Important note

Even though this policy may indicate that a particular service or supply may be considered covered, this conclusion is not based upon the terms of your particular benefit plan. Each benefit plan contains its own specific provisions for coverage and exclusions. Not all benefits that are determined to be medically necessary will be covered benefits under the terms of your benefit plan. You need to consult the Evidence of Coverage to determine if there are any exclusions or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and your plan of benefits, the provisions of your benefits plan will govern. However, applicable state mandates will take precedence with respect to fully insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, Federal mandates will apply to all plans. With respect to Senior Care members, this policy will apply unless Medicare policies extend coverage beyond this Medical Policy & Criteria Statement. Senior Care policies will only apply to benefits paid for under Medicare rules, and not to any other health benefit plan benefits. CMS's Coverage Issues Manual can be found on the CMS website.

SERVICE: Spinal Cord Stimulators

PRIOR AUTHORIZATION: Required.

POLICY: SWHP may consider a trial of percutaneous spinal cord stimulation medically necessary for the treatment of chronic neuropathic pain due to one of the following conditions:

- Chronic pain caused by lumbosacral arachnoiditis that has not responded to medical management including physical therapy.
  - Presence of arachnoiditis is usually documented by presence of high levels of proteins in the CSF and/or by myelography or MRI.
- Intractable pain caused by nerve root injuries, post-surgical or post-traumatic including that of post-laminectomy syndrome (failed back syndrome).
- Intractable pain caused by complex regional pain syndrome I & II.
- Intractable pain caused by phantom limb syndrome that has not responded to medical management.
- Intractable pain caused by end-stage peripheral vascular disease, when the patient cannot undergo revascularization or when revascularization has failed to relieve painful symptoms and the pain has not responded to medical management.
- Intractable pain due to diabetic peripheral neuropathy (DPN) that has not responded to standard non-surgical therapies
- Intractable pain caused by plexopathy.
- Intractable pain caused by intercostal neuralgia that did not respond to medical management and nerve blocks.
- Intractable pain caused by cauda equina injury.
- Intractable pain caused by incomplete spinal cord injury.

AND when ALL of the following criteria have been met:

- The implantation of the stimulator is used only as a late/last resort for patients with chronic intractable pain.
- Other treatment modalities (pharmacological, surgical, physical or psychological therapies) have been tried and did not prove satisfactory or are judged unsuitable or contraindicated for the given patient.
• Failure of ≥ 6 consecutive months of physician-supervised conservative medical management (e.g., pharmacotherapy, physical therapy, cognitive therapy, and activity lifestyle modification).
• An evaluation by a mental health provider (e.g., a face-to-face assessment with or without psychological questionnaires and/or psychological testing) reveals no evidence of an inadequately controlled mental health problem (e.g., alcohol or drug dependence, depression, psychosis) that would negatively impact the success of an SCS or contraindicate its placement.
• All facilities, equipment and personnel required for the proper diagnosis, treatment, training and follow-up of the patient must be available.
• Demonstration of pain relief during a trial of percutaneous spinal cord stimulation.

Following a trial of percutaneous spinal cord stimulation SWHP may consider implantation of a permanent subcutaneous spinal cord stimulator medically necessary if the patient met the criteria above and experienced pain relief during a trial of percutaneous spinal cord stimulation.

SWHP may consider the use of implantable spinal cord stimulator for pain which is related to occupational or recreational activities other than those associated with activities of daily living not medically unnecessary.

OVERVIEW:
Spinal cord stimulation, also known as dorsal column stimulation, is a reversible therapy applied for neuropathic pain with techniques that include multi-output implanted pulse generators and a choice of electrodes, some of which can be placed percutaneously. The technical goal of this therapy is to achieve stimulation of paresthesia of spinal nerve root(s) at a subjectively comfortable level, overlapping a patient’s topography of pain. The procedure initially involves a trial of three to seven (3-7) days of percutaneous spinal cord stimulation, prior to the subcutaneous implantation of the spinal cord stimulation device, to determine whether the spinal cord stimulator device will provide sufficient pain relief to justify permanent placement.

MANDATES: None

CODES: None

Important note:
CODES: Due to the wide range of applicable diagnosis codes and potential changes to codes, an inclusive list may not be presented, but the following codes may apply. Inclusion of a code in this section does not guarantee that it will be reimbursed, and patient must meet the criteria set forth in the policy language.

