Spinal Cord Stimulators for Pain Management

I. Policy

University Health Alliance (UHA) will reimburse for a spinal cord stimulator for pain management when it is determined to be medically necessary and when it meets the medical criteria guidelines (subject to limitations and exclusions) indicated below.

II. Criteria/Guidelines

A. Spinal cord stimulation is covered (subject to the Limitations/Exclusions and Administrative Guidelines below) with standard or high-frequency stimulation for the treatment of severe and chronic pain of the trunk or limbs that is refractory to all other pain therapies.

B. Patient selection focuses on determining whether or not the patient is refractory to other types of treatment. All of the following criteria must be met before implantation of a temporary electrode:

1. The treatment is used only as a last resort; other applicable treatment modalities including pharmacological, surgical, psychological, and/or physical have been tried and failed or are judged to be unsuitable or contraindicated.
2. Pain is neuropathic in nature, i.e., resulting from actual damage to the peripheral nerves. Common indications include, but are not limited to, failed back syndrome, complex regional pain syndrome (i.e., reflex sympathetic dystrophy), arachnoiditis, radiculopathies, phantom limb/stump pain and peripheral neuropathy.
3. No serious untreated drug habituation exists; and
4. Patient was carefully screened, evaluated, and diagnosed by a multidisciplinary team prior to application of this therapy.
    a. Consultation notes from a psychologist and/or psychiatrist are required.

C. In addition to the above criteria, the following must be met prior to permanent implantation of the stimulator:

1. The patient demonstrates at least 50% pain relief for one week with a temporarily implanted electrode preceding permanent implantation.

NOTE:

This UHA payment policy is a guide to coverage, the need for prior authorization and other administrative directives. It is not meant to provide instruction in the practice of medicine, and it should not deter a provider from expressing his/her judgment.

Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or members' individual benefit plans may apply, and this policy is not a guarantee of payment. UHA reserves the right to apply this payment policy to all UHA companies and subsidiaries.

UHA understands that opinions about and approaches to clinical problems may vary. Questions concerning medical necessity (see Hawaii Revised Statutes §432E-1.4) are welcome. A provider may request that UHA reconsider the application of the medical necessity criteria in light of any supporting documentation.

III. Limitations/Exclusions

A. Spinal cord stimulation is not covered for all other indications including, but not limited to, the following:

1. Critical limb ischemia as a technique to forestall amputation;
2. Nociceptive pain (resulting from irritation, not damage to the nerves);
3. Central deafferentation pain (related to CNS damage from a stroke or spinal cord injury);
4. Treatment of refractory angina pectoris, heart failure, and cancer-related pain.

B. Replacement of a functioning standard dorsal column stimulator with a high-frequency dorsal column stimulator is considered not medically necessary and is not a covered benefit.

C. Wireless injectable dorsal root ganglion neurostimulation is not covered for treatment of severe and chronic pain of the trunk or limbs.

D. In addition to evaluation of the type of chronic pain and appropriateness for SCS therapy, patients should be screened for comorbidities, contraindications to the technique, and potential technical difficulty. Spinal cord stimulators are not covered when patients exhibit the following:

1. Coagulopathy
2. Systemic or local infection
3. Pacemakers
    a. For patients with cardiac pacemakers and internal cardiac defibrillators, compatibility with SCS should be established prior to spinal cord stimulator trial.
4. Inadequate or inconclusive psychological screening
5. SCS may be less effective if performed many years after the onset of chronic pain. Current data on this subject should be discussed with patient as part of the consent for procedure.
6. Spinal cord stimulators are not placed in pregnant patients. For patients with stimulators who become pregnant, options for neuraxial analgesia and anesthesia may be affected by the device. This information must be addressed as part of the consent for procedure in women of childbearing age.

E. Magnetic resonance imaging (MRI) compatibility should be confirmed, and manufacturer's recommendations should be followed for patients who undergo perioperative MRI. This information should be clearly documented in the patient medical record.

IV. Administrative Guidelines

A. Prior authorization is required before implantation of a temporary electrode **AND** before permanent implantation of the stimulator.

B. Prior authorization is required for the replacement, revision, or removal of a permanently implanted spinal neurostimulator pulse generator.

C. Replacement of a functioning standard dorsal column stimulator with a high-frequency dorsal column stimulator is considered not medically necessary and is not a covered benefit.

D. To request prior authorization, please submit via UHA's online portal. If a login has not been established, you may contact UHA at 808-532-4000 to establish one.

E. The following documentation should be included with the prior authorization request for the implantation of a temporary electrode:

1. Clinical notes related to the diagnosis and treatment of chronic neuropathic pain;
2. Documentation of all treatments tried and failed (e.g., medications, surgical notes, physical therapy notes, psychological notes, etc.);
3. Consultation notes from a psychologist and/or psychiatrist.

F. Prior Authorization is not required for required electronic analysis of a permanently implanted spinal neurostimulator pulse generator.

G. The following must be submitted before the permanent implantation of the stimulator:

1. The patient's pain log (e.g., diary) and physician clinical notes documenting a successful one week trial of a temporarily implanted electrode.

CPT Code	Description
63650	Percutaneous implantation of neurostimulator electrode array, epidural
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural
63661	Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed
63662	Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed
63663	Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed
63664	Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling
63688	Revision or removal of implanted spinal neurostimulator pulse generator or receive
95970	Electronic analysis of implanted neurostimulator pulse generator/transmitter (e.g., contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without programming
95971	Electronic analysis of implanted neurostimulator pulse generator/transmitter (e.g., contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple spinal cord or peripheral nerve (e.g., sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional
95972	Electronic analysis of implanted neurostimulator pulse generator/transmitter (e.g., contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with complex spinal cord or peripheral nerve (e.g., sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional

HCPCS Code	Description
C1767	Generator, neurostimulator (implantable), nonchargeable
C1778	Lead, neurostimulator (implantable)
C1787	Patient programmer, neurostimulator
C1820	Generator, neurostimulator (implantable), with rechargeable battery and charging system
C1822	Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system

C1883	Adaptor/extension, pacing lead or neurostimulator lead (implantable)
C1897	Lead, neurostimulator test kit (implantable)
L8679	Implantable neurostimulator, pulse generator, any type
L8680	Implantable neurostimulator electrode, each
L8685	Implantable neurostimulator pulse generator, single array, rechargeable, includes extension
L8686	Implantable neurostimulator pulse generator, single array, non-rechargeable, includes extension
L8687	Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension
L8688	Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension

V. Policy History

Policy Number: MPP-0069-120301

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PAP Approved Date: 03/01/2012

References: HMSA Medical Payment Policy (prevailing plan) **Policy Number:** MM.06.013