -5.4, $p=.0001$). Benefits partially persisted after 8 weeks of treatment cessation without rebound above baseline. Safety showed no grade ≥ 2 device-related adverse events and only mild, transient discomfort in 6.8% of participants.

Limitations included non-randomized control assignment, open-label design, and use of patient-reported outcomes.

Buchfuhrer et al (2023) conducted a prospective, open-label, single-arm clinical trial evaluating whether TOMAC could enable opioid dose reduction in patients with refractory RLS.⁽¹¹⁾ Twenty adults on ≤ 60 morphine milligram equivalents (MME)/day were enrolled, having failed an average of 3.2 prior RLS medications and maintained stable opioid therapy for an average of 5.3 years. Participants self-administered 30-minute TOMAC sessions bilaterally over the peroneal nerve during symptom onset. Opioid doses were tapered every 2–3 weeks until the CGI-I score exceeded 5. The primary endpoint, $\geq 20\%$ opioid dose reduction with CGI-I ≤ 5 , was achieved by 70% of participants (14/20), exceeding the prespecified 50% success criterion. The mean opioid dose reduction was 29.9% (SD 23.7%), from 39.0 to 26.8 MME/day. Of 15 participants who had any successful opioid dose reduction the average CGI-I score at the reduced dose was 4.0 (95% CI: 3.3 to 4.7) and the average change in IRLS score from baseline at the reduced dose was 3.4 (95% CI: 0.4 to 6.4). Adherence to TOMAC was 85%, and all adverse events were mild and non-serious. Limitations included the underpowered sample, lack of a control group, short study duration, and open-label design, which may introduce bias.

A summary of study characteristics and key results are presented in Tables 5. and 6.

Table 5. Summary of Key Nonrandomized Study Characteristics

Study	Study Type	Country	Dates	Participants	TOMAC	Follow-Up
Roy (2023) ¹⁰	Prospective, open-label extension	US	2012-2022	Individuals with medication-refractory moderate-to-severe primary RLS	N=103 (n=44, TOMAC; n=59, Control)	24 weeks
Buchfuhrer (2023) ¹¹	Prospective, open-label, single-arm	US	2021-2023	Individuals with medication-refractory primary RLS	N=20	2-3 weeks

RLS: restless legs syndrome; TOMAC: tonic motor activation

Table 6. Summary of Key Nonrandomized Study Results

Study	IRLS, Change from Baseline (95% CI)	CGI-I Responder Rate, % (95% CI)
Roy (2023) ¹⁰		
	24 Weeks	24 Weeks
TOMAC (n=44)	-11.3 (-8.8 to -13.9)	72.7 (58.2 to 83.7)
Control (n=59)	-5.4 (-3.7 to -7.2)	13.6 (7.0 to 24.5)
p-value	<.0001	<.0001
Buchfuhrer (2023) ¹¹		
	2 to 3 Weeks ^a	2 to 3 Weeks ^a
TOMAC (N=15) ^b	3.4 (0.4 to 6.4)	4.0 (3.3 to 4.7)
p-value	NR	NR

^aOutcomes reported at maximum reduced dose.

^bOutcomes reported for participants with any successful opioid reduction.

CGI-I: Clinician Global Impression of Improvement; CI: confidence interval; IRLS: International Restless Legs Syndrome Score; NR: not reported.

Systematic Reviews and Meta-Analyses

Two systematic reviews and meta-analyses have been published evaluating the efficacy and safety of TOMAC for RLS.(12,13) Winkleman et al (2025) only included 2 of the available RCTs and will not be further discussed in this review.

Mohamed et al (2025) conducted a systematic review and meta-analysis evaluating the efficacy and safety of TOMAC for moderate-to-severe RLS.(12) Three RCTs and an open-label extension study (N=320) were included, with primary outcomes being changes in International IRLS scores, PGI-I responder rates, and sleep quality indices (MOS-I, MOS-II). TOMAC significantly reduced IRLS scores compared to sham (mean difference [MD]: -3.66; 95% CI: -5.07 to -2.25; p<.00001), improved PGI-I response (risk ratio [RR]: 3.16; 95% CI: 1.35 to 7.37; p=.008), and enhanced sleep quality (MOS-I MD: -9.28; p <.00001; MOS-II MD: -10.06; p <.00001). Adverse events were more frequent with TOMAC (RR: 1.68; p=.004) but were mild and self-limiting, with no severe or device-related discontinuations. Limitations include the small number of RCTs with underpowered samples sizes, inclusion of medication-naive individuals in the overall analysis, short follow-up durations, and limited data on long-term safety.