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>63650</td>
<td>Percutaneous implantation of neurostimulator electrode array, epidural</td>
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<tr>
<td>63655</td>
<td>Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural</td>
</tr>
<tr>
<td>63661</td>
<td>Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed</td>
</tr>
<tr>
<td>63662</td>
<td>Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed</td>
</tr>
<tr>
<td>63663</td>
<td>Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array</td>
</tr>
<tr>
<td>63664</td>
<td>Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy</td>
</tr>
<tr>
<td>63685</td>
<td>Insertion or replacement of spinal neurostimulator pulse generator or</td>
</tr>
</tbody>
</table>
MEDICAL COVERAGE POLICY

SERVICE: Spinal Cord Stimulators

Policy Number: 078
Effective Date: 07/01/2018
Last Review: 04/24/2018
Next Review Date: 04/24/2019

CPT Not Covered:

- L8681 - Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only
- L8682 - Implantable neurostimulator radiofrequency receiver
- L8683 - Radiofrequency transmitter (external) for use with implantable neurostimulator
- L8685 - Implantable neurostimulator pulse generator, single array
- L8686 - Implantable neurostimulator pulse generator, single array
- L8687 - Implantable neurostimulator pulse generator, dual array
- L8688 - Implantable neurostimulator pulse generator, dual array
- L8689 - External recharging system
- L8695 - External recharging system for battery

ICD10 codes:

- G90.511 – complex regional pain syndrome I of right upper limb
- G90.512 – complex regional pain syndrome I of left upper limb
- G90.513 – complex regional pain syndrome I of both upper limbs
- G90.519 – complex regional pain syndrome I of unspecified upper limb
- G90.521 – complex regional pain syndrome I of right lower limb
- G90.522 – complex regional pain syndrome I of left lower limb
- G90.523 – complex regional pain syndrome I of both lower limbs
- G90.529 – complex regional pain syndrome I of unspecified lower limb
- M96.1 – Postlaminectomy syndrome, not elsewhere classified
- M96.1 – Failed back syndrome
- E10.4x – Type 1 diabetes mellitus with neurological complications
- E11.4x – Type 2 diabetes mellitus with neurological complications

CMS: National Coverage Determination (NCD) for Electrical Nerve Stimulators (160.7) effective August 7, 1995: “… the implantation of dorsal column (spinal cord) neurostimulators may be covered as therapy for the relief of chronic intractable pain, subject to the following conditions:

- Implantation of the stimulator is used only as a late resort (if not a last resort) for patients with chronic intractable pain;
- Other treatment modalities (pharmacological, surgical, physical, or psychological therapies) have been tried and did not prove satisfactory, or are judged to be unsuitable or contraindicated;
- Patients have undergone careful screening, evaluation, and diagnosis by a multidisciplinary team prior to implantation (must include psychological, as well as physical, evaluation);
- All of the facilities, equipment, and professional and support personnel required for the proper diagnosis, treatment training, and follow-up of the patient must be available; and
- Demonstration of pain relief with a temporarily implanted electrode precedes permanent implantation.”


POLICY HISTORY:

<table>
<thead>
<tr>
<th>Status</th>
<th>Date</th>
<th>Action</th>
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<tbody>
<tr>
<td>New</td>
<td>12/6/2010</td>
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<tr>
<td>Reviewed</td>
<td>8/2/2012</td>
<td>Reviewed.</td>
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<td>Reviewed</td>
<td>4/25/2013</td>
<td>No changes</td>
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<tr>
<td>Reviewed</td>
<td>4/24/2014</td>
<td>No significant changes</td>
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</table>
MEDICAL COVERAGE POLICY

SERVICE: Spinal Cord Stimulators

Policy Number: 078
Effective Date: 07/01/2018
Last Review: 04/24/2018
Next Review Date: 04/24/2019

Reviewed 4/30/2015  Minimal changes
Reviewed 6/25/2015  Updated policy to reflect LCD changes. No reduction in coverage
Reviewed 7/07/2016  Updated codes
Reviewed 06/13/2017  Criteria expanded, codes added. CMS NCD added.
Reviewed 04/24/2018  No changes.

REFERENCES:


