Spinal cord and implanted peripheral nerve stimulation

These services may or may not be covered by your HealthPartners plan. Please see your plan documents for your specific coverage information. If there is a difference between this general information and your plan documents, your plan documents will be used to determine your coverage.

Administrative Process

Prior authorization is required for the trial insertion permanent placement, or replacement of a spinal cord stimulator.

Prior authorization is required for both the trial insertion and permanent placement when request is for the following non-covered indications.

- Dorsal root ganglion stimulator
- Peripheral nerve stimulator and peripheral nerve field stimulator
- Occipital nerve stimulator

Prior authorization is not required for removal of a spinal cord stimulator.

Coverage

Spinal cord stimulation to treat intractable chronic neuropathic pain that is refractory to other treatment modalities (specific service) is generally covered subject to the indications listed below and per your plan documents.

The member is to be offered patient decision support. The following are recommendations for a robust informed consent discussion between physician and patient:

1. Provide information about treatment options and their probabilities for success in sufficient detail for decision making.
2. Present probabilities of outcomes in an unbiased and understandable way.
3. Include methods for clarifying and expressing patients’ values

Indications that are covered

Criteria for a trial insertion
A temporary spinal cord stimulator is covered to treat intractable chronic neuropathic pain when all of the following criteria are met

1. The pain is a result of one of the following:
   A. Failed back surgery syndrome with intractable radicular pain refractory to medical management; or
   B. Complex regional pain syndrome, including upper or lower extremity pain; or
   C. Diabetic peripheral neuropathy (DPN).
2. Documentation submitted by the operating physician demonstrates compliance with all of the following criteria:
   A. The treatment is recommended after all other patient-appropriate therapies have been tried and proven ineffective, including but not limited to pharmacological management, injection therapies, physical therapy, surgery and psychological treatment if indicated.
   B. Preoperative psychiatric/psychological evaluation conducted by a licensed psychiatrist, psychologist or other licensed mental health professional who has a working knowledge of the psychological issues involved in chronic pain syndromes. The goals of this assessment are to rule out major psychiatric comorbidities or major substance abuse issues that would be strong predictors of poor outcomes and to select motivated patients who would be more likely to adhere to a follow-up plan.

Criteria for Permanent Placement

1. All of the criteria listed above for trial insertion, and
2. A trial insertion of a minimum of three days (preceding permanent implantation) leads to ≥50% pain relief and improvement in function.

Replacement of spinal cord stimulator
The replacement of an existing spinal cord stimulator is considered medically necessary for an individual when the existing stimulator and or battery/generator is no longer under warranty and cannot be repaired.
**Indications that are not covered**

1. Use of spinal cord stimulation (SCS) is considered experimental and investigational for the following conditions, including but not limited to:
   A. Chronic pain from malignancy (cancer);
   B. Other chronic non-malignant pain, including but not limited to cephalgia, headache, inguinal pain, intercostal neuralgia, occipital neuralgia, phantom limb syndrome, post-herpetic neuralgia and trigeminal neuralgia;
   C. Spasticity disorders.
   D. For cervical SCS: cervical trauma, disc herniation, or failed cervical spine surgery syndrome, presenting with arm pain, neck pain or cervicogenic headache;
   E. Any conditions not listed as covered.

2. Dorsal root ganglion (DRG) stimulation is considered experimental and investigational because its efficacy and safety have not been established.

3. Peripheral nerve stimulation (PNS) including peripheral nerve field stimulation (PNFS) (64999) is considered experimental and investigational because its efficacy and safety have not been established.

4. Occipital nerve stimulation is considered experimental and investigational because its efficacy and safety have not been established.

**Definitions**

**Dorsal root ganglion (DRG) stimulation** is a modified SCS technique that specifically targets the spinal cord’s afferent sensory neurons.

**Occipital nerve stimulation (ONS)** also called peripheral nerve stimulation (PNS) of the occipital nerves, is used to treat intractable chronic migraine patients. The treatment involves the use of mild electrical impulses to stimulate the greater occipital nerve and lesser occipital nerve which are part of the peripheral nervous system and are located at the back of the head just above the neck area.

**Peripheral nerve (PNS) and peripheral field stimulation (PNFS)** is a type of neuromodulation, which is a surgical procedure that implants electrodes in the body to change how the nervous system works. Peripheral nerve and field stimulation involves placing the electrodes directly on nerves or under the skin in the region of pain. It is a minimally invasive procedure, requiring a small incision over the targeted area. Peripheral nerve and field stimulation is different from spinal cord stimulation because it places the stimulating device directly over the nerve at the targeted pain area, not on the spinal cord where the nerve originates.

**Spinal Cord Stimulation (SCS)** also known as a dorsal column stimulator involves electrical stimulation of spinal nerves using electrodes implanted in the epidural space of the spinal column. The goal of SCS is to suppress pain in specific areas for patients with a variety of chronic pain disorders, including chronic, refractory, neuropathic pain.

**Codes**

*If available, codes are listed below for informational purposes only, and do not guarantee member coverage or provider reimbursement. The list may not be all-inclusive.*

<table>
<thead>
<tr>
<th>Codes</th>
<th>Description</th>
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<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(s), including fluoroscopy, when performed</td>
</tr>
<tr>
<td>63664</td>
<td>Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed</td>
</tr>
<tr>
<td>63685</td>
<td>Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling</td>
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<tr>
<td>63688</td>
<td>Revision or removal of implanted spinal neurostimulator pulse generator or receiver</td>
</tr>
<tr>
<td>64555</td>
<td>Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)</td>
</tr>
<tr>
<td>64575</td>
<td>Incision for implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)</td>
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References

1. Abdi, S. Complex regional pain syndrome in adults: Prevention and management In:UpToDate, Rosenquist, E (Ed), UpToDate, Waltham, MA. (Accessed on December 7, 2017)

Products

This information is for most, but not all, HealthPartners plans. Please read your plan documents to see if your plan has limits or will not cover some items. If there is a difference between this general information and your plan documents, your plan documents will be used to determine your coverage. These coverage criteria may not apply to Medicare Products if Medicare requires different coverage. For more information regarding Medicare coverage criteria or for a copy of a Medicare coverage policy, contact Member Services at 952-883-7979 or 1-800-233-9645.