An overview of included trials and characteristics of the systematic review and meta-analysis are summarized in Tables 7 and 8. Results of the systematic review and meta-analysis are summarized in Table 9.

Table 7. Comparison of Trials Included in Systematic Reviews and Meta-Analyses

Study	Mohamed (2025)
Singh (2024) ⁸ .	•
Bogan (2023) ⁷	•
Roy (2023) ¹⁰	•
Buchfuhrer (2021) ⁹ .	•

Table 8. Systematic Reviews and Meta-Analyses Characteristics

Study	Dates	Trials	Participants	N (Range)	Design	Duration
Mohamed (2025) ¹²	2021-2024	4	Adult with moderate-to-severe RLS	320 (39-133)	RCTs and open-label extension	2 to 24 weeks

RCT: randomized controlled trial; RLS: restless legs syndrome.

Table 9. Systematic Reviews and Meta-Analyses Results

Study	IRLS Mean Difference (Change from Baseline)	CGI-I/PGI-I Risk Ratio	MOS-I Mean Difference (Change from Baseline)	MOS-II Mean Difference (Change from Baseline)	Any AE Risk Ratio	Device-Related AE Risk Ratio	Grade 1 AE Risk Ratio
Mohamed (2025)¹²,							
Overall	N=250	N=178	N=178	N=178	N=250	N=250	N=250
Pooled effect (95% CI)	-3.66 (-5.07 to -2.25)	3.16 (1.35 to 7.37)	9.28 (-13.43 to -5.13)	-10.06 (-14.17 to -5.94)	1.68 (1.18 to 2.40)	1.90 (1.22 to 2.94)	1.7 (1.17 to 2.46)
p-value	<.00001	.004	<.00001	<.00001	.004	.004	.004

I2 (P)	0% (.83)	20% (.26)	0% (.85)	0% (.81)	0% (.96)	0% (.66)	0% (.51)
Medication Refractory	N=198	N=158					
Pooled effect (95% CI)	-4.50 (-7.57 to -1.46)	2.72 (1.58 to 4.70)					
p-value	.008	.0003					
I2 (P)	0% (.95)	0% (.64)					

AE: adverse event; CGI-I: Clinician Global Impression of Improvement; IRLS: International Restless Legs Syndrome Score; MOS: Medical Outcomes Study; PGI-I: Patient Global Impression of Improvement; RLS: restless legs syndrome.

Section Summary: Tonic Motor Activation in Individuals with Restless Legs Syndrome Refractory to Medication

The evidence includes randomized controlled trials (RCTs), nonrandomized studies, and a systematic review and meta-analysis. Relevant outcomes are changes in symptoms, functional outcomes, quality of life, and medication use. The pivotal RCT showed a higher Clinical Global Impression of Improvement (CGI-I) responder rate in the TOMAC group compared to the control group (45% vs. 16%; difference: 28%). They also showed greater reductions in International RLS Study Group Rating Scale (IRLS) scores in the TOMAC group compared to the sham group (-7.2 vs. -3.8). The meta-analysis, which includes the RCT results comparing TOMAC to sham controls, showed significantly reduced IRLS scores (mean difference: -3.66), improved Patient Global Impression of Improvement (PGI-I) response (risk ratio: 3.16), and enhanced sleep quality (MOS-I mean difference: -9.28; MOS-II mean difference: -10.06). Across studies, adverse events were mild with no serious device-related events reported. Limitations included underpowered sample sizes, short study durations, potential loss of blinding due to perceived treatment, a lack of long-term randomized data, and risk of bias from patient-reported outcomes. Sufficiently powered RCTs, with long-term follow-up to investigate safety and durability, are needed to further evaluate the net health outcomes.

Supplemental Information

PRACTICE GUIDELINES AND POSITION STATEMENTS

American Academy of Sleep Medicine

In 2025, the American Academy of Sleep Medicine (AASM) published clinical practice guidelines on the treatment of RLS and periodic limb movement disorder.⁽¹⁴⁾ The AASM gave a conditional recommendation with moderate certainty of evidence for the use of bilateral high-frequency peroneal nerve stimulation over no peroneal nerve stimulation in adults with RLS.

A conditional recommendation by AASM for peroneal nerve stimulation for RLS reflects limited and uncertain evidence variable patient response, and lack of long term or comparative effectiveness data. As such it does not establish standard of care and supports classification of this therapy as experimental/investigational and not medically necessary for routine use.

U.S. Preventive Services Task Force Recommendations

Not applicable.

Ongoing and Unpublished Clinical Trials

Some trials that might influence this review are listed in Table 10.

Table 10. Summary of Key Trials

NCT No.	Trial Name	Planned Enrollment	Completion Date
Ongoing			
NCT06076499 ^a	A Post-Market Observational Clinical Study to Determine the Long-Term Effectiveness and Safety of the Noctrix NTX100 TOMAC (Tonic Motor Activation) System for the Treatment of Restless Legs Syndrome - The THRIVE Study	325 (estimated)	Dec 2026
NCT07144631	PENS-P: Peroneal Electrical Nerve Stimulation in Pregnancy for Restless Legs Syndrome (RLS)	15 (estimated)	Oct 2026
Completed			
NCT04698343 ^a	Exploratory Study Assessing the Response of Restless Legs Syndrome (RLS) Patients to Non-invasive Peripheral Nerve Stimulation (NPNS) During Opioid Medication Reduction	21 (actual)	Mar 2023
NCT05196828 ^a	Open-label Extension Study to Evaluate Longer-Duration Response to the NTX100 Neuromodulation System for Patients With Medication-Refractory Primary Restless Legs Syndrome (RLS)	103 (actual)	Nov 2022
NCT04874155 ^a	A Multi-Center, Randomized, Double-Blind, Sham-Controlled Study to Evaluate the NTX100 Neuromodulation System for Patients With Medication-Refractory Primary Restless Legs Syndrome (RLS) - The RESTFUL Study	133 (actual)	Apr 2022
NCT04700683 ^a	Chronic Efficacy and Usability of Transcutaneous Electrical Nerve Stimulation in Subjects With Restless Leg Syndrome (RLS)	43 (actual)	Mar 2020
Unpublished			
NCT05214963 ^a	Exploratory Clinical Study to Assess Tolerability, Safety, and Response to Non-invasive Peripheral Nerve Stimulation (NPNS) in Medication-naïve and Medication-refractory Restless Legs Syndrome (RLS) Patients	58 (actual)	Oct 2023

NCT: national clinical trial.

^a Denotes industry-sponsored or cosponsored trial.

Regulatory Status

The NTX100 Tonic Motor Activation (TOMAC) System (Noctrix Health, Inc; Pleasanton, CA) received De Novo classification (DEN220059) from the FDA for its intended use "to reduce symptoms of primary moderate-severe Restless Legs Syndrome (RLS) and to improve sleep quality in adults refractory to medication." (2) Product Code: QWD

Government Regulations National/Local:

No National or Local determinations found regarding the use of devices for restless leg syndrome.

(The above Medicare information is current as of the review date for this policy. However, the coverage issues and policies maintained by the Centers for Medicare & Medicare Services [CMS, formerly HCFA] are

Related Policies

- Implantable Peripheral Nerve Stimulation and Peripheral Subcutaneous Field Stimulation Devices for the Treatment of Chronic Pain
 - Percutaneous Electrical Nerve Stimulation (PENS), Percutaneous Neuromodulation Therapy (PNT) and Restorative Neurostimulation Therapy (e.g., ReActiv8)
 - Transcutaneous Electrical Nerve Stimulation (e.g., Cefaly®, eTNS, Axon) and Transcutaneous Afferent Patterned Stimulation (e.g., Cala ONE™, Cala TRIO™, CALA kIQ,)
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The articles reviewed in this research include those obtained in an Internet based literature search for relevant medical references through 01/23/26, the date the research was completed.

Joint BCBSM/BCN Medical Policy History

Policy Effective Date	BCBSM Signature Date	BCN Signature Date	Comments
5/1/26	2/17/26		Joint policy established Vendor: N/A

Next Review Date: 1st Qtr, 2027

BLUE CARE NETWORK BENEFIT COVERAGE
POLICY: TONIC MOTOR ACTIVATION (TOMAC) FOR RESTLESS LEGS SYNDROME

I. Coverage Determination:

Commercial HMO (includes Self-Funded groups unless otherwise specified)	Not covered
BCNA (Medicare Advantage)	See government section
BCN65 (Medicare Complementary)	Coinsurance covered if primary Medicare covers the service.

II. Administrative Guidelines:

- The member's contract must be active at the time the service is rendered.
- Coverage is based on each member's certificate and is not guaranteed. Please consult the individual member's certificate for details. Additional information regarding coverage or benefits may also be obtained through customer or provider inquiry services at BCN.
- The service must be authorized by the member's PCP except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Services must be performed by a BCN-contracted provider, if available, except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Payment is based on BCN payment rules, individual certificate and certificate riders.
- Appropriate copayments will apply. Refer to certificate and applicable riders for detailed information.
- CPT - HCPCS codes are used for descriptive purposes only and are not a guarantee of coverage.
- *Duplicate (back-up) equipment is not a covered benefit.*